NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 7 December 2021, Newton Suite, Forest Pines, Ermine Street, Broughton, DN20 0AQ
Time – 9.00 am – 12.30 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 & Nicola Crook, Highly Specialist Speech & Language Therapist	Note	09:00 hrs	Verbal
2.	**Business Items**			
2.1	**Chair's Opening Remarks** Linda Jackson, Acting Chair	Note	09:10 hrs	Verbal
2.2	**Apologies for Absence** Linda Jackson, Acting Chair	Note		Verbal
2.3	**Declarations of Interest** Linda Jackson, Acting Chair	Note		Verbal
	2.3.1 Update Register of Directors' Interests Linda Jackson, Acting Chair	Approve		NLG(21)246
2.4	**To approve the minutes of the previous Public meeting held on Tuesday, 5 October 2021** Linda Jackson, Acting Chair	Approve		NLG(21)247 Attached
2.5	**Urgent Matters Arising** Linda Jackson, Acting Chair	Note		Verbal
	2.5.1 Mortuary and Body Store Assurance – Trust Board response to NHS England / Improvement Mick Chomyn, Associate Director of Pathology	Note		NLG(21)248 Attached
2.6	**Trust Board Action Log - Public** Linda Jackson, Acting Chair	Note		NLG(21)249 Attached
2.7	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note	09:30 hrs	NLG(21)250 Attached
2.8	**Integrated Performance Report (IPR)**	Note		NLG(21)251 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Executive Report – Quality & Safety** Dr Kate Wood, Medical Director & Jenny Hinchliffe, Deputy Chief Nurse	Note	09:40 hrs	NLG(21)252 Attached

3.2	**Quality & Safety Committee Highlight Report and Board Challenge** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	Note	09:45 hrs	NLG(21)253 Attached
3.3	**Quality Improvement Strategy** Paul Holmes, Quality Improvement Academy Manager	Approve	09:50 hrs	NLG(21)254 Attached
3.4	**Establishment Reviews** Jenny Hinchliffe, Deputy Chief Nurse	Note	09:55 hrs	NLG(21)255 Attached
3.5	**Executive Report – Performance** Ab Abdi, Deputy Chief Operating Officer	Note	10:25 hrs	NLG(21)256 Attached
3.6	**Finance & Performance Committee Highlight Report and Board Challenge – Performance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	10:30 hrs	NLG(21)257 Attached
BREAK – 10:35 hrs – 10:50 hrs				
4.	**Strategic Objective 2 – To Be a Good Employer**			
4.1	**Executive Report – Workforce** Christine Brereton, Director of People	Note	10:50 hrs	NLG(21)259 Attached
4.2	**Workforce Committee Highlight Report and Board Challenge** Michael Whitworth, Non-Executive Director & Chair of the Workforce Committee	Note	10:55 hrs	NLG(21)260 Attached
4.3	**Freedom to Speak Up Guardian (FTSUG) - Quarter 2** Liz Houchin, FTSUG	Note	11:00 hrs	NLG(21)261 Attached
4.4	**Overview on NHSE/I Future of HR and OD Development Report** Christine Brereton, Director of People	Note	11:10 hrs	NLG(21)262 Attached
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Executive Report – Finance – Month 07 (including Financial Special Measures & H2 Planning)** Lee Bond, Chief Financial Officer	Note	11:20 hrs	NLG(21)263 Attached
5.2	**Finance & Performance Committee Highlight Report & Board Challenge – Finance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:30 hrs	NLG(21)264 Attached
5.3	**Emergency Care Centre Update and Ambulance Handovers** Ab Abdi, Deputy Chief Operating Officer	Note	11:35 hrs	NLG(21)265 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Executive Report – Strategic & Transformation** Ivan McConnell, Director of Strategic Development	Note	11:45 hrs	NLG(21)266 Attached
6.2	**Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – 2021** Gill Ponder, Non-Executive Director	Note	11:50 hrs	NLG(21)267 Attached
6.3	**Humber Acute Services Development Committee Highlight Report & Board Challenge –2021** Linda Jackson, Acting Chair	Note	11:55 hrs	NLG(21)268 Attached

6.4	**Strategic Development Committee Highlight Report & Board Challenge** Linda Jackson, Acting Chair	Note	12:00 hrs	NLG(21)269 Attached
7.	**Strategic Objective 5 – To Provide Good Leadership**			
	None			
8.	**Governance**			
8.1	**Audit Risk & Governance Committee Highlight Report & Board Challenge** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	Note	12:05 hrs	NLG(21)270 Attached
8.2	**Board Assurance Framework - Quarter 2** Helen Harris, Director of Corporate Governance	Note	12:10 hrs	NLG(21)271 Attached
9.	**Approval (Other)**			
	None			
10.	**Items for Information / To Note (please refer to Appendix A)** Linda Jackson, Acting Chair	Note	12:20 hrs	
11.	**Any Other Urgent Business** Linda Jackson, Acting Chair	Note		Verbal
12.	**Questions from the Public**	Note		Verbal
13.	**Date and Time of Next meeting** **Public & Private Meeting** Tuesday, 1 February 2022, Time TBC **Board Development** Tuesday, 1 March 2022, Time TBC	Note		Verbal

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

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

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

APPENDIX A

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

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

10.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
10.1	**Finance & Performance Committee Minutes – August & September 2021** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(21)272 Attached
	Quality & Safety Committee	
10.2	**Quality & Safety Committee Minutes – September & October 2021** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(21)273 Attached
~~**10.3**~~	~~**Patient Experience Report (incorporating Annual Inpatient Survey Result and Action Plan)**~~ ~~Ellie Monkhouse, Chief Nurse~~	~~NLG(21)275~~
10.4	**Guardian of Safe Working Hours – Quarter 2** Dr Liz Evans, Guardian of Safe Working Hours	NLG(21)276 Attached
	Workforce Committee	
10.5	**Workforce Committee Minutes – September 2021** Michael Withworth, Non-Executive Director & Chair of the Workforce Committee	NLG(21)277 Attached
	Audit, Risk & Governance Committee	
10.6	**Audit, Risk & Governance Committee Minutes – July & August 2021** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(21)278 Attached
	Health Tree Foundation Trustees' Committee	
10.7	Health Tree Foundation Trustees' Committee Minutes – July, September & October 2021 Neil Gammon, Chair of the Health Tree Foundation Trustees' Committee	NLG(21)279 Attached
	Other	
10.8	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(21)280 Attached
10.9	**Timetable of Board & Sub-Committee Meetings** Helen Harris, Director of Corporate Governance	NLG(21)281 Attached
10.10	**Documents Signed Under Seal** Helen Harris, Director of Corporate Governance	NLG(21)282 Attached

NHS
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NLG(21) 246

DATE OF MEETING	7th December 2021
REPORT FOR	Trust Board of Directors – Public Meeting
REPORT FROM	Helen Harris, Director of Corporate Governance
CONTACT OFFICER	Alison Hurley, Assistant Director of Corporate Governance
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 December 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)	n/a

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

REGISTER OF DIRECTORS' INTERESTS
Updated as at December 2021 (v3)

NAME & POSITION	INTERESTS	DATE
Linda Jackson, Acting Chair & Non-Executive Director	➢ Associate NED at Hull University Teaching Hospitals NHS Trust ➢ Both Sister and Sister-in-law works at DPoW (in Women's and Children division)	06.10.2021
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 ➢ Co-Chair Disabled NHS Directors Network	06.10.2021
Lee Bond, Chief Financial Officer	➢ Chief Finance Officer and Deputy Chief Executive Officer at Hull University Teaching Hospitals ➢ Trustee of WISHH Charity ➢ Vice President, Healthcare Financial Management Association (HFMA)	01.12.2021
Ellie Monkhouse, Chief Nurse	➢ Husband is foot and ankle Consultant Orthopedic Surgeon at Leeds Teaching Hospitals ➢ Husband is a Yorkshire and Humber Regional Consultants and Specialists Committee Member	14.05.2021
Shaun Stacey, Chief Operating Officer	➢ None	06.10.2021
Dr Kate Wood, Medical Director	➢ Husband is Trust employee (Theatre Manager, DPoWH)	18.08.2021
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	07.10.2021
Helen Harris, Director of Corporate Governance	➢ Member of Patient Participation Group, central Surgery, Barton-upon-Humber (NLCCG)	11.10.2021
Jug Johal, Director of Estates & Facilities (non-voting director)	➢ Chairman, Asian Sports Foundation	06.10.2021
Ivan McConnell, Director Of Strategic Development (non-voting director)	➢ None	11.10.2021
Shauna McMahon, Chief Information Officer	➢ I am on an Exam Writing group to add UK content to the Certified Health CIO credential.	08.10.2021

NAME & POSITION	INTERESTS	DATE
Stuart Hall, Associate Non-Executive Director	➢ Non –Executive/Vice Chair, Hull University Teaching Hospitals NHS Trust	06.10.2021
Fiona Osbourne, Non-Executive Director	➢ Parish Councilor for Leverton Parish Council, Lincolnshire	10.09.2021
Simon Parkes, Non-Executive Director	➢ Director of Lincoln Science and Innovation Park (Unremunerated)	12.08.2021
Gillian Ponder, Senior Independent Director, Interim Deputy Chair and Non-Executive Director	➢ Employed by Openreach Ltd in role responsible for large scale recruitment, supply chain and logistics ➢	07.10.2021
Michael Proctor, Non-Executive Director	➢ Non-Executive Chair of Conclusio (Health Care Consultancy).	25.08.2021
Maneesh Singh, Associate Non-Executive Director	➢ None	28.10.2021
Michael Whitworth, Non-Executive Director	➢ Interim Chief Executive Officer of Barnet Federated GPs (part-time) ➢ Owner/Director of Michael Whitworth Consultancy Ltd	18.08.2021
Ade Beddow, Associate Director of Communications	➢ None	20.10.2021

NLG(21)247

NHS
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Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 5 October 2021 at 9.00 am
The Sands Venue, Glanford Park, Scunthorpe

For the purpose of transacting the business set out below:

Present:

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

In Attendance:

Adrian Beddow	Associate Director of Communications
Lynn Benefer	Deputy Head of Safeguarding (for item 3.8)
Christine Brereton	Director of People
Elaine Criddle	Deputy Improvement Director
Stuart Hall	Associate Non-Executive Director
Helen Harris	Director of Corporate Governance
Jug Johal	Director of Estates & Facilities
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Maurice Madeo	Assistant Chief Nurse / Deputy Director of Infection Prevention & Control (for item 3.7)
Fiona Osborne	Associate Non-Executive Director
Melanie Sharp	Deputy Chief Nurse (for item 1)
Brian Shipley	Deputy Director of Finance (for item 5.1 & 5.5)
Maneesh Singh	Associate Non-Executive Director
Becky Southall	Quality Governance Lead, NHSE/I
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Trust Secretary (note taker)

Linda Jackson welcomed everyone to the meeting and declared it open at 9.00 am.

1. Patients' Story and Reflection

Melanie Sharpe presented the patient story "Chloe", this was a patient who had deteriorated quickly following a caesarean section at 33 weeks due to contracting COVID-19.

Melanie Sharpe advised Chloe had been very positive about the care received from the Neonatal Intensive Care Unit (NICU) and Intensive Care Unit (ICU), however, when asked what could be improved Chloe advised the communication could have been better. The team had therefore looked at ways they could improve on communication to patients and families.

The team was also aware there was an issue with discharge planning and this had been heavily considered in the Nursing, Midwifery & AHP Strategy. The issues regarding managing expectations had been discussed and the story had been shared with Jane Warner to discuss with the teams.

Ellie Monkhouse felt this was a good reflection on the experience some mums had had with childbirth during COVID-19. This had been a very testing time psychologically in respect of how poorly some mums had been. Linda Jackson recognised the feedback on how Chloe had been cared for which had been positive. Maneesh Singh wanted to highlight the decisions made by clinical staff on the delivery of babies early as some hospitals had delayed delivery and this had affected some patients. It was asked for the comments to be fed back to the teams.

2. Business Items

2.1 Chair's Opening Remarks

Linda Jackson welcomed everyone to the meeting and declared it open at 9.00 am. Both Linda Jackson and Dr Peter Reading had discussed holding board meetings until March 2022 in person and asked for agreement from the board to put this in place. Due to social distancing the meetings would be need to be held off site. This decision would of course be reconsidered should anything change with the pandemic. Board members agreed to this decision.

2.2 Apologies for Absence

Apologies for absence were received from Lee Bond. Brian Shipley would be in attendance and provide the Finance updates.

2.3 Declarations of Interest

No declarations of interests were received.

2.4 To approve the minutes of the Public Meeting held on Tuesday, 3 August 2021 – NLG(21)194

The minutes of the meeting held on the 3 August 2021 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made.

- Dr Kate Wood referred to item 2.4 in respect of the changes made to the minutes of the meeting held on the 1 June 2021. A request was made for the updated minutes to be uploaded to the meeting site on sharepoint.
- Ellie Monkhouse referred to page 9, item 5.2, second paragraph and requested the wording to be changed from "quality improvement assurance" to Quality Impact Assessment.

Dr Kate Wood wanted to update the Trust Board in respect of the change in title to Chief Medical Officer, referred to at item 11 on page 13. This had not been put in place as yet due to other changes that were required first.

2.5 Urgent Matters Arising

Linda Jackson 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)195

Linda Jackson 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)196

Dr Peter Reading advised the report shared included the Trust Priorities. The main headlines for the Trust had been included within the report. A summary of the current position with the development of the Humber Coast & Vale (HCV) and Care Partnerships was also included within the report. An announcement was expected within the next few days on who had been appointed as the Integrated Care System (ICS) Chair and Chief Executive Officer (CEO). The CEO appointment also required parliamentary approval. Developments in respect of Place had also created new demands on the Executive teams and Senior Managers at the Trust.

Linda Jackson queried whether it would be beneficial to revisit the stakeholder map. Linda Jackson and Stuart Hall had been involved in the Joint Chair recruitment and felt this would be useful in providing information to enable the vision of the external agenda as well as the internal one. Dr Peter Reading agreed this would be useful once all appointments had been made in the ICS.

Linda Jackson referred to the Quality Improvement (QI) section within the report and asked if there was any further update. Ellie Monkhouse advised the Trust had developed good foundations and there were some projects that had been undertaken in respect of this which had been positive. The first QI council had also taken place which would also build on improvements.

2.8 Integrated Performance Report (IPR) – NLG(21)197

Helen Harris advised the IPR was for noting at the meeting.

3. Strategic Objective 1 – To Give Great Care

3.1 Executive Report – Quality & Safety - NLG(21)198

Dr Kate Wood referred to information within the IPR in respect of Venous Thromboembolism (VTE). The Trust had previously been an outlier for the way it was reported and treated. Changes had been put in place to resolve issues and Dr Kate Wood was pleased to report that the Electronic Prescribing & Medicines Administration (EPMA) solution was now live and had been for two weeks. This would mean that when a patient was admitted to hospital and the EPMA was commenced the first screening they would receive was the VTE status. This would improve compliance for the Trust and the care of patients. The information for this would not be reflected in the IPR until December 2021.

A “Never Event” had been reported in respect of the wrong patient being given an angiogram. A Serious Incident (SI) Review meeting had been held the previous day to discuss the incident. It was reported the patient was well and duty of candour was in place.

Ellie Monkhouse advised the pressure with staffing had increased due to staff isolating and sickness. The establishment review for staff had now been completed and would be shared at the next board meeting.

Dr Peter Reading referred to the report and was pleased it highlighted to the board the issue of no changing and toilet facilities at the Scunthorpe site as this was a legal requirement. A further point of concern included in the report was in respect of the lack of funding to continue with an Acute Learning Disability Liaison Nurse at Scunthorpe. Acute Trusts required them otherwise it could impact on patient care. This post would be given prioritisation in business plans for next year. Ellie Monkhouse advised this had been included in the business plan previously and had been funded temporarily through COVID funds.

Jug Johal referred to the issue with the changing rooms facility and advised this was NLAG’s number one bid, if this did not make the requirements it would be funded through the capital programme next year. Shaun Stacey referred back to the Acute Learning Disability Nurse role and advised this had been reviewed that week, agreement had been made that this was a must do. A conclusion for this would be shared before business planning.

Stuart Hall referred to the safeguarding points on the report in respect of the increased attendance at Accident & Emergency (A&E) of children with mental health concerns. It was felt the mitigation did not explain fully what the next steps would be to resolve the issue. Ellie Monkhouse advised NHS England / Improvement (NHSE/I) were fully aware of the issues around this and it was also included within the Operating Framework. Dr Peter Reading advised this had unfortunately been a consequence of lockdown and the referrals to Community Child & Adolescent Mental Health Service (CAMHS) that had gone up incredibly

fast. The Government were aware of this but was struggling to recruit staff to this area. This had then impacted on ECC attendances which included inpatient admissions. Ellie Monkhouse advised this issue was included on the risk register.

Fiona Osborne referred to the safe staffing review and queried whether this would be shared with a baseline for nurse staffing or whether a different approach would be taken. Ellie Monkhouse advised conversations had taken place as to whether the Trust should over recruit by 10% or to continue with a full establishment for staffing.

3.2 Quality & Safety Committee Highlight Report and Board Challenge – NLG(21)199

Mike Proctor wanted to highlight concern in respect of staffing issues, the overcrowding issues in A&E which could impact on quality and safety issues and the team were doing all they could to address any issues. There were also significant changes with legislation in respect of safeguarding.

3.3 Quality & Safety Committee Self-Assessment – NLG(21)200:

- **Committee Effectiveness Reviews**
- **Terms of Reference**
- **Workplans**

Mike Proctor advised changes had been made to the Terms of Reference of the Quality & Safety Committee (Q&SC) to ensure they aligned with other committees. The Self-Assessment had also been shared for information with the paper. A request was made for an attendance matrix to be included at the bottom of sub-committee minutes. It was agreed all Chairs of sub-committees would ensure this was put in place.

Jug Johal referred to the overcrowding issue in A&E. The Infection Prevention Control (IPC) team had reviewed capacity and this had now been increased. In terms of the queuing outside of A&E, a canopy had been installed along the side of the Diana, Princess of Wales Hospital (DPOWH) building to protect patients who had to queue. Heating had also been installed under the canopy. Linda Jackson thanked everyone for the great work undertaken to resolve the issues within A&E. Gill Ponder queried whether the canopy installed included seating for patients. Jug Johal advised drop down seating had been installed and was socially distanced.

Dr Kate Wood referred to the Terms of Reference and advised some items needed to be updated within the workplan. The membership section at 6.1 also included some disparity across the different sub-committees. Some amendments also needed to be made at section 6.2 in terms of the Associate Director of Quality Governance role. Helen Harris advised the red text in the paper shared would be removed and the yellow text was new text that would be added. Due to further required changes in respect of voting members it was agreed to review them outside of the meeting.

Action: Helen Harris

Linda Jackson asked Board members to approve the Terms of Reference noting the agreed amendments. The Trust Board agreed to approve the Terms of Reference. Gill Ponder asked if the updated Terms of Reference could be shared for information at the next meeting.

3.4 Executive Report – Performance – NLG(21)201

Shaun Stacey advised the A&E performance continued to cause significant challenge in delivery of care. The teams were commended for all the work being undertaken. The biggest pressure was ensuring the correct skilled staff were in the correct areas to ensure safety. One other challenge was the A&E department had seen a 25% increase in attendance. Patients who had arrived by ambulance were assessed on arrival as a minor intervention and some were able to be sent home. Patients who required discharge to a hospital bed was difficult between the times of 4.00 pm and 7.00 am the following morning due to no beds being available. This had meant up to 21 additional patients were residing in A&E on a daily basis until a bed was available. This impacted on staff in that area as they were then caring for those patients as well as those arriving in A&E.

Partners of the organisation were striving to support patients but they had been in a position of struggling to recruit staff. Despite these issues the Trust were still the best in the region for model of care discharge to assess, however there was still a high level of patients residing in hospital longer than required.

The Trust electives continued to do well along with improvements being seen with 52 week wait patients with further decreased numbers.

Stuart Hall referred to the ambulance crews who had been using out of date protocols, this had implications as if they could not receive the guidance in a timely manner they were still taking patients to A&E whether it was required or not. A further query was how much senior presence on wards after 10.00 pm was resulting in further in day discharge. Shaun Stacey advised the focus was on 104 weeks nationally and the Trust currently had no patients waiting that long. In respect of early discharge this was still a challenge as the Trust were still not able to discharge patients early morning. This was due to partner organisations not taking receipt of patients before lunch as they did not have the capacity. The second challenge was the issues around job planning as this still did not allow ward rounds to take place before 10.30 am in a morning which would facilitate patients being discharged before lunch. Further improvements would be made shortly on this due to specialist support.

3.5 Winter Plan & Potential COVID-19 Third Wave 2021-22 (DCM567) – NLG(21)202

Shaun Stacey advised the plan was a live document so was constantly under review and would continue to be live throughout the winter. The most significant challenge as mentioned earlier in the meeting was workforce. This had caused a major challenge for daily rosters including the flow of patients. An option would be to consider using the same day emergency care facility. The use of the Integrated Assessment Unit would also be an option as it would increase the number of patients that could go through there. Both of those options required a lot of

support from colleagues in Northern Lincolnshire. Work had been carried out on pathways but they were still not where they needed to be to maximise other services. The Improvement Team and Quality Improvement Team were working to embed pathways.

Ellie Monkhouse advised there was a fear around flu this year along with the increased COVID cases, this could affect the plan throughout the winter. The Trust was in a position that it did not have the isolation facilities that other Trusts had. On the whole there was a lot to consider in respect of performance for the Trust.

Fiona Osborne queried whether the Trust was able to collect data on staff that had received a flu vaccine outside of the Trust. Christine Brereton advised the Trust were to offer the flu vaccine and COVID booster at the same time to staff. It was highlighted that 65% of staff had received the flu vaccine at the same time as the booster vaccine. If staff had declined the flu vaccine they had been asked if this had been received elsewhere to enable it to be recorded.

3.6 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(21)203

Gill Ponder referred to the five points highlighted within the report and provided an update.

3.7 Infection Control Annual Report – NLG(21)204

Maurice Madeo advised the past year had been a challenge for the IPC team. The year had seen a significant drop in C-Difficile cases which had been a reduction of 23% from the previous year. This had meant the Trust had been one of the lowest. One of the challenges remained the coronavirus pandemic due to the issues with the infrastructure and estate. The lack of isolation rooms and wash basins became the forefront of issues at the Trust.

Ellie Monkhouse wanted to formally thank Maurice Madeo and the team on behalf of the Trust Board as they had “stepped up” during this busy time and also worked closely with emergency planning. The achievement of producing the report during this busy time was also noted. Ellie Monkhouse felt the team had down played the performance achieved as they had done well regionally and nationally and should be proud of what had been achieved. The achievement of getting to the final of the Health Service Journal (HSJ) Award for the risk assessments was also noted.

Linda Jackson felt the Trust was safer due to the work of the team so wanted to personally note thanks for this. Christine Brereton wanted to note how thorough the self-assessments had been completed and that the team had recognised what needed to be put in place before suggestions had been made regionally. Due to this some Trust systems had been replicated regionally. Dr Peter Reading agreed that the HSJ shortlisting was a fabulous achievement for the team. The Trust had done well this year with four nominations for various awards.

Stuart Hall felt the report shared was of a high quality report and referred to page 39 of the report in respect of the major challenge to achieve Trust agreement of

several business cases for additional staff. Dr Peter Reading advised this was in the business planning process, the need for additional staff would impact on the Trust Capital Improvement Programme (CIP) as if agreement was reached for the additional staff the funds would have to be taken from elsewhere.

The Trust Board approved the IPC Annual Report.

3.8 Safeguarding Annual Report – NLG(21)205

Lynn Benefer advised there had been increased safeguarding cases. Due to the increased number the team had met weekly with an average of 30 cases a week to review. Although numbers remained high the team had now reduced to twice monthly meetings. An implemented change was that every child through the department would be given a Child Protection Information Sharing (CPIS) check. This would prevent them "slipping through the net" if they were to move around the country. The team had also progressed by putting in place processes for Deprivation of Liberty Safeguards (DOLS). The Trust now had a main nurse who led on the Mental Capacity Act (MCA) and DOLS. One challenge would be the change in the authorisation of the deprivation of liberty, this was currently undertaken by the Local Authorities but going forward would be the Hospital Manager.

Linda Jackson noted the changes and agreed for this to be discussed at a board development session.

Ellie Monkhouse wanted to thank the team on behalf of the board which included the production of the report during a busy time. As the Trust now had a Deputy Head of Safeguarding the team had strengthened. There would be a need to now review what resources would be required to carry further work forward as funding would be required to support this.

Linda Jackson felt the report shared was very comprehensive and showed unseen implications of COVID. Linda Jackson wanted to thank the team for the work undertaken.

The Trust Board approved the Safeguarding Annual Report.

Shaun Stacey wanted to highlighted that right care right place would have further impact on the team as the Trust were already seeing the effect of this through increased attendance at A&E.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Executive Report - Workforce – NLG(21)206

Christine Brereton advised there had been a good response to vaccinations being offered and information was being captured if staff had received vaccinations elsewhere. The staff survey had recently been sent out on line and via the internal mail in paper based format and thanked Jug Johal's team for distribution of the paper based forms. Staff should be encouraged to complete the survey this year

as it was more important to receive feedback this year than previously due to increased pressures.

Two significant challenges around workforce was recruitment and sickness absence, however, sickness was still in the acceptable range in terms of the IPR. The teams were working with managers to start to focus on short term sickness management, however, this would not be put in place at the moment due to how staff were feeling. Plans were in place to address the recruitment non-registered nurses with a campaign planned. There continued to be issues around national recruitment due to EU Exit.

Gill Ponder had recently taken part in a 15 steps visit and conversations had taken place with clinical staff that had struggled to access mandatory training due to issues with the Employee Staff Record (ESR) system; and queried whether further guidance on how to access the system could be shared. Christine Brereton advised a full review was to be undertaken around mandatory training. The teams would look at hot spot areas of staff who had not completed the training and this would then be discussed at PRIMS.

Gill Ponder was surprised to read in the Workforce Race Equality Standard Report (WRES) that there was a 6.02 times greater chance of being appointed to a role if the candidate was white. Christine Brereton advised this had increased significantly compared to previous years, but the Trust in general did have more white candidates apply for roles. Work was being undertaken across the ICS to form a more targeted approach.

Dr Kate Wood referred to mandatory training and asked if the divisional teams could be supported as they had rated the individual teams as red on the CQC reporting for mandatory training. This was not necessarily the case and was not showing on reports produced but the teams were rating this as red. Christine Brereton felt this should be reviewed and agreed to raise this with Human Resources Business Partners.

Action: Christine Brereton

Stuart Hall queried the £31,000 not spent on health and well-being as the deadline to spend the money was the end of the financial year. Christine Brereton advised some of the money had been supported by the Health Tree Foundation Trustees' Committee (HTFTC) and had been used to fund a co-ordinator role. There were further ideas that the funding could be used for so this would be spent in time.

Stuart Hall referred to exit questionnaires and queried whether staff received them when leaving the Trust. Christine Brereton advised this was currently not the case but was part of a wider cultural plan whereby staff that had left in the last 12 months would be reviewed.

Linda Jackson was pleased to see the issue with mandatory training had been highlighted.

4.2 Workforce Race Equality Standard Report – NLG(21)207

Christine Brereton advised the report had been through the relevant approval process. Plans were to be put in place in accordance with the report. A board development session was due to be held on the 2 November 2021 that would include race equality.

4.3 Workforce Disability Equality Standards Report – NLG(21)208

Christine Brereton advised the report had been through the relevant approval process. Plans were to be put in place in accordance with the report. A board development session was due to be held on the 2 November 2021 that would include disability equality.

4.4 Workforce Committee Highlight Report and Board Challenge – NLG(21)209

Michael Whitworth advised the committee had undertaken a deep dive at the last meeting. Linda Jackson commented that deep dives were useful and this had gone well.

4.5 Workforce Committee Self-Assessment – NLG(21)210:

- **Committee Effectiveness Reviews**
- **Terms of Reference**
- **Workplans**

Michael Whitworth went through the changes to the Terms of Reference and noted the Committee Effectiveness Review outcome was included within the paper.

Linda Jackson asked board members to approve the Terms of Reference noting the agreed amendments in respect of other sub-committee Terms of Reference.

The Trust Board approved the Terms of Reference.

5. Strategic Objective 3 – To Live Within our Means

5.1 Executive Report - Finance – Month 05 - NLG(21)211

Brian Shipley reported the Trust had been £10.31 million below plan for the month in respect of income. Brian Shipley highlighted key points from the report shared and noted key pressures remained the same as with previous months. It had been highlighted that H2 would be more of a challenge than H1 had been. Fiona Osborne referred to the balance sheet being 10% in stock for the month and whether this would impact on A&E going forward and if this was down to the increase in patients. Brian Shipley advised that due to work pressures with COVID the team had stopped undertaking monthly stocktakes, this therefore, was not an indication of activity levels but more accounting levels as this was being carried out less frequently. The monthly stock takes had now reverted back to being carried out monthly, particularly in pharmacy.

Stuart Hall queried the required threshold not being met and whether the money was ring fenced to increase activity to see if those thresholds could now be met. Brian Shipley advised the Trust would still try to maximise core capacity to hit the remaining thresholds where possible. The issue was that for every 1% that was earned above the new threshold would only attract circa £80,000 of funding. The cost of delivering additional activity at a premium would therefore be delivered at a loss. The Trust had delivered above the minimum thresholds in the first quarter whilst the thresholds were low and therefore would enable the Trust to still incur the planned expenditure throughout quarter two to hit a balanced position.

5.2 Executive Report – Estates & Facilities – NLG(21)212

Jug Johal explained that due to the new National Standards of Healthcare Cleaning released in April 2021 there had been a requirement for increased cleaning audit. The monitoring of this had caused a significant staff shortfall and resulted in cost pressure. The Security Car Parking contract had been successfully mobilised and the new CCTV system had started construction. Confirmation had been received from North Lincolnshire Council (NLC) that the Trust could re-occupy children's centres for Maternity Services following the pandemic. Phase One of the fire alarm system at DPOWH was now complete with funds secured for phase two. However, the Trust had been notified that the contractor had gone into administration so the impact of this would be assessed in the hope work would continue, if this was not the case it would be highlighted to the F&PC. The Trust would move back to face to face fire training from January which would support some of the compliance issues around the training.

Jug Johal wanted to highlight and note thanks to the team due to the work pressures currently faced.

5.3 Finance & Performance Committee Highlight Report and Board Challenge – August & September 2021 – Finance - NLG(21)213

Gill Ponder highlighted key areas from the report and advised robust discussion and challenge had taken place in respect of the spend on temporary staffing in non-patient facing roles.

5.4 Finance & Performance Committee Self-Assessment – NLG(21)214:

- **Committee Effectiveness Reviews**
- **Terms of Reference**
- **Workplans**

Gill Ponder advised the workplan had not been updated as yet but would be shared at the next meeting of the F&PC. An action plan had been completed in respect of the self-assessment of the committee and a number of actions had already been completed.

Linda Jackson asked Board members to approve the Terms of Reference noting the agreed amendments in respect of other sub-committee Terms of Reference.

The Trust Board approved the Terms of Reference.

5.5 Business Planning / CIP Timetable – H2

Brian Shipley advised the timetable would need to be refreshed due to guidance received on the 2 September 2021. This would then be shared with Trust Management Board (TMB) and Trust Board. Gill Ponder queried whether the Trust would achieve completion of the H2 plan as this was required to exit financial special measures by the end of October. Brian Shipley confirmed the Trust had met with the Financial Special Measures team the previous week and the Trust was on track to achieve this. This would be shared with the Trust Board in November, it was noted the timetable would need to be amended as it currently stated December.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Executive Report – Strategic & Transformation – NLG(21)216

Ivan McConnell advised more engagement work was being undertaken at the moment to move this forward. Ivan McConnell went through the key highlights detailed in the report which included any mitigations.

Dr Peter Reading wanted to give great credit to Ivan McConnell and those who had mobilised the work in NLAG and Hull University Teaching Hospital (HUTH) and the Humber Acute Services Review (HASR) programme over the last year. The feedback received regionally had been extremely positive. The Trust being able to get onto the programme would mean a massive boost for hospital services. There was also a strong hint regionally that the Trust's ability to succeed would be partly contingent to the delivery of programme one and there was an expectation in the future of seeing the evidence of delivery against activities. The ability to deliver would be a critical indicator in terms of evaluation.

Gill Ponder referred to the public consultation and queried when this was planned for. Ivan McConnell advised programme one was a long lasting service and the public had already been engaged with on this. There was also a pressure to accelerate the delivery of this. Programme two would follow a statutory and legal process but this would not take place until May 2022. The consultation would only take place if it was approved by the Clinical Commissioning Groups (CCG) Governing body which would hopefully take place before March 2023. The intention was to keep engagement going to ensure this was built on.

Linda Jackson queried whether the approach would need to be looked at if it was accelerated. Dr Peter Reading advised that changes to programme one were about consolidating services. Ivan McConnell and Adrian Beddow were also regularly briefing the Overview & Scrutiny Committees of any changes.

6.2 Submission of Humber Hospitals £720 million Expression of Interest in the DHSC Health Infrastructure (Future Hospitals) Plan – NLG(21)217

Ivan McConnell advised the expression of interest had been submitted in line with national requirements.

This had been submitted as part of the HAS Programme with support from the Clinical Commissioning Groups (CCGs) and HCV. The NHSE/I Regional team had also been engaged during the development process and supported the application process. The Expression of Interest portfolio totalled £720 million which included £250 million for Scunthorpe General Hospital (SGH), £120 million for DPOWH and £250 million for HUTH.

This would now go through various processes with a completed date of March 2022.

6.3 Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – July 2021 – NLG(21)218

Gill Ponder advised a sum of £79,785 had been granted for a Fusion Biopsy machine and an accompanying Ultrasound machine for the Trust's Urology Services.

6.4 Committees in Common (CIC) Highlight Report and Board Challenge – August 2021 - NLG(21)219

Linda Jackson shared the report with the Board and advised communications would be discussed at the next meeting to see how this would be dealt with going forward.

7. Strategic Objective 5 – To Provide Good Leadership

7.1 Board Development Timetable – NLG(21)220

Helen Harris asked the Board to note the report and advised changes would be made due to updates at this meeting. The programme for 2022 / 23 would also be looked at going forward.

Linda Jackson asked if Board members could consider anything they would feel of benefit for the development sessions and advise Helen Harris of this. Ellie Monkhouse queried what the process was for board development sessions as a brief was required on safe staffing before it was shared at public board. Helen Harris noted the request. A query was also raised as to the difference between a briefing and development session. Dr Peter Reading confirmed Board Development was team building and reviewing how the team work. A Board Briefing was a topic that needed to be shared with board members.

Dr Kate Wood queried when a decision would be made as to when the Trust Board meetings would be held. Linda Jackson confirmed the meeting would remain as the first Tuesday of the month for 2022. It was advised an additional sub-committee would also be added to the cycle.

8. Governance

8.1 Audit, Risk & Governance Committee (AR&GC) Highlight Report & Board Challenge – September 2021 - NLG(21)221

Board Members received the highlight report.

8.2 Emergency Preparedness, Resilience & Response Core Standards 2020/21 – Assurance Process Statement of Compliance 2020/21 - NLG(21)222

Shaun Stacey advised the process of achieving compliance was undertaken on an assessment tool and the Trust had achieved substantial assurance. The Trust had some significant risks due to the number of power stations in the area. It was reported there had been some slippage with training but this was due to the pandemic as staff could not be released to undertake training.

9. Approval (Other)

There were no items of approval.

10. Items for Information

11. Any Other Urgent Business

There were no items of any other urgent business.

12. Questions from the Public

Linda Jackson sought comments from members of the public. No questions were received.

13. Date and Time of the next meeting

Board Development
Tuesday, 2 November 2021, Time TBC

Formal Trust Board Meeting
Tuesday, 7 December 2021, Time: TBC
Via video conference

The Private Trust Board meeting was due to follow at 13:00 hrs.

Linda Jackson closed the meeting at 12.09 hours.

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

Name	Possible	Actual	Name	Possible	Actual
Terry Moran	2	2	Ellie Monkhouse	4	4
Dr Peter Reading	4	4	Fiona Osborne	1	1
Lee Bond	4	3	Simon Parker	1	1
Christine Brereton	4	4	Gillian Ponder	3	3
Neil Gammon	1	1	Michael Proctor	4	4
Stuart Hall	4	3	Maneesh Singh	3	3
Helen Harris	4	4	Andrew Smith	3	2
Linda Jackson	4	4	Shaun Stacey	4	4
Jug Johal	4	4	Michael Whitworth	4	4
Ivan McConnell	4	4	Dr Kate Wood	4	4
Shauna McMahon	4	3			

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)248

DATE OF MEETING	07 December 2021
REPORT FOR	Trust Board
REPORT FROM	Mick Chomyn, Associate Director of Pathology
CONTACT OFFICER	Robert Hughes, Directorate Manager, Cellular Pathology
SUBJECT	Mortuary Services Board Assurance Report
BACKGROUND DOCUMENT (if any)	NHSE&I 'Trust Board assurance re mortuary or body store' letter, Oct 2021 (C1435)
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Trust Board Ad-Hoc Sub-Committee 15 November 2021 Outcomes: · Completed NHSEI online submission 16 November 2021 · Completed installation of CCTV and swipe card access to Goole body store, and · Confirmed governance arrangements for Goole body store
EXECUTIVE SUMMARY	Recent NHSE&I letter published 12 October provides additional guidance for mortuaries and body stores. Trust Boards are required to be assured of satisfactory compliance with the revised and respond accordingly by 16 November. This report provides an update and assurance to meeting required standards of compliance. At its meeting on 2 November 2021, Trust Board delegated action on this to an Ad Hoc Sub-Committee which met on 15 November. This report summarises outcomes from the Sub-Committee plus subsequent and currently outstanding actions. Trust Board is asked to receive and note the report.

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 of non-delivery of constitutional performance targets (Human Tissue authority Licensed activities)				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
				✓	

Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust

TRUST BOARD MORTUARY ASSURANCE REPORT

07 December 2021

1 Background & Requirement

Official Publication approval reference: C1435 received 12 October 2021

NHS England and NHS Improvement (NHSEI) requested that Boards of organisations with either a mortuary or body store, ensure they are compliant with existing HTA guidance, and take additional steps set out to:

1. Ensure all access points to the mortuary or body store are controlled by swipe card security access. Where this is not immediately possible, organisations must assure themselves that there is sufficient mitigation in place to ensure the facilities are secure and there is auditable access
2. There must be effective CCTV coverage in mortuary areas and this should be reviewed on a regular basis by an appropriately trained and authorised individual. Specialist training and mental health support may be required to support staff to undertake this task
3. A documented risk assessment of the facilities should be undertaken with regard to the operation, security and construction of the mortuary or body store area
4. Ensure there is consistent application of appropriate levels of DBS checks for all Trust and contracted employees, specifically in line with requirements of the NHS Standard Contract

Trust Boards were asked to assure themselves that they have reviewed the evidence in response to each of the above actions and confirm that they are satisfied that the appropriate response has been taken

A completed return was submitted online following discussion at an Ad Hoc Sub-Committee of the Trust Board on 15 November. The minutes of the meeting have been delayed due to ill health of the administrator and will be shared at the February 2022 Trust Board meeting. A copy of the online completed return is attached as Appendices A and B.

The following provides an update on outstanding actions and provides further assurance on Trust compliance with the requirements

2 Trust Mortuary & Body Store Facilities Update

2.1. Compliance with Current HTA Guidance

As applicable to DPoW and SGH mortuaries **only**:

At the time of the letter, 12 October 2021, there were no material gaps in compliance so that both mortuaries were fully compliant with HTA guidance

Subsequent updated HTA Guidance, issued 25 October 2021, emphasised the requirements for controlled access and CCTV in addition to providing new guidance for:

- Long-term storage of bodies and bariatric bodies (transferring to freezer storage beyond 30 days or before, depending on the condition of the body)

It is a requirement for establishments to have sufficient freezer storage facilities for bodies, including bariatric bodies, to meet their needs. If long-term storage facilities are not available, alternative arrangements should be in place

The Path Links mortuary service is fully compliant with the requirements of the updated guidance with **the exception of freezer storage facilities for bariatric bodies**

Further work is ongoing to determine storage requirements and an outline business case will be submitted for consideration in due course

However, the updated guidance with specific reference to long-term bariatric body storage does not form part of the requirement of evidence submission to NHSEI

Accordingly:

The Trust Board can be assured that the Path Links mortuary service covering Diana Princess of Wales Hospital, Grimsby, and Scunthorpe General Hospital is fully compliant with HTA guidance (with the interim exception of bariatric body long-term storage)

2.2. All access points to the mortuary or body store are controlled by swipe card security access. Where not immediately possible, assurance is required that mitigation is in place to ensure facilities are secure and there is auditable access

SGH	DPoW	GDH
Swipe access to internal and external doors including external access for viewings. Confirmed as compliant and auditable	Swipe access to internal and external doors including external access for viewings. Confirmed as compliant and auditable	Swipe access to internal and external doors installed 01 December 2021. Confirmed as compliant and auditable

Accordingly:

The Trust Board can be assured that the Path Links mortuary service covering Diana Princess of Wales Hospital, Grimsby, and Scunthorpe General Hospital, and Goole & District Hospital are fully compliant with the requirement for swipe card, auditable access

Note:

NLG compliance matrix has been updated by NHSEI to reflect the change

2.3. There must be effective CCTV coverage in mortuary areas, reviewed on a regular basis by appropriately trained and authorised individuals

SGH	DPoW	GDH
· Internal & External CCTV operational. Installed 2020 · Standard Operating Procedure for ongoing review of CCTV footage in conjunction with swipe card access data	· Internal & External CCTV operational. Installed 2020 · Standard Operating Procedure for ongoing review of CCTV footage in conjunction with swipe card access data	· Internal & External CCTV operational. Installed 18 November 2021 · Standard Operating Procedure for ongoing review of CCTV footage in conjunction with swipe card access data

Procedures for the concurrent review of CCTV footage and swipe card access data have been developed after taking professional security advice. Procedures incorporate the following:

- Reviews to be undertaken jointly by two persons
- Regular (monthly) intelligence led review of CCTV and swipe card access information against recorded mortuary activities (e.g. body admissions and releases)
- 'Spot' reviews where an incident has occurred or is suspected to have occurred
- Reporting of untoward findings

The full text of the relevant Path Links SOP is provided at Appendix B.

- The Path Links SOP has been reviewed and approved by the Path Links Management Board on 24 November 2021

- Provisional agreement has been made between Path Links and the Community & Therapies Clinical Division for Community & Therapies to progress the SOP through their governance process for approval and implementation

Accordingly:

The Trust Board can be assured that mortuary services covering Diana Princess of Wales Hospital, Grimsby, and Scunthorpe General Hospital, and Goole & District Hospital are fully compliant with the requirement for CCTV coverage

The process for regular review of CCTV footage in conjunction with swipe card access data is scheduled for completion

Note:

1 NLG compliance matrix has been updated by NHSE&I to reflect the change

2 There is a requirement for ongoing oversight of CCTV/access review compliance. It is recommended that appropriate oversight is maintained by the Audit, Risk, and Governance committee

2.4. A documented risk assessment is undertaken with regard to operation, security and construction of the mortuary and body store

SGH	DPoW	GDH
· Documented risk assessment available · Reviewed 21.9.2020 and updated 18.10.2021	· Documented risk assessment available · Reviewed 21.9.2020 and updated 18.10.2021	· Documented risk assessment available · Created 10.11.2021

Accordingly:

The Trust Board can be assured that mortuary services covering Diana Princess of Wales Hospital, Grimsby, and Scunthorpe General Hospital are fully compliant with the requirement for a documented risk assessment

The Goole & District Hospital risk assessment is available and awaiting formal governance approval

Note:

There is a requirement to provide confirmation documented risk assessments are in place for all mortuary and body store facilities, and confirm these risk assessments have been approved by the Trust Board (e.g. date of discussion, where support evidence can be found e.g. minutes et al).

The risk assessment was provided to the ad-hoc Trust Board on the 15 November and awaiting formal governance approval for Goole. This is

scheduled for the next Divisional governance meeting of Community & Therapies

2.5. A consistent application of DBS checks for all Trust and contracted employees

In line with NHS Employers guidance, DBS checks are undertaken at recruitment stage prior to a new employee commencing with the Trust, where the role is eligible, and as determined by the DBS eligibility tool. Further DBS checks are only undertaken should the employee move roles, and that role requires a DBS check. Where an employee is registered with the update service this is linked to records accordingly

Should an existing employee have any criminal issues whilst in employment they are required to declare this to the Trust

Trust Boards are required to:

- Provide confirmation all Trust and contracted employees have DBS checks in place, and, describe the process in place to ensure these are updated in advance of their expiry

- Provide confirmation the Board has assured itself these processes are in place (e.g. date of discussion, where support evidence can be found e.g. minutes et al)

Accordingly:

The Trust Board can be assured of meeting the criteria for Trust compliance with a consistent application of DBS checks for all Trust & contracted employees

Note:

Further guidance on specific requirements for staff DBS checks in relation to mortuary activity is anticipated

Action has been taken to audit DBS status of Path Links mortuary and other support staff, who either have not been required to have a DBS check or whose employment pre-dated the requirements. Consequently,

- All Path Links drivers who are involved with the transfer of bodies between sites have now been DBS checked
- All Path Links mortuary staff have now been, or are in the process of being DBS checked
- DBS checks are undertaken for all other Trust staff that require regular mortuary access e.g. portering staff. All other staff e.g. estates and domestic staff are restricted to supervised access only, accompanied by mortuary staff

Appendix A

Copy of the online NHSEI Trust Board assurance submission

Questions

8. **Does the trust have mortuary or body store facilities?**

Yes

9. **Ensure all access points to the mortuary or body store are controlled by swipe card security access?**

Where this is not immediately possible, organisations must assure themselves that there is sufficient mitigation in place to ensure the facilities are secure and there is auditable access.
If no, please list each of the Trust's mortuary or body stores/ post mortem rooms and for each of these areas - provide confirmation a risk assessment has been undertaken/ and a description of the steps taken to ensure each facility is sufficiently secure.

- If currently absent, please specify a date when swipe card, auditable, security access will be in place.
- Please also confirm any associated risk assessments have been approved by the Trust Board (and provide details of where such risk assessments are recorded/ steps taken to ensure all Trust facilities are sufficiently secure).

No

10. Free text response for the question above.

- **The Diana Princess of Wales Hospital, Grimsby (DPOW) and Scunthorpe General Hospital (SGH) mortuary facilities are fully compliant with the requirement.**
- **The Goole and District Hospital (GDH) body store is non-compliant with regard to swipe card and auditable access. Auditable swipe card access for the GDH body store has been procured and is scheduled for installation on 22 November. A Risk Assessment has been submitted for governance purposes and interim measures are in place to ensure secure and auditable access. Assurance is given that the interim provisions for GDH are sufficient to meet the requirement and that full compliance will be achieved following installation.**

11. **There must be effective CCTV coverage in all mortuary areas and this should be reviewed on a regular basis by an appropriately trained *and* authorised individual?**
Specialist training and mental health support may be required to support staff to undertake this task.
To provide further clarity on the CCTV:

- Ensure there is effective CCTV coverage, monitoring access to and from mortuary areas. CCTV data should be reviewed, alongside swipe card data, by an appropriately trained and authorised individual to audit access.

- If no/ in the absence of current CCTV provision, please advise when this will be introduced and confirm the Trust Board has approved the timeline for the installation of any necessary additional CCTV provision/ and describe how the implementation of associated delivery plans will be monitored at a Board level.

No

12. Free text response for the question above.

The mortuary services covering the Diana Princess of Wales Hospital, Grimsby (DPOW) and Scunthorpe General Hospital (SGH) are compliant with the requirement for CCTV coverage. Goole and District Hospital (GDH) will achieve compliance following installation on 22 November 2021. An SOP for CCTV review is currently being drafted, with appropriate training and individuals to be identified. The Board discussed this at an extra ordinary session on 15 November and was assured the due processes were in place to achieve this compliance.

13. **A documented risk assessment of the facilities should be undertaken with regard to the operation, security and construction of the mortuary or body store area?**

- Please provide confirmation documented risk assessments are in place for all mortuary and body store facilities, and confirm these risk assessments have been approved by the Trust Board. (e.g. date of discussion, where support evidence can be found e.g. minutes et al).
- Please describe the process for the Board to monitor any estates improvement work required at pace, to enhance the security of such facilities.

No

14. Free text response for the question above.

The Trust Board is assured that mortuary services covering the Diana Princess of Wales Hospital, Grimsby (DPOW) and Scunthorpe General Hospital (SGH) are fully compliant. Goole and District Hospital's (GDH) risk assessment (for the body store) is completed but awaiting formal governance approval.

15. **Ensure there is consistent application of appropriate levels of DBS checks for all Trust and contracted employees, specifically in line with requirements of the NHS Standard Contract?**

Employers are required to pay attention to the security features of a DBS certificate and support can be found at DBS checks: Guidance for employers.

https://www.gov.uk/government/publications/dbs-identity-checking-guidelines
Please provide confirmation all Trust and contracted employees have DBS checks in place, and, describe the process in place to ensure these are updated in advance of their expiry.

- Please provide confirmation the Board has assured itself these processes are in place (e.g. date of discussion, where support evidence can be found e.g. minutes et al).

  No

  DBS checks comply with NHS Employers guidance for those staff being employed by the Trust where the role is eligible. DBS checks are currently being arranged for all Mortuary staff employed prior to DBS checks being required, as well as for other staff who handle bodies. A list of these employees has been submitted to the Trust's Head of Recruitment for action. The Board discussed this at an extra ordinary session on 15 November and was assured the due processes are in place.

PATH LINKS
NHS PATHOLOGY

Mortuary Security Review

INT-SOP-160

Contents

Purpose of Procedure

The Mortuary Department is an area offering safe and secure storage of bodies received from hospital wards, and from the community where HM Coroner is conducting post-mortem investigations

Strict security is a requirement for all Mortuary buildings, each having working closed circuit television (CCTV) and swipecard access to external doors. The Lincoln and Grantham mortuary facilities are additionally protected by intruder alarm systems

Access into the Mortuary building is strictly controlled and limited to staff and visitors as outlined in INT-INS-129, Mortuary Access & Security

This procedure outlines actions required to monitor and review security arrangements within Path Links Mortuaries on a regular basis, including intelligence led CCTV and swipecard access reviews, and spot reviews as required in the event of a known or suspected incident

Place of Work

All Mortuary Departments within Path Links Pathology Services (Lincoln, Grimsby, Scunthorpe, Grantham, Boston)

Training

Core competence within the mortuary must be achieved by at least one reviewer prior to commencing the security review. A period of observation is followed by direct/indirect supervision

Train-88: Competency Assessment - Mortuary Register Completion
Train-464: Competency Assessment - Mortuary Access & Security
Train-554: Competency Assessment - Mortuary Admission of Bodies
Train-555: Competency Assessment - Mortuary Release of Bodies

It is recognised that staff reviewing CCTV recordings may in the course of performing this duty observe some footage that they may find disturbing. All staff have access to Occupational Health support either via their manager or self-referral

In addition, staff have access to Trust wide employee support services; information of which is displayed locally or can be found on the Intranet Trust home page

Quality

Swipe access logs are retained by the site facilities department who, on request, can provide a report on a regular or ad-hoc basis

CCTV recording hardware and records are located within a secure area of either the Mortuary or Pathology department. Access to these systems are password protected to prevent unintended use and or deletion of data. The CCTV systems provide a minimum of 30 days storage after which recordings are overwritten

Reviews will be included in the Cellular Pathology annual audit schedule and uploaded to Q-Pulse. No CCTV footage or personal data will be retained as part of the review within Q-Pulse

Who can perform this task

- Mortuary Manager
- Mortuary Staff
- Pathology Site Manager

The procedure must only be performed by a trained mortuary member of staff supported by the Pathology Site Manager (or delegated senior pathology manager) to verify findings

Under no circumstance should the review be undertaken independently by an authorised or unauthorised member of staff

Primary Author:

Andy Milner, Path Links Mortuary Manager

Approved by:

Rob Hughes, Cellular Pathology Directorate Manager

References

EXT-STD-14-HTA standards and codes of practice A-E (B)
INT-QMS-3-Control of clinical material, process and quality records
ICO Code of Practice

Procedure

Regular Review

A scheduled review of CCTV and swipecard access will be conducted at each Mortuary on a monthly basis

Frequency of reviews may be amended as appropriate by agreement with Cellular Pathology Directorate and Path Links Quality Management Team

Intelligence Led Review

The Mortuary Manager (or mortuary staff member) and the Pathology Site Manager (or nominated deputy) will review the swipecard access log to determine dates and times that the Mortuary has been accessed, and by which staff

Mortuary access logs are obtained by contacting the relevant persons for each site as below, and need to be actioned in advance of undertaking the review to enable sufficient time to ascertain which entries require CCTV review

Mortuary Site	Contact
Lincoln	Kane Brewster (Kane.Brewster@ULH.nhs.uk)
Boston	David Everitt (David.Everitt@ulh.nhs.uk)
Grantham	Grace Wrigglesworth (Grace.Wrigglesworth@ULH.nhs.uk) Jeanette Pepper (Jeanette.Pepper@ulh.nhs.uk)
Grimsby	Steve Hargraves (steve.hargraves@nhs.net)
Scunthorpe	Emma Barrett (emma.barrett1@nhs.net)

ULHT Systems have approximately 60 days recording capacity and NLaG Systems have approximately 30 days recording capacity, after which the system will overwrite the saved images. Accordingly, review of the CCTV must take place within the defined timescale

Together, staff performing the review will determine where the swipe access logs match with known activities in the Mortuary Register or Database, i.e. body admissions or releases. One of these activities will be selected from the previous month and reviewed against CCTV system recordings. In doing so they will confirm that:

- The CCTV is working
- The CCTV has effectively captured the activity selected
- There is concordance between swipecard and CCTV footage data
- The defined Mortuary procedures were followed

Where the Mortuary has been accessed and it does not match with known body movements, the Mortuary and Pathology Site Managers will prioritise the review of these

CCTV images to determine the reasons for this access and to ensure that any duties carried out were within remit

Spot Review

A spot review will be conducted if an incident has occurred or is suspected to have occurred. This will be a fact-finding review to establish circumstances around a known or suspected incident and the findings will be reported accordingly

Untoward findings

Where any untoward findings have been discovered, e.g., activities outside the scope of the procedure being conducted or in the event of unauthorised access, these will be reported via the Trust's incident reporting system (Datix/Ulysses) and recorded on QPulse

Where findings suggest an incident requires reporting as an HTA Reportable Incident (e.g. Serious Security Breach), this will be done as outlined in INT-INS-73, Mortuary Incident Reporting Guidance and the following people will be informed

United Lincolnshire Hospitals NHS Trust
Prof Ciro Rinaldi, ULHT HTA Designated Individual
Yaves Lalloo, Divisional Managing Director CSS
Charlie Carroll, Cancer Services Manager

Northern Lincolnshire & Goole NHS Trust
Dr Steven Griffin, NLaG HTA Designated Individual & Clinical Director for CSS
Mick Chomyn, Associate Director of Pathology

NLG(21)249

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2021/2022

Kindness · Courage · Respect

ACTION LOG & TRACKER

NHS
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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?
11	03/08/2021	Any Other Urgent Business - Sub-Committee Terms of Reference		Sub-Committees to follow the same process in respect of Terms of Reference.	Helen Harris	Oct-21	At the October 2021 meeting the Terms of Reference were submitted for approval. Approval was agreed with agreement they would again be shared at the November meeting. The Terms of Reference were shared and approved at the November 2021 meeting.		Board Papers	Papers are held on NLAG Hub
3.8	05/10/2021	Safeguarding - Changes to Deprivation of Liberty Safeguards authorisation.		It was agreed a board development session would be held to look at Safeguarding changes.	Helen Harris	2022	The session has been added to the 2022/23 programme to be approved.			
4.1	05/10/2021	Executive Report - Workforce - Support in respect of Mandatory training to divisional teams		Support to be offered to the divisional teams in presenting current ratings for mandatory training in reports, specifically for the CQC.	Christine Brereton	Dec-21	Further update to be provided at the December 2021 meeting.			
5.5	05/10/2021	Business Planning / CIP Timetable H2		Trust Board to receive the H2 plan due to the requirement to exit financial special measures. Trust Board advised this would be available in November.	Lee Bond	Dec-21	Further update to be provided at the December 2021 meeting.			

Key:

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

ACTION LOG & TRACKER

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Board Public Meeting

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

NLG(21)250

DATE OF MEETING	Tuesday, 7 December 2021
REPORT FOR	Trust Board - Public
REPORT FROM	Dr Peter Reading, Chief Executive
CONTACT OFFICER	Dr Peter Reading, Chief Executive
SUBJECT	Chief Executive's Briefing
BACKGROUND DOCUMENT (if any)	Not applicable.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Not applicable.
EXECUTIVE SUMMARY	The report provides an overview of the following: • Development of the HCV ICS • Operational issues

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**
		✓			

Chief Executive's Overview

1. Development of the ICS (HCV Health and Care Partnership)

Stephen Eames, who has been the ICS Independent Lead for the last two years, has been appointed Chief Executive-designate of the Integrated Care Board (ICB) for HCV. He (and the Chair-designate, Sue Symington) will take up their new post substantively on 1 April 2022, subject to legislation.

Recruitment is now under way for the nationally mandated executive members of the Integrated Care Board (Financial, Medical and Nursing) and the ICB is consulting local stakeholders on possible other members of the ICB.

Guidance has been offered by Stephen Eames to the emerging Collaboratives and Place-based Partnerships in HCV as to which should lead on what.

2. Main operational issues currently

In common with most acute and community Trusts in the UK, the main operational issues for the Trust are maintaining patient safety, the quality of care and staff well-being in the face of very substantial pressures on urgent and emergency care and the challenges of elective recovery. Key aspects of this are covered in papers and reports on the agenda for this Board meeting. The greatest concern of the Executive Team is staff well-being, both in its own right and because we can achieve nothing without our staff.

NLaG is doing everything it can to maintain a safe urgent and emergency care service and to reduce waiting times, but this is in a context of the high levels of urgent care demand, huge elective, out-patient and diagnostic backlogs built up during the pandemic, running with c.14-15% fewer general and acute beds (largely, because of IPC measures), high levels of staff absence due to sickness and self-isolation, staff who are very tired indeed after their outstanding efforts over the last 21 months, c.100,000 vacancies across the NHS, extraordinary pressures in social and community care and the continuing other multiple ramifications of the pandemic. The winter ahead is expected to put the NHS generally under as much pressure as it has ever experienced, and trusts like NLaG which already have more challenges than many (multiple small sites, high levels of medical and nursing vacancies, coastal location, poor estates infrastructure, few single rooms) are likely to feel this pressure particularly severely.

In preparation, the Trust has been working hard with regard to staff well-being initiatives, introducing improvements in patient flow and urgent care (Discharge to Assess, regular board rounds, strengthened leadership in the emergency departments, introducing the Urgent Care Service in Scunthorpe) and continuing to undertake as much elective, outpatient and diagnostic work as it can (including additional outsourcing to the independent sector). While, relative to the rest of the country, 4 hour performance in the EDs has been very poor through the autumn, elective performance is among the best in the Region.

Peter Reading
Chief Executive

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)251

DATE OF MEETING	07 December 2021
REPORT FOR	Trust Board - Public
REPORT FROM	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Medical Director Christine Brereton, Director of People
CONTACT OFFICER	Shauna McMahon, Chief Information Officer
SUBJECT	Integrated Performance Report (IPR)
BACKGROUND DOCUMENT (if any)	Access and Flow – IPR (October Data) Quality and Safety – IPR (September Data) Workforce – IPR (October Data)
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance and Performance Committee (November 2021) Quality and Safety Committee (November 2021) Workforce Committee (November 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. **2. Access and Flow** The executive summary of the Access and Flow section is provided over on page five. **3. Quality and Safety** The executive summary of the Quality and Safety section is provided over on page six. **4. Workforce** The executive summary of the Workforce section is provided over on page seven. **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
✓	✓			✓

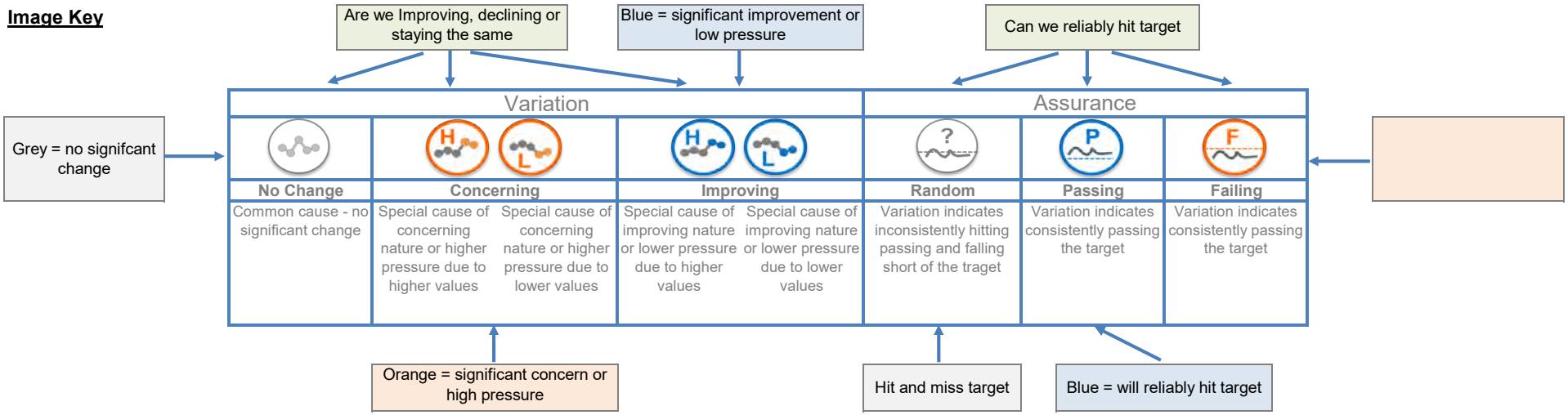
TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response	✓	**Workforce and Leadership**	✓
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	**Strategic Objective 1: 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**
		✓			

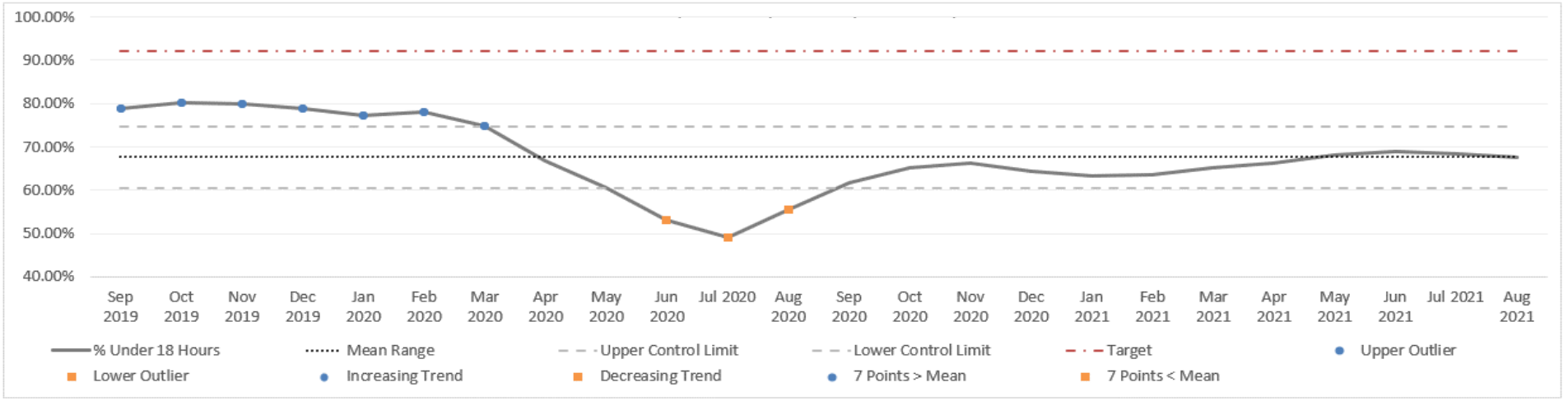
Northern Lincolnshire and Goole NHS Foundation Trust

Image Key



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

SPC Key - example SPC chart



Orange Squares = significant concern or high pressure / change required to hit target

Blue Circles = significant improvement or low pressure / will reliably hit target

Access and Flow
Objective: To give great care

The Emergency Departments (ED) 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) and 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.

A new Urgent Care Service (UCS) model has gone live in SGH with a phased approach from 18th October 2021 to provide a streamlined patient pathway for accessing urgent and emergency care. The new pathway has two dedicated services, the UCS combining the traditional minors and UTC cohort of patients, and the ED with retains the majors and resus patients. All walk-in patients have an immediate initial assessment by a senior practitioner before booking into the most suitable service for their presentation. The UCS should see a reduction in ED patient waits, a reduction in unnecessary triage and investigations, and an improved patient experience.

The Department 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 and went live with direct bookable arrival slots in ED at Grimsby for the single point of access (SPA) as part of the "NHS111 First" initiative programme to try and increase performance. Also in conjunction with the system partners three 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.

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.

Referral to treatment (RTT) continues to see an increasing number of patients waiting, resulting in an unvalidated performance of 66.8% for October 2021; (unvalidated 66.3% for November 2021 as of 17th November 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 an unvalidated 463 in October 2021; (unvalidated 423 for November 2021 as of 17th November 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 (2ww) standard continues to be achieved at 95.6% 2ww however Breast Symptomatic was 91.3% in October 2021; though there have been some pressures in achieving the 31 day first treatment standard (May and August) the target of 96.0% has been met since; the 62 day standard was 58.1% for October 2021; the 62 day screening standard was 71.4% against national standard of 90%

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.

Quality and Safety
Objective: To give great care

Mortality: The Hospital Standardised Mortality Ratio (HSMR) is within the as expected threshold and remains under 100 (91.49 for July 2021). Both in hospital and out of hospital SHMI demonstrate an improvement to beneath the Trust's mean average performance which continues to be driven largely by the in-hospital SHMI reduction. Out-of-hospital (<30 days of discharge) SHMI for May 2021 is 127.94 (DPOW: 141.9 / SGH: 113.4). To investigate the site disparity and identify key learning or themes attributing to inappropriate hospital admissions, work is underway in collaboration with NHSEI and the CCGs to undertake a review of patients.

Structured Judgement Reviews (SJR): There remains a backlog of priority SJRs that require completion. NHSEI continue to support and a further three training sessions on the electronic SJR system (ORIS) are scheduled to take place for all divisions to attend over the next three months. The training should support more timely initial review using SJR by broadening the number of trained reviewers available.

Safe Care

• **VTE Risk Assessments** - Compliance has been impacted upon adversely in response to an increasing demand of Covid-related (or Covid-suspected) acute admissions. Issues have been identified within ECC in relation to the e-risk assessment tool linked to the Trust's Electronic Prescribing and Medicines Administration (EPMA) system. Mitigations have been proposed and are currently being worked through. Updates the Trust's VTE policy and information (in line with the latest NICE Clinical Guideline and Quality Standard, published in August 2021) has not progressed as hoped due to operational demand. Further support has been offered to progress the completion.

Prescribing:

Weighing and prescribing: Whilst the chart analysis is not available, audit intelligence for September 2021 indicates that whilst the majority of patients are having a weight recorded, only 36% are actual weight. This represents a greater risk to patients close to 50kg who are being prescribed paracetamol whose weight is being estimated. Where risk is identified, individual case note reviews are being undertaken for all patients identified as being close to 50kg with feedback on prescribing practice in cases that may represent risk.

Diabetes Inpatient Care: These patients should have their blood sugars monitored at least 4 times per day, measured between 2-3am and BM repeated where appropriate. September 2021 compliance is 78.6%, just falling short of the target of 80%. Compliance is impacted with 2-3am BM testing which is slightly inconsistent across the Trust. Deputy Chief Nurse in Medicine & Diabetes Inpatient Nurse Specialist attended/attending Ward Manager meetings in November 2021 to highlight the need to conduct BM monitoring between 2-3am.

CHPPD: A peak in CHPPD was seen in April/May 2020 due to the pandemic when bed number were reduced and elective activity cancelled to support management of the pandemic and increased patient acuity. Further smaller peaks were seen in Nov/Dec 2020 and April 2021 when the nursing workforce was being supported by student nurses on paid placements. Covid related absence has affected the availability of staff throughout the pandemic. RN vacancies remain high and the reduced availability of temporary staffing during the pandemic has affected CHPPD. The latest model hospital data for May 2021 (this is latest data available) indicates a national median of 9.1 and peer median of 8.9 against the trust CHPPD of 8.3. It remains difficult to benchmark using this data due to changes in ward demographic and acuity over the past 15 months.
Actions:
A workforce plan and RN forecast has been developed. 73 NQNs are joining the Trust in the autumn. International nurse recruitment continues with a further 65 INs to join the trust before the end of March 2022. HCSW turnover has increased over the last four months and work is underway to understand the reasons for this. Recruitment continues to recruit to the HCSW Pool to ensure swift appointments to replace leavers. The induction programme has been reviewed, career clinics are being established and workshops are being developed.

Workforce
Objective: To give great care
Trustwide Vacancies The vacancy rate increased in month by 37.61 WTE, this is attributed to the trainee rotation and a slight increase in unregistered nursing vacancies Recruitment at an increased rate is ongoing, with recruitment activity increasing by 19.88% over the last 12 months, sourcing candidates locally, nationally, and internationally. Registered Nurse Vacancies Regular recruitment activity is underway sourcing candidates from overseas via the internal Talent Acquisition Team, and via an agreement with Yeovil NHS Trust, and regular ongoing activity. Over the last 12 months 99 international nurses have commenced in post. Medical Vacancies The drop in medical vacancies seen in July is due to Foundation 1 trainees commencing shadowing as part of their trainees while existing Foundation 1 trainees were in post. The vacancy factor then rose in August due to a fill rate for trainees of 80.10%. Unregistered Nurse Vacancies 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), however it remains higher than forecast due to large numbers of leavers. Turnover The latest turnover data point (9.84%) is 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%. Sickness Following a period of normal variation the sickness level has peaked again at rates simular to that of the November 2020 rates. Please note sickness will always be a month in arrears due to the extraction of information from the Health Roster System. PADR The non medical PADR compliance position currently stands at 80% this is below the Trust target of 85% . Medical Staff PADR Compliance currently stands at 83% as of October 2021. The combined appraisal complaince currently stands at 81% as of Ocotber 2021. Mandatory Training The Core Mandatory Training position currently stands at 92%. This continues to be above the Trust target of 90%, Performance has exceeded the target since Feb The Role Specific Mandatory Training position currently stands at 80% (October 2021). This is continues to be in line with the Trust target of 80%,

Summary Radar - Access and Flow

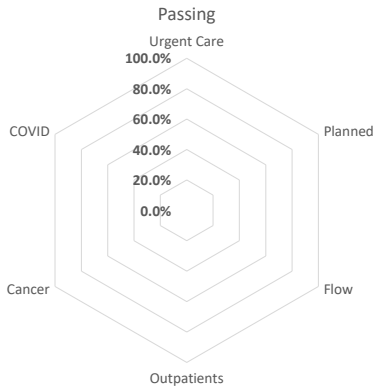
Note: Only indicators with a target are relevant for this page as it is based on the target assurance element of the indicator.

* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR

Northern Lincolnshire and Goole NHS Foundation Trust

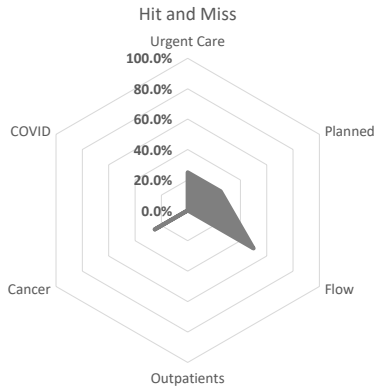
Consistently Passing

Total: **0**



Hit and Miss

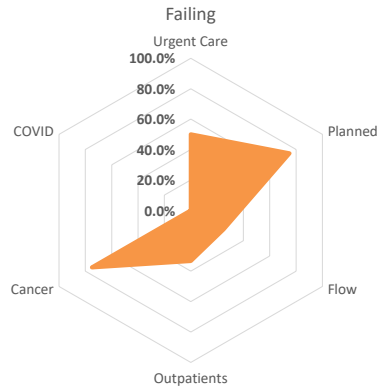
Total: **7**



Cancer	Cancer Waiting Times - 62 Day GP Referral*
Flow	Bed Occupancy Rate
	Inpatient Elective Averge Length Of Stay
	Inpatient Non Elective Averge Length Of Stay
	% Discharge Letters Completed Within 24 Hours of Discharge
Planned	Total Inpatient Waiting List Size
Urgent Care	Decision to Admit - Number of 12 Hour Waits

Consistently Failing

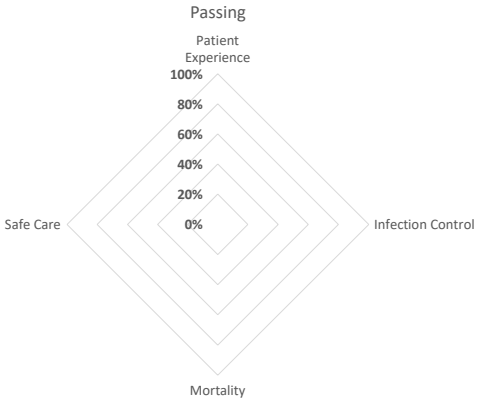
Total: **11**



Cancer	Cancer Waiting Times - 104+ Days Backlog*
	Cancer - Patients With Confirmed Diagnosis Transferred By Day 38*
	Cancer - Request To Test In 14 Days*
Flow	% Inpatient Discharges Before 12:00 (Golden Discharges)
	% Patients Discharged On The Same Day As Admission
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)
Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)
	% Under 18 Weeks Incomplete RTT Pathways*
	Number of Incomplete RTT pathways 52 weeks*
Urgent Care	Ambulance Handover Delays - Number 60+ Minutes
	Emergency Department Waiting Times (% 4 Hour Performance)

Consistently Passing

Total: **0**



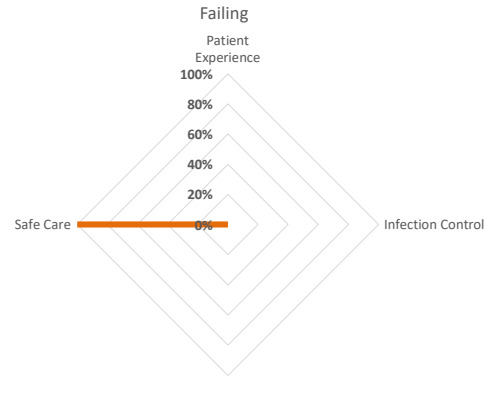
Hit and Miss

Total: **5**

Infection Control	Gram Negative Infections
	Number of E Coli Infections
	Number of MRSA Infections
	Number of MSSA Infections
	Number of Trust Attributed C-Difficile Infections

Consistently Failing

Total: **1**



Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate

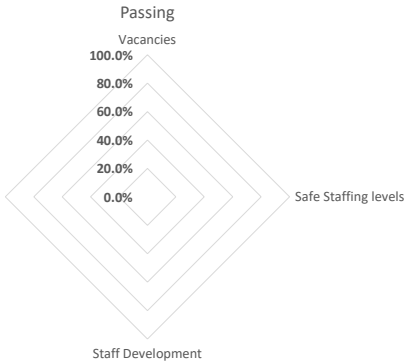
Summary Radar - Workforce

Note 'Action Required' is stated on the Scorecard when either the Variation is showing special cause concern or the Assurance is indicating failing the target.

*Indicators marked with an asterix are unvalidated at the time of producing the IPR report.

Consistently Passing

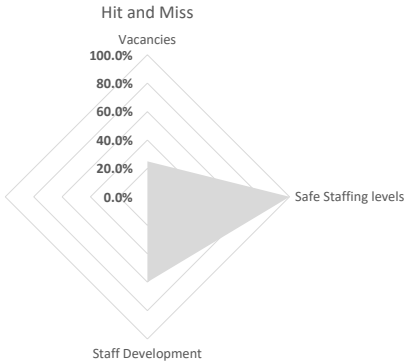
Total: **0**



There are no indicators consistently passing the target

Hit and Miss

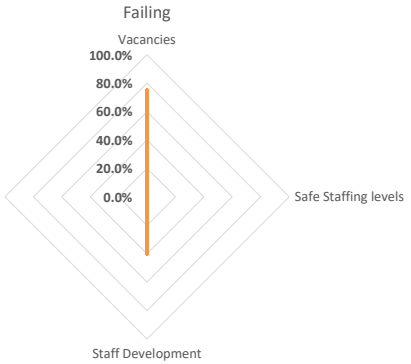
Total: **6**



Staff Development	Core Mandatory Training Compliance
	PADR Rate
	Role Specific Mandatory Training Compliance
Staffing Levels	Sickness
	Turnover Rate
Vacancies	Medical Vacancy Rate*

Consistently Failing

Total: **5**



Staff Development	Medical Staff PADR Rate
	Combined AfC and Medical Staff PADR Rate
Vacancies	Unregistered Nurse Vacancy Rate*
	Registered Nurse Vacancy Rate*
	Trustwide Vacancy Rate*

Summary Matrix - Access and Flow

Note: Only indicators with a target are relevant for this page as it is based on the target assurance element of the indicator.

* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR

Northern Lincolnshire and Goole NHS Foundation Trust

Oct 2021		Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail	Hit and Miss / Common Cause
Variance: Special Cause Improvement			Inpatient Non Elective Averge Length Of Stay Total Inpatient Waiting List Size	Cancer Waiting Times - 104+ Days Backlog* % Patients Discharged On The Same Day As Admission Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Cancer Waiting Times - 62 Day GP Referral* Inpatient Elective Averge Length Of Stay % Discharge Letters Completed Within 24 Hours of Discharge
Variance: Common Cause			**See Hit and Miss / Common Cause Box (right)**	Cancer - Patients With Confirmed Diagnosis Transferred By Day 38* Cancer - Request To Test In 14 Days* % Inpatient Discharges Before 12:00 (Golden Discharges) % Under 18 Weeks Incomplete RTT Pathways*	
Variance: Special Cause Concern			Bed Occupancy Rate Decision to Admit - Number of 12 Hour Waits	Ambulance Handover Delays - Number 60+ Minutes Emergency Department Waiting Times (% 4 Hour Performance)	

Oct 2021			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement	H			
		L			
	Common Cause			Gram Negative Infections Number of E Coli Infections Number of MRSA Infections Number of MSSA Infections Number of Trust Attributed C-Difficile Infections	
	Special Cause Concern	H			Venous Thromboembolism (VTE) Risk Assessment Rate
		L			

Summary Matrix - Workforce

Note 'Action Required' is stated on the Scorecard when either the Variation is showing special cause concern or the Assurance is indicating failing the target.

*Indicators marked with an asterix are unvalidated at the time of producing the IPR report.

Variance		Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail
Special Cause Improvement	H / L		Core Mandatory Training Compliance	Combined AfC and Medical Staff PADR Rate
Common Cause			PADR Rate Role Specific Mandatory Training Compliance Medical Vacancy Rate*	Medical Staff PADR Rate Unregistered Nurse Vacancy Rate* Registered Nurse Vacancy Rate*
Special Cause Concern	H / L		Sickness Turnover Rate	Trustwide Vacancy Rate*

Scorecard - Access and Flow

Note: 'Action Required' is stated when either Variation is showing special cause concern or Assurance indicates failing target.

* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Planned	% Under 18 Weeks Incomplete RTT Pathways*	Oct 2021	66.8%	92.0%	Action Required		F
Planned	Number of Incomplete RTT pathways 52 weeks*	Oct 2021	463	0	Action Required	H	F
Planned	Total Inpatient Waiting List Size	Oct 2021	9,916	11,563		L	?
Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Sep 2021	31.5%	1.0%	Action Required	L	F
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Oct 2021	58.1%	85.0%			?
Cancer	Cancer Waiting Times - 104+ Days Backlog*	Oct 2021	22	0	Action Required	L	F
Cancer	Cancer - Patients With Confirmed Diagnosis Transferred By Day 38*	Oct 2021	0.0%	75.0%	Action Required		F
Cancer	Cancer - Request To Test In 14 Days*	Oct 2021	83.9%	100.0%	Action Required		F
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Oct 2021	53.0%	95.0%	Action Required	L	F
Urgent Care	Number Of Emergency Department Attendances	Oct 2021	11,988	No target	Action Required	H	No target
Urgent Care	Ambulance Handover Delays - Number 60+ Minutes	Oct 2021	639	0	Action Required	H	F
Urgent Care	Decision to Admit - Number of 12 Hour Waits	Oct 2021	114	0	Action Required	H	?
Flow	% Patients Discharged On The Same Day As Admission	Oct 2021	35.7%	92.0%	Action Required	H	F
Flow	Patients with an Extended Stay of 21+ Days (Month End Snapshot)	Oct 2021	71	No target		L	No target
Flow	Inpatient Elective Averge Length Of Stay	Oct 2021	2.3	2.4			?
Flow	Inpatient Non Elective Averge Length Of Stay	Oct 2021	3.6	4.1		L	?
Flow	Number of Ward Medical Outliers	Oct 2021	2,597	No target	Action Required	H	No target
Flow	% Discharge Letters Completed Within 24 Hours of Discharge	Oct 2021	85.3%	85.0%			?
Flow	% Inpatient Discharges Before 12:00 (Golden Discharges)	Oct 2021	16.4%	30.0%	Action Required		F
Flow	Bed Occupancy Rate	Oct 2021	93.9%	92.0%	Action Required	H	?
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Oct 2021	30,774	9,000	Action Required	H	F
Outpatients	Outpatient Did Not Attend (DNA) Rate	Oct 2021	9.6%	No target	Action Required		No target
Outpatients	% Outpatient Non Face To Face Attendances	Oct 2021	29.9%	No target			No target
COVID	Number of COVID patients in ICU beds (Weekly)	Oct 2021	16	No target	Action Required	H	No target
COVID	Number of COVID patients in other beds (Weekly)	Oct 2021	52	No target			No target
COVID	% COVID staff absences (Weekly)	Oct 2021	16.5%	No target		L	No target

Scorecard - Quality and Safety

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

Infection Control	Number of MRSA Infections	Sep 2021	0	0			
	Number of E Coli Infections	Sep 2021	5	9			
	Number of Trust Attributed C-Difficile Infections	Sep 2021	3	3			
	Number of MSSA Infections	Sep 2021	4	0			
	Gram Negative Infections	Sep 2021	10	12			
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Jul 2021	91.5	As expected			As expected
	Summary Hospital level Mortality Indicator (SHMI)	Apr 2021	108.2	108.2			As expected
Safe Care	Patient Safety Alerts actioned by specified deadlines	Sep 2021	100%	100%			n/a
	Number of Serious Incidents raised in month	Sep 2021	18	No target			n/a
	Occurrence of 'Never Events' (Number)	Sep 2021	1	0		n/a	n/a
	Duty of Candour Rate	Sep 2021	100%	No target			n/a
	Falls on Inpatient Wards (Rate per 1000 bed days)	Sep 2021	4.5	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate per 1000 bed days)	Sep 2021	3.6	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Sep 2021	78.2%	95.0%	**Action Required**		
	Care Hours Per Patient Day (CHPPD)	Sep 2021	8.3	No target	**Action Required**		n/a
	Mixed Sex Accommodation Breaches (To be added)						
Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Sep 2021	5.0	No target		n/a	n/a
	Complaints Responded to on time (To be added in due course)						
	Compliments (To be added in due course)						
	Friends and Family Test (FFT)						
	Percentage of Positive Inpatient Scores	Sep 2021	94.1%	No target		n/a	n/a
	Percentage of Positive A&E Scores	Sep 2021	59.8%	No target		n/a	n/a
	Percentage of Positive Community Scores	Sep 2021	94.6%	No target		n/a	n/a
	Number of Positive Maternity Antenatal Scores	Sep 2021	12 out of 20	No target		n/a	n/a
	Number of Positive Maternity Birth Scores	Sep 2021	66 out of 74	No target		n/a	n/a
	Number of Positive Maternity Post-Natal Scores	Sep 2021	6 out of 6	No target		n/a	n/a
	Number of Positive Maternity Ward Scores	Sep 2021	40 out of 42	No target		n/a	n/a

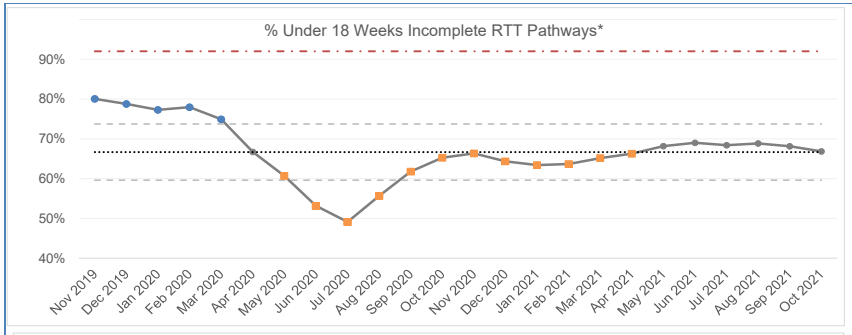
Scorecard - Workforce

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

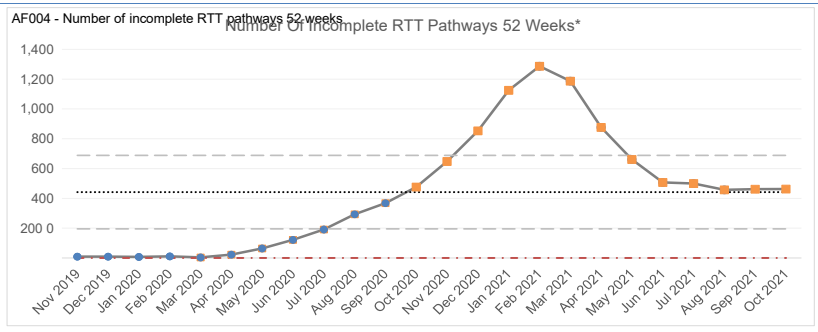
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate*	Oct 2021	7.8%	2.0%	Action Required		
Vacancies	Registered Nurse Vacancy Rate*	Oct 2021	9.4%	8.0%	Action Required		
Vacancies	Medical Vacancy Rate*	Oct 2021	13.5%	15.0%			
Vacancies	Trustwide Vacancy Rate*	Oct 2021	9.4%	7.0%	Action Required		
Staffing Levels	Turnover Rate	Oct 2021	10.6%	9.4%	Action Required		
Staffing Levels	Sickness	Sep 2021	6.4%	4.1%	Action Required		
Staff Development	PADR Rate	Oct 2021	80.0%	85.0%	Action Required		
Staff Development	Medical Staff PADR Rate	Oct 2021	82.0%	85.0%	Action Required		
Staff Development	Combined AfC and Medical Staff PADR Rate	Oct 2021	81.0%	85.0%	Action Required		
Staff Development	Core Mandatory Training Compliance	Oct 2021	92.0%	90.0%			
Staff Development	Role Specific Mandatory Training Compliance	Oct 2021	80.0%	80.0%			

Access and Flow - Planned

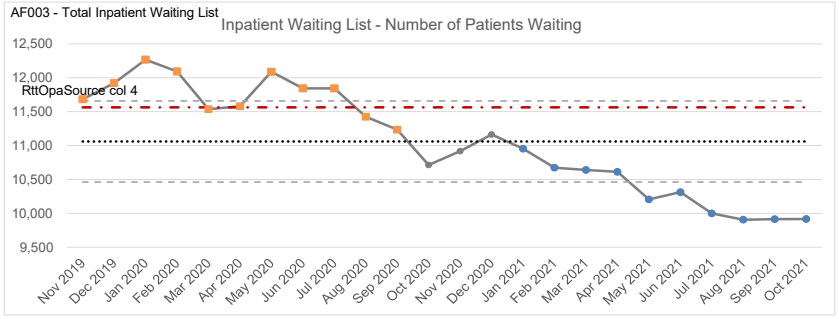
* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR



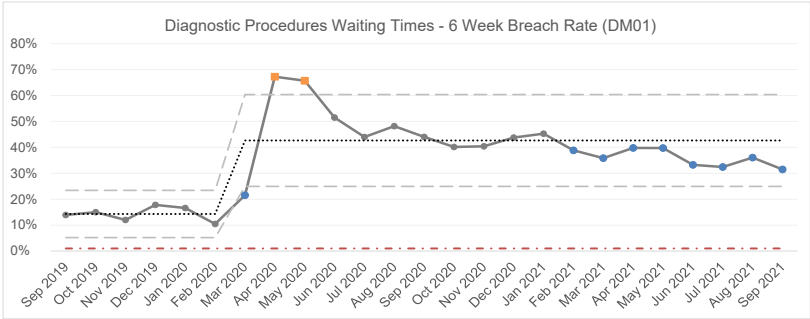
Oct 2021	66.8%
Target	92.0%
Variance	Common cause - no significant change
Assurance	Variation indicates consistently falling short of the target



Oct 2021	463
Target	0
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Variation indicates consistently falling short of the target



Oct 2021	9,916
Target	11,563
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Variation indicates inconsistently hitting passing and falling short of the target



Sep 2021	31.5%
Target	1.0%
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Variation indicates consistently falling short of the target

Data Analysis:

Under 18 weeks incomplete : Performance has stabilised following the onset of the pandemic last year, however this is at a level lower than seen pre-pandemic. This process is showing common cause variation and is not capable of meeting the target without process redesign.
Incomplete 52 weeks*: The number of 52 week waits has reduced over recent months and shows early signs of stabilising following the spike in waiters caused by the pandemic. The number of waiters is significantly higher than numbers seen pre-pandemic.
Inpatient waiting list: There has been a significant reduction in the size of the inpatient waiting list with 9,916 waiters in October. This compares to a target of 11,563.
Diagnostics 6 Week Wait (DM01): At the time of running the report, the latest validated figure was for Sept 21. For future reporting it may be possible to show an unvalidated figure for the most recent month. There has been a significant improvement in this measure following the impact of covid last year. Latest performance (September) is 31.5% compared to the target of 1%

Challenges

- Medicine division performance is currently 72% with a week on week improvement for the last few weeks. The division has 4/11 specialties above 92% threshold with the remaining specialties showing improvements in RTT performance week on week.
- Mutual aid for HUTH is creating new long RTT waits that need treating
- Endoscopy is recovering well against plan, however currently experiencing issues around patient choice

Key Risks:

- Across most specialties in medicine, there remains some capacity risks in the coming weeks due to 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
- Potential further COVID waves
- Carry over of annual leave - clinician availability
- Anaesthetic pre-assessment
- Non-Obstetric Ultrasound is a low performing area.
- Consultant Radiologists: 50% vacancy rate

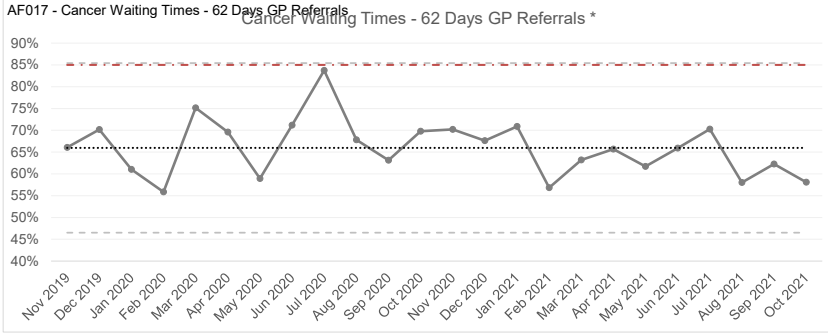
Actions

- Medicine Division Activity Recovery Plans for 2021-22 for every specialty are in place
- External Providers sourced for Gastroenterology, Respiratory, Cardiology, Endocrinology and Rheumatology. Additional sessions being delivered by internal consultants also.
- Medicine have secured external provider for New RTT patients which has seen a further reduction in the number of 40+wks patients.
- Note review of all Anaesthetic pre-assessment patients
- Band 3 pre-communication staff member to ensure the patients planned for surgery are contacted 10/7/5/3 days pre-op to reduce on the day cancelations
- Conversations are happening with NL CCG and another two IS providers to source additional NOUS capacity
- Business cases are being written to appoint more substantive staff in Diagnostic departments to bridge the gap between demand and capacity

Mitigations:

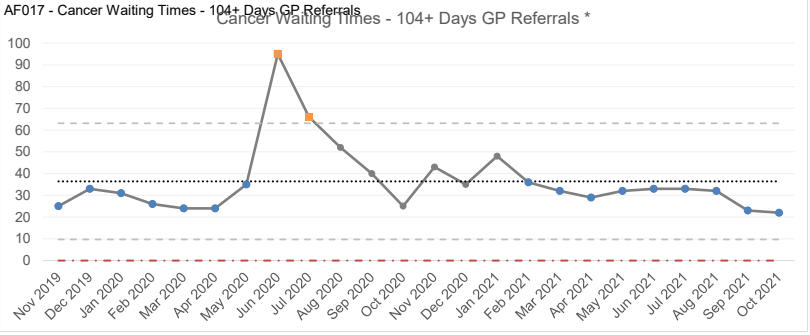
- Medicine Division continue with recovery with additional sessions by NLaG clinicians. Working with various external providers to provide additional clinic capacity and reduce the time patients wait to receive treatment.
- Medicine are progressing with securing additional external provider sessions.
- Locum staff in place
- Weekly assurance that on the H2 planning numbers we continue to see a reduction in longer waiters and movement towards constitutional standards
- Audiology recovery plan
- Ongoing recruitment of Consultant Radiologists (UK and abroad).

AF017 - Cancer Waiting Times - 62 Days GP Referrals



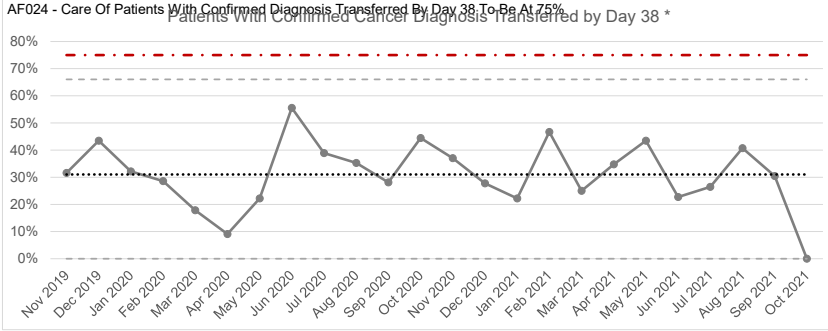
Oct 2021	Target	Variance	Assurance
58.1%	85.0%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target

AF017 - Cancer Waiting Times - 104+ Days GP Referrals



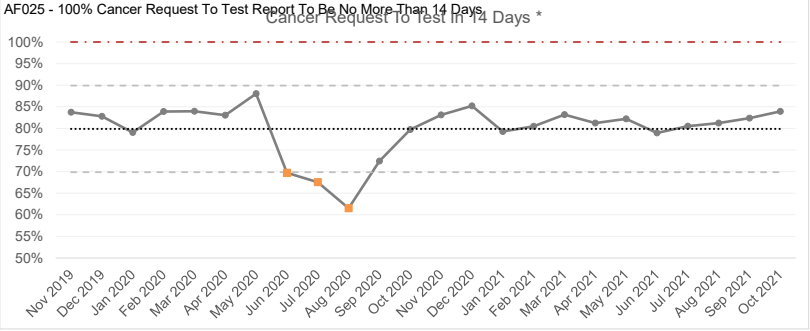
Oct 2021	Target	Variance	Assurance
22	0	Special cause of improving nature or lower pressure due to lower values	Variation indicates consistently falling short of the target

AF024 - Care Of Patients With Confirmed Diagnosis Transferred By Day 38 To Be At 75%



Oct 2021	Target	Variance	Assurance
0.0%	75.0%	Common cause - no significant change	Variation indicates consistently falling short of the target

AF025 - 100% Cancer Request To Test Report To Be No More Than 14 Days



Oct 2021	Target	Variance	Assurance
83.9%	100.0%	Common cause - no significant change	Variation indicates consistently falling short of the target

Data Analysis:
62 days GP referral*: Performance has remained stable since September 2019 (common cause variation). This target has not been achieved within the last 2 years. It will fail to meet the target without process redesign.
104+ days GP referrals*: The number of 104+ day waiters has stabilised to pre-pandemic levels over recent months. There are now 22 patients waiting compared to a target of 0.
Transferred by day 38*: Performance has not changed significantly over the past 2 years. The target has not been achieved within the last 2 years and in October 21 it fell to 0%. It will continue to fail the target without process redesign.
Request to test 14 days*: Performance has stabilised close to pre-pandemic levels following a period of poorer performance last summer and is showing common cause variation (no significant change). This target has not been achieved within the last 2 years. It will continue to fail the target without process redesign.

Challenges

• Colorectal is a challenge but the teams are working to improve referrals in to ensure the right pts receive the diagnostics required

Key Risks:

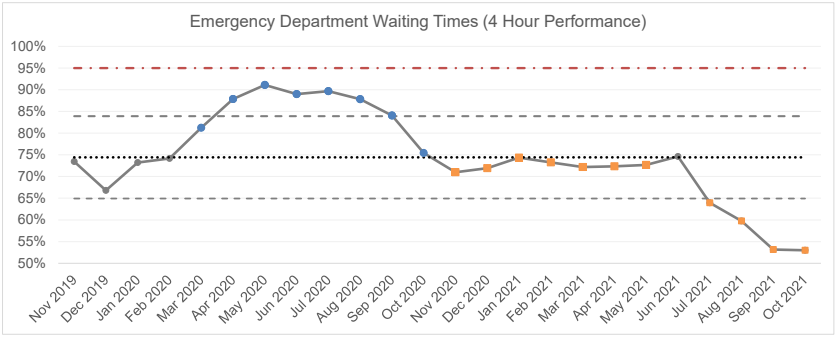
• There are a number of issues related to visiting consultant services (e.g urology, oncology), tertiary based staging scans (EUS, PET CT) which affect the ability to transfer (IPT) for treatment by Day 38

Actions

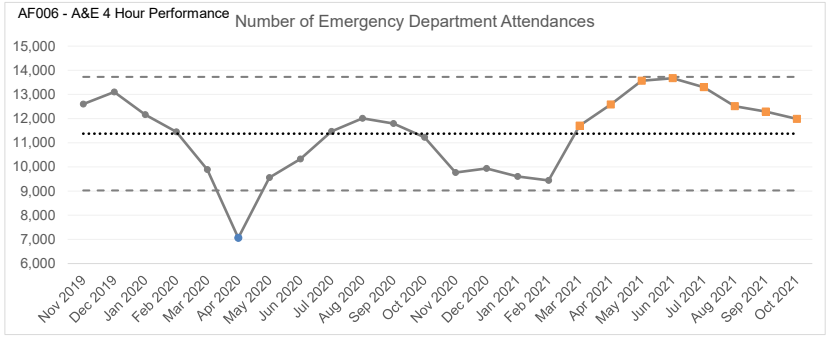
• 62 day performance is being reviewed and managed weekly
• The Cancer Transformation team has completed a pathway analysis on 100 patient pathways for Lung. Outputs of this analysis have identified several areas for improvement and discussions are continuing with HUTH (joint pathway transformation and implementation of national optimal pathway)

Mitigations:

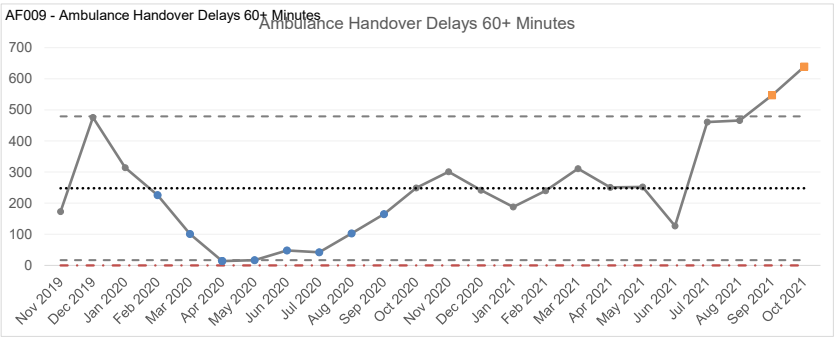
• The pathway analyser tool that has been developed within NLAG (using the IST tool) and the in depth analysis of pathways will enable teams to identify where improvements in NLAG can be achieved
• The joint transformation pathway work with HUTH will help with the transfer of patients between NLAG/ HUTH and to identify areas where the pathway can be accelerated



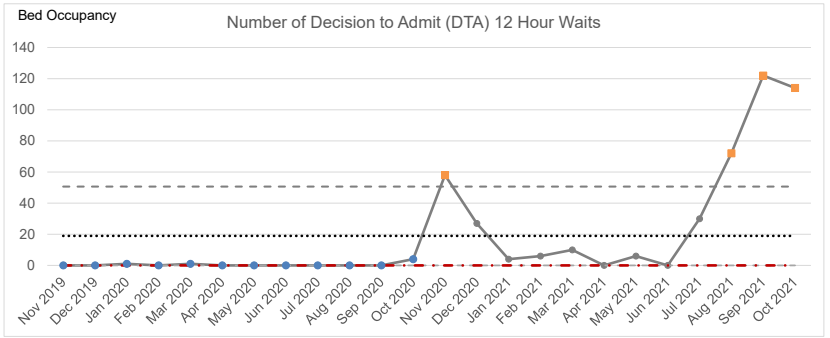
Oct 2021
53.0%
Target
95.0%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Variation indicates consistently falling short of the target



Oct 2021
11,988
Target
No target
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
There is no target therefore target assurance is not relevant



Oct 2021
639
Target
0
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates consistently falling short of the target



Oct 2021
114
Target
0
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

Emergency Dept 4 hour performance: There has been a significant deterioration in performance which coincides with higher levels of attendances. This target has not been achieved within the past 2 years and it will continue to fail to meet target without process redesign.

Emergency Dept Attendances: There has been an increase in the number of attendances over the past 8 months with attendance numbers returning to pre-pandemic levels.

Ambulance handover 60+ minutes: There have been four consecutive months of significantly higher numbers of delays (special cause variation) with October having 639 delays against a target of 0.

DTA 12 hours: There have been three consecutive months of significantly higher numbers of patients waiting (special cause variation) with 114 patient waiting more than 12 hours for a bed from the decision to admit in October.

Challenges

• ED attendances continue to be higher than last year
• Workforce sickness, covid-19 isolation, low morale and impacts on staff wellbeing continue to challenge rota fill with a reduction of bank/agency pick up
• Northern Lincolnshire is experiencing the highest levels of acuity for EMAS conveyances and this is resulting in longer waits in resus
• Exit block out of ED is resulting in stagnant patient flow and ED reaching beyond full capacity each day. This leads to no capacity to offload incoming ambulances and delays in wait to be seen times
• Implications of COVID19 (zoning segregation, PPE, awaiting swab results, staff sickness and isolation) creating challenges and delays for patient pathway through the ED
• Delays in diagnostic imaging at times and in specialty in-reach not meeting the less than 30min attendance to review Emergency Care Standards
• Inappropriate attendances to ED due to lack of access to alternative, more appropriate services
• Ambulance handover delays and 60min+ 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
• Delays in completing ambulance handover have a negative impact on the 4hr A&E performance
• 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

Key Risks

• Shortages in available workforce to meet service needs (skill mix and experiece)
• Inappropriate attendances and conveyances to ED
• Covid-19 impacting phsyical capacity within the current ED footprint
• Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission and long patient waits in ED
• High acuity levels and patients remaining in resus for significant periods of time rather than being stablised and transferred to a suitable service (ITU/HDU)

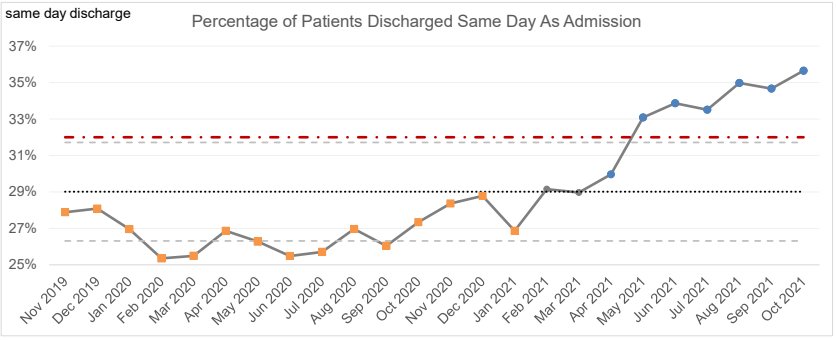
Actions

• The Urgent Care Service (UCS) at SGH went live from 18th October 2021
• New patient pathways with streamlined access from arrival to seeing a clinician within the UCS
• MDT working with primary care to ensure patients are seen by the right person, first time
• Updated SOPs for Integrated Acute Assessment Unit (IAAU) and Same Day Emergency Care (SDEC) services to further improve direct accessibility to these services from primary care and ED
• New ED leadership structure in place to support improvement changes in ED and UCS
• NHS111 First Initiative to reduce avoidable ED attendances
• New ED/AAU builds in development to increase ED phsyical capacity and bring ED and IAAU to a joint location
• Ambulance Handover Task and Finish Group with system partners to drive System-wide Ambulance Handover Improvement Plan
• Ambulance pathway direct to SDEC relaunched to improve crew awareness and usage including weeky review into any failed referrals
• Discharge to assess initiative to ensure patients are discharged in a timely manner to support adequate patient flow throughout the hospital
• Senior second reviews and long length of stay (LOS) reviews carried out

Mitigations

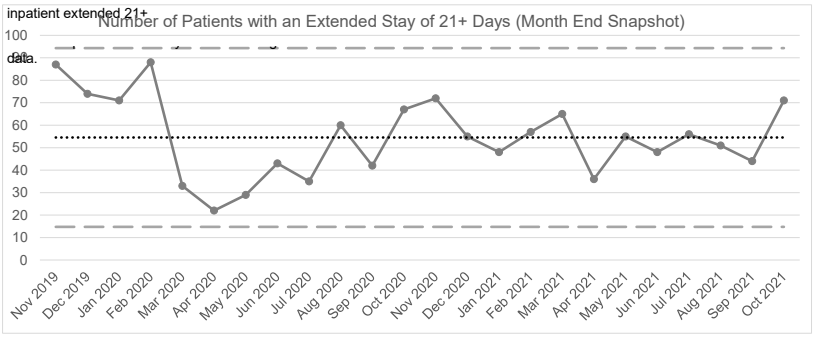
• Tier system of Medicine senior management in place for prompt escalation, resolution and support for ED
• Fast track paediatric process in place
• Increased staffing in ED
• 2 hourly board rounds with EPIC and Clinical Coordinator with nursing care needs monitored through care round document – risk assess for pressure ulcers, falls, nutrition, hydration, comfort
• Alternatives to trolleys – beds, recliner chairs. Choice of meals for patients during prolonged ED stays

same day discharge

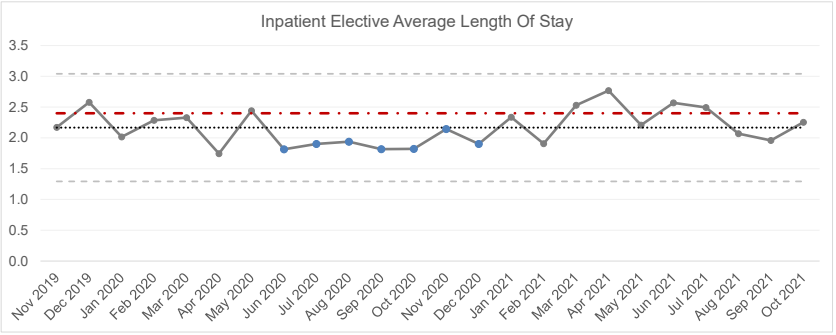


Oct 2021	Target	Variance	Assurance
35.7%	32.0%	Special cause of improving nature or lower pressure due to higher values	Variation indicates consistently falling short of the target

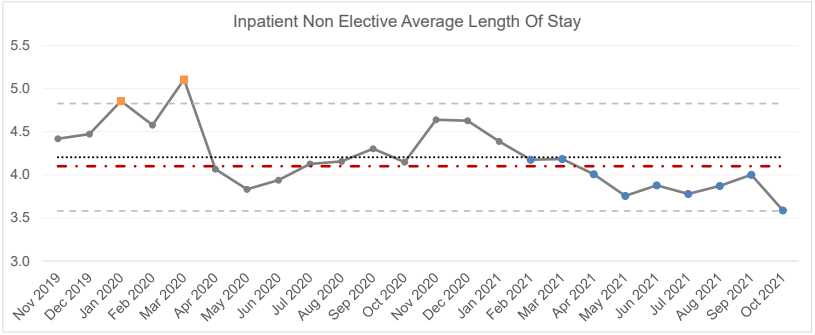
inpatient extended 21+ data.



Oct 2021	Target	Variance	Assurance
71	No target	Common cause - no significant change	There is no target therefore target assurance is not relevant



Oct 2021	Target	Variance	Assurance
2.3	2.4	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Oct 2021	Target	Variance	Assurance
3.6	4.1	Special cause of improving nature or lower pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:
Discharged same day as admission: For seven months there has been a higher level of same day discharges (good special cause variation) and for six of these months the target of 32% has been achieved. If this improvement is sustained for several more months, it will be possible to recalculate the process limits.
Extended stay 21+ days: The number of patients has remained stable for over a year.
Elective length of stay: Elective length of stay has been stable for the past several months. The target of 2.4 days was achieved for the past three months, however sometimes the target will be achieved and sometimes it will fail at random.
Non elective length of stay: There has been a decrease over the past year. This coincides with an increase in the percentage of patients discharged on the same day as admission.

Challenges

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

Key Risks

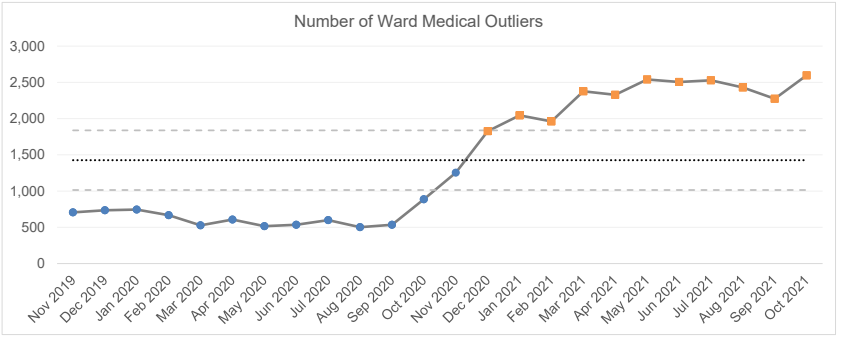
- Shortages in available workforce to meet service needs which results in inconsistancy and delays in patient pathways
- Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission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

Actions
- Daily board rounds on wards
- Discharge rounds at weekends

. LLOS reviews in place for medicine twice per week led by the senior tri
. Regular meetings with system partners to understand current delays/issues
. Discharge imporvement plan currently being developed which pulls together all areasof discharge including checklist, discharge lounge, board rounds & transport
. Continuous engagement with ward staff around the discharge pathway

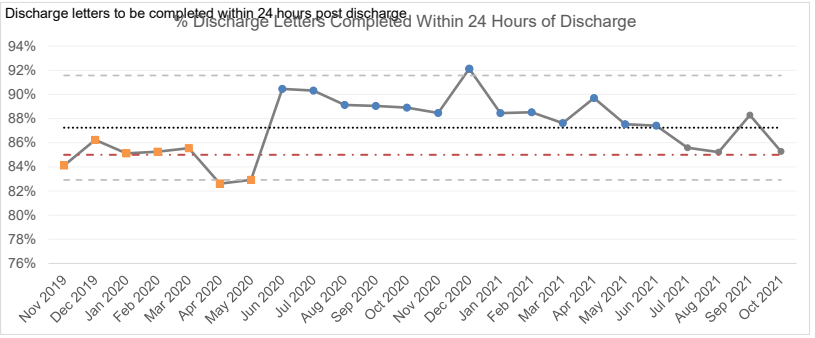
Mitigations
- Daily board rounds on wards - work to further develop these to ensure they are effective and timley
- Discharge rounds at weekends
- LLOS reviews in place for medicine twice per week led by the senior tri, next step is to ensure this is in place for surgery as LOS for surgery have increased
- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clear action plan for delayed discharge and escalation plan. Any outstanding are escalated through their internal agencies with an outcome/plan for discharge to reported back by 2pm. if there is still no confirmation on a plan for the patient to leave the acute bed on that day this is then escalated to the system strategic leads for further action.

.Themes are collated during the week from these escalations and fed back to a fortnightly discharge improvement meeting and this feeds our improvement plan.

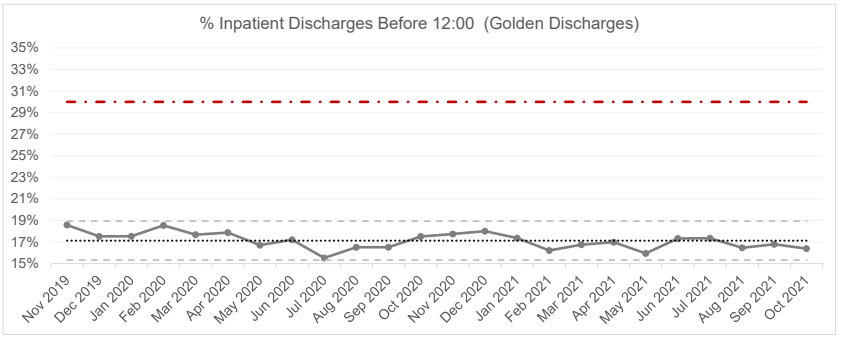


Oct 2021	2,597
Target	No target
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	There is no target therefore target assurance is not relevant

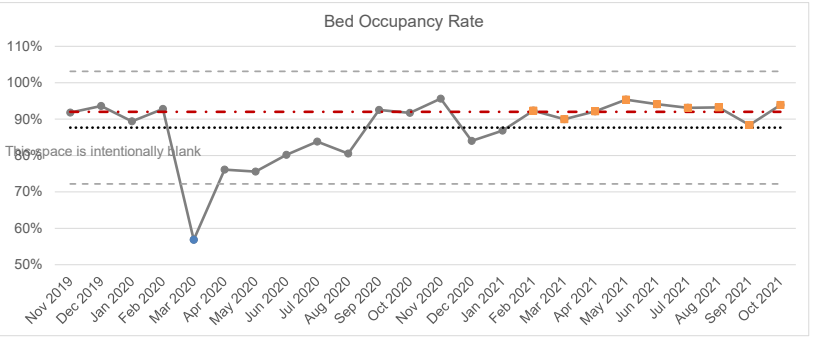
Discharge letters to be completed within 24 hours post discharge



Oct 2021	85.3%
Target	85.0%
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and falling short of the target



Oct 2021	16.4%
Target	30.0%
Variance	Common cause - no significant change
Assurance	Variation indicates consistently falling short of the target



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Oct 2021	93.9%
Target	92.0%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

Ward medical outliers: For the past 11 months, there has been a significantly higher number of medical outliers. There has been a five-fold increase in numbers compared to September 2020.

Inpatient discharge letters: Performance is currently stable. The target has been achieved for the previous 17 months.

Inpatient discharges before 12:00: Performance has remained relatively stable since September 2019. Performance in October was 16.4% against a target of 30%. Currently, the highest percentage that can be expected without redesign is 19%.

Bed Occupancy: Higher levels of occupancy have been experienced over the past 9 months.

Challenges

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

Key Risks

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

Actions

.
. Daily board rounds on wards
- Discharge rounds at weekends

. LLOS reviews in place for medicine twice per week led by the senior tri
. Regular meetings with system partners to understand current delays/issues and encouraging patients to discharge lounge to wait for medicaltion, letters & transport
. Discharge imporvement plan currently being developed which pulls together all areasof discharge including checklist, discharge lounge, board rounds & transport
. Continuous engagement with ward staff around the discharge pathway

Mitigations

- Working through the IAAU model as part of implementation of the Urgent Care Service to ensure right patient, right bed

. Daily board rounds on wards - work to further develop these to ensure they are effective and timley
- Discharge rounds at weekends
- LLOS reviews in place for medicine twice per week led by the senior tri, next step is to ensure this is in place for surgery as LOS for surgery have increased
- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust

. Currently planning to implment the criteria toadmit tool within ED

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Oct 2021
30,774

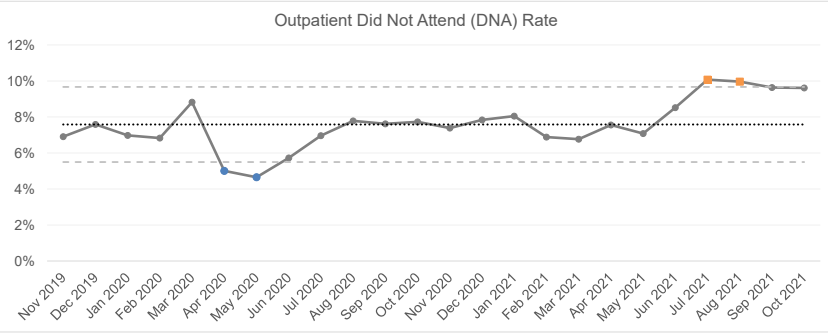
Target
9,000

Variance

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

Assurance

Variation indicates consistently falling short of the target



Oct 2021
9.6%

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant

Oct 2021
29.9%

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant

Data Analysis:
Outpatient Overdue follow up: The number of overdue follow ups has shown a significant increase over the past 8 months with 30,774 patients waiting longer for a follow up than they should. This is against a target of 9,000.
Outpatient DNA rate: DNA rates have been significantly higher for 5 months following a period of stability since November 2019.
Non Face To Face Outpatient Attendances: There has been a gradual decrease in the percentage of non face to face outpatient appointments since the significant increase in April 2020.

Challenges

• Overdue follow-up pts are not to anticipated levels in Urology, Ophthalmology and T&O

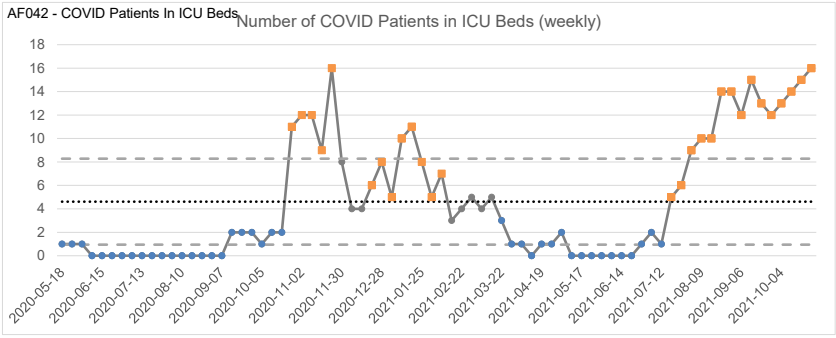
Actions:

• PIFU - Cardiology and Respiratory on trajectory
• Targetted work with other specialties to increase the number of patients on a PIFU pathway in line with expected Trajectory
• CHN continues with cardiology seeing reduction in overall waiting list position.
• Further collaborative work with Primary Care Networks: Clinics being held by GPWSI in Rheumatology
• Heart Failure at home being trialled as part of PKB in Cardiology.

Mitigations

• Weekly assurance that on the H2 planning numbers we continue to see a reduction in longer waiters and movement towards constitutional standards

AF042 - COVID Patients In ICU Beds



2021-10-25
16

Target
No target

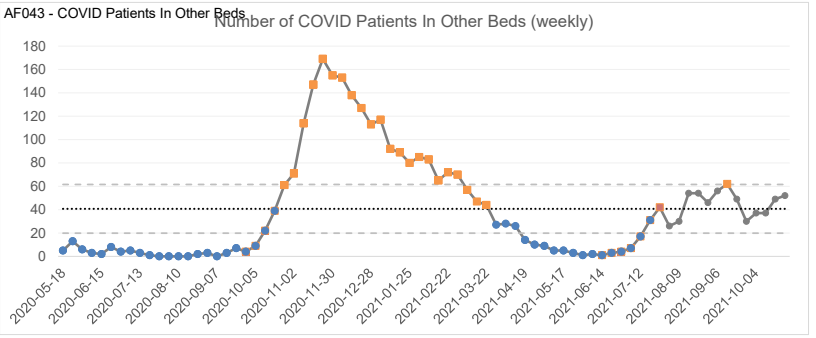
Variance

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

Assurance

There is no target therefore target assurance is not relevant

AF043 - COVID Patients In Other Beds



2021-10-25
52

Target
No target

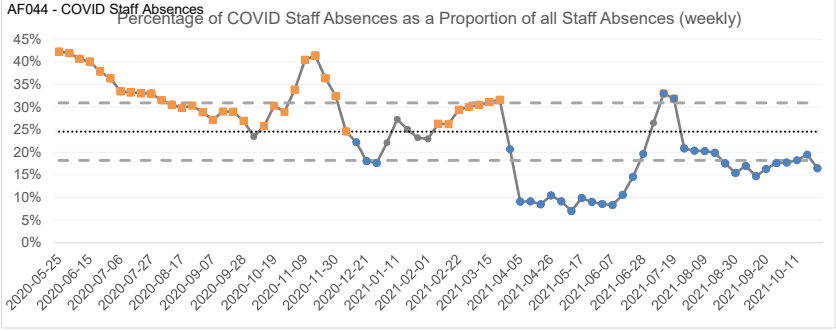
Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant

AF044 - COVID Staff Absences



2021-10-25
16.5%

Target
No target

Variance

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

Assurance

There is no target therefore target assurance is not relevant

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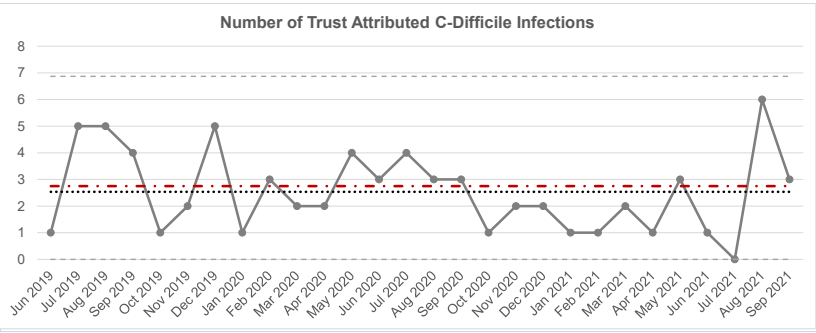
Data Analysis:
COVID Patients In ICU beds: The number of covid patients in ICU remains significantly higher than number during springtime.
COVID Patients In Other Beds: The number of covid patients in other beds remains stable. □
COVID Staff Absences: : The proportion of staff absences related to covid has reduced since a peak in July.

Sep 2021	Target	Variance	Assurance
0	0	Common cause - no significant change	Variation indicates inconsistently hitting passing and failing the target



Sep 2021	Target	Variance	Assurance
3	2.8	Common cause - no significant change	Variation indicates inconsistently hitting passing and failing the target

Sep 2021	Target	Variance	Assurance
5	9.2	Common cause - no significant change	Variation indicates inconsistently hitting passing and failing the target

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Data Analysis:
MRSA: No infections have occurred since December when there was one occurrence.
C Diff: 3 infections occurred in September. This is within the expected range of variation.
E Coli: 5 infections occurred within September. This is within the expected range of variation

Commentary:

MRSA
> Cases of MRSA hospital onset bacteraemia remain stable and within parameters.

E Coli
> The new NHS standards contract gives the Trust a threshold of 5% reduction on 2019 cases, for NLaG this is 110.
> Case numbers remain within expected parameters. Seasonal variation as expected.

C Diff
> In August we experienced an increase in hospital associated cases but since stabilised
> > Deep clean schedule is being tackled as some wards behind

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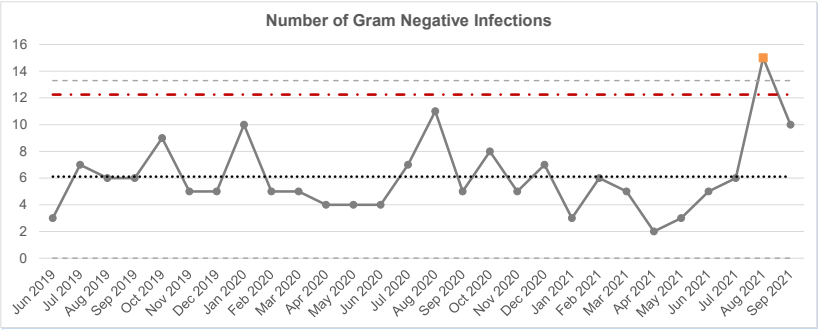
Sep 2021	Target	Variance	Assurance
4	0	Common cause - no significant change	Variation indicates inconsistently hitting passing and failing the target



Sep 2021	Target	Variance	Assurance
10	12	Common cause - no significant change	Variation indicates inconsistently hitting passing and failing the target

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Data Analysis:

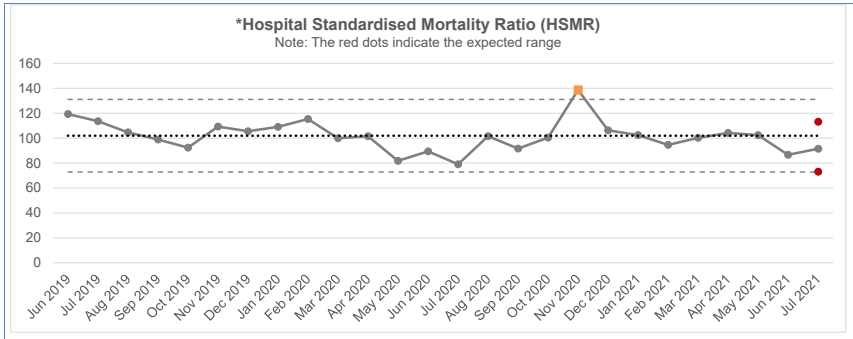
MSSA: 4 infections occurred in September. This is within the expected range of variation.

Gram Neg: 15 infections occurred in August which exceeded the target of 12, followed by 10 in September which is within the expected range of variation.

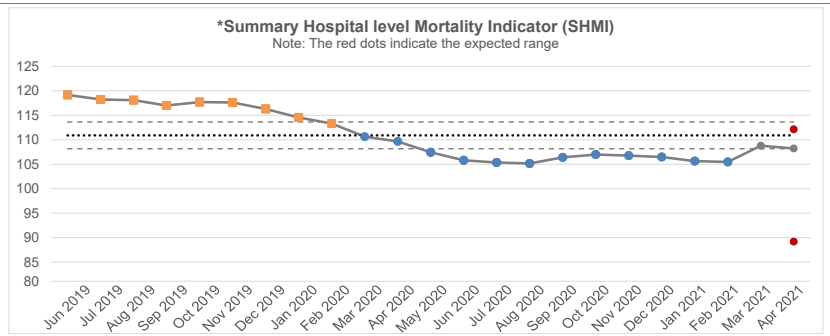
Commentary:

Northern Lincolnshire and Goole NHS Foundation Trust

***There are national problems with the mortality data provided by NHS Digital and HED resulting in no rolling update since the last IPR**



Jul 2021
91.5
Target
As expected
Variance
Common cause - no significant change
Assurance
Within 'Expected' range



Apr 2021
108.2
Target
As expected
Variance
Common cause - no significant change
Assurance
Within 'Expected' range

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Data Analysis:
***Note:** There are currently national problems with the mortality data provided by NHS Digital and HED resulting in no rolling update since the last IPR.
HSMR: Performance remains within the expected range.
SHMI: Performance remains within the expected range.

Commentary:
HSMR

HSMR is a ratio between the number of actual deaths (in hospital) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. This is reported on a rolling 12 month basis and is a national indicator. Originally the data on deaths comes from the Trust PAS system, and the scores themselves are calculated and then provided back by NHS Digital and HED so ensure these balanced across the country using data from all hospitals. NHS Digital Provide the Official SHMI, and the HED system provide a slight variation on that SHMI and the HSMR information.

The Trust's HSMR remains under the target of 100.

The HSMR along with other mortality indices are overseen by the Trust's Mortality Improvement Group (MIG). Significant progress has been seen with SHMI and HSMR during 2020/21.

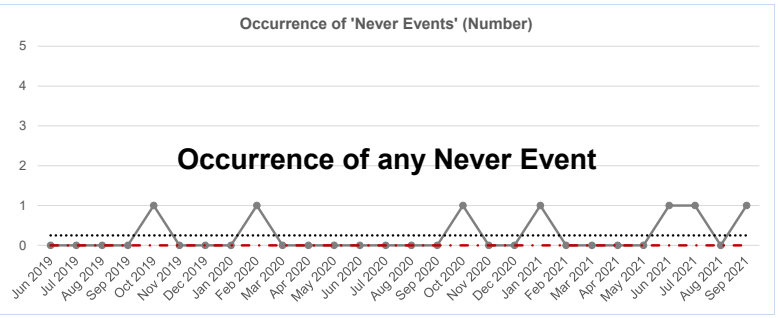
SHMI

SHMI is a ratio between the number of actual deaths (in hospital and within 30 days of discharge from hospital) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. This is reported on a rolling 12 month basis and is a national indicator. Originally the data on deaths comes from the Trust PAS system, and the scores themselves are calculated and then provided back by NHS Digital and HED so ensure these balanced across the country using data from all hospitals. NHS Digital Provide the Official SHMI, and the HED system provide a slight variation on that SHMI and the HSMR information.

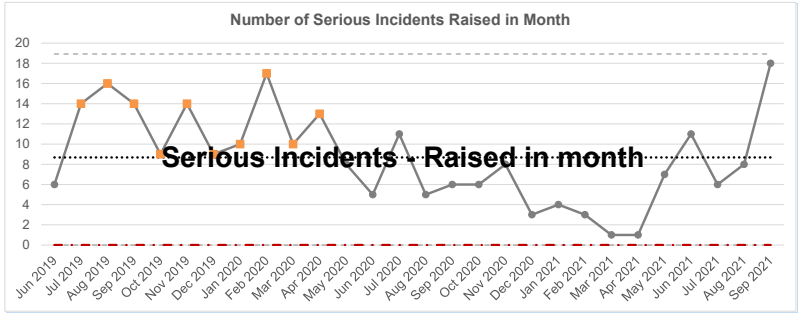
The chart tells us that the Trust's SHMI performance has improved to a statistically significant reduction.

The Trust's SHMI is still above the national average (100) but is statistically described as being 'as expected'. The SHMI includes out of hospital deaths as well as in-hospital deaths. when breaking the indicator down into its component parts, the in-hospital SHMI is beneath 100, but the out of hospital component, which measures deaths within 30 days of discharge, is higher than 100.
Actions: SHMI performance as well as the Trust's performance against other mortality indices is overseen by the Trust's Mortality Improvement Group (MIG). The out of hospital SHMI is a Trust Quality Priority for 21/22 and the Trust is working with NHSE/I to undertake a review of out of hospital deaths and EOL care. A local case review has also commenced to review patients who died with >3 admissions in the last 3 months of life.

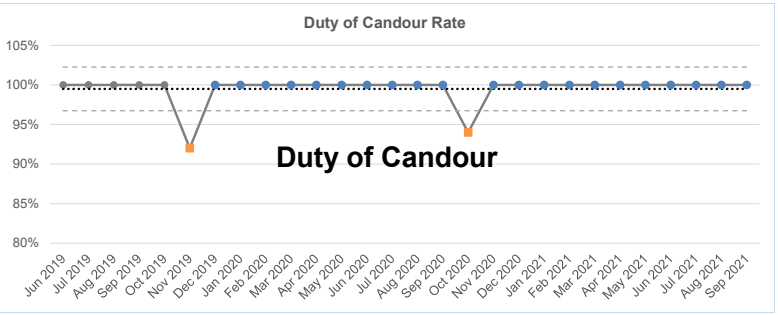
Sep 2021
100%
Target
No target
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
There is no target, therefore target assurance is not relevant



Sep 2021
1
Target
0
Variance
Due to the infrequency of Never Events a line chart is considered more appropriate than an SPC chart therefore variance is not relevant.
Assurance
Due to the infrequency of Never Events a line chart is considered more appropriate than an SPC chart therefore target assurance is not relevant.



Sep 2021
18
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Sep 2021
100%
Target
No target
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:
Patient Safety Alerts: Performance for September continued at 100%.
Never Events: There was 1 never event recorded for the month of September.
Serious Incidents: There were 18 serious incidents recorded for September, which is the highest figure in the last two years, however still within the expected range of variation.
Duty of Candour: Performance for August continued at 100%.

Commentary:

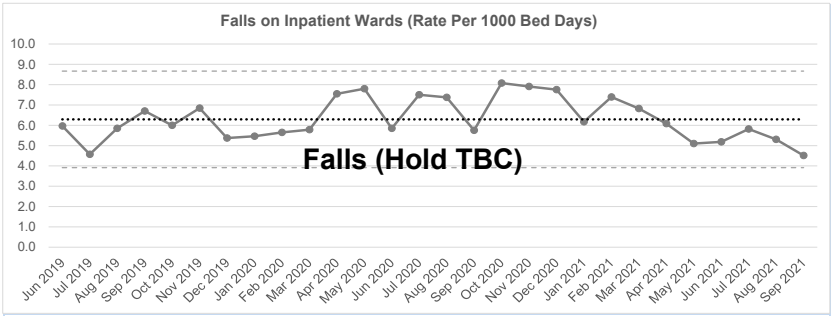
Patient Safety Alerts
This indicator is based on National Patient Safety Alerts (NatPSAs), a type of alert received via the Central Alerting System (CAS). There are no National Patient Safety alerts open past the specificed deadline, therefore the compliance for September 2021 continues at 100%.

Actions: The Quality Governance Group receives a monthly update on this subject which includes a review of all open National Patient Safety Alerts as well as other alerts received via CAS.

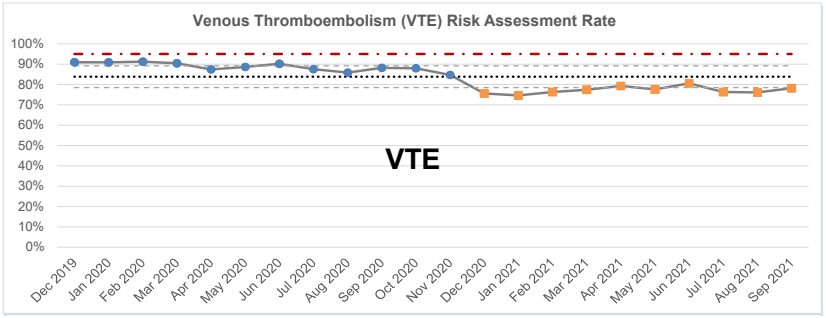
Never Events
In June there was one never event declared, a wrong site injection. In July there was a further never event declared which related to a retained swab in Theatres at SGH. The chart indicates that during September 2021 the Trust had a further Never Event, this time in Cardiology where results being dictated into the wrong patient's letter led to that patient being brought for an unecessary angiogram. No harm resulted and the patient who required the angiogram has since had this. **Actions:** The post Never event meeting, chaired by the Medical Director, seeks to identify where the error occured and any related issues that require further investigation as part of the never event investigation process that follows. Ations are followed up at the SI Panel. Given more than one never Event in Ophthalmology, the division brought a review of previous actions to QGG and undertook further work to share the learning from previous never events as well as those recently declared. **Mitigations:** Each never event reported will identify key learning and mitigations. The WHO checklist usage is being regularly assessed.

Serious Incidents
The chart shows that the number of Serious Incidents (SIs) raised per month had been reducing. However, in May 2021 an increase was observed. In September 2021 a significant increase in comparison to previous months (18 SIs) was reported. **Actions:** Ongoing monitoring and review of incidents reported is overseen by the Trust's SI Panel that reports into Quality Governance Group and a monthly report is produced for Quality & Safety Committee. Key Serious Incidents and All Maternity Serious Incidents Report feautures the details surrounding Serious Incidents and is discussed monthly at Quality and Safety Committee. Details are also provided through the executive report. **Mitigations**: A Serious Incident Review Group undertakes deep dive focus into specific and identified themes arising from SIs to support a focus on embedding improvements in response and support the Trust's aspiration of being a learning organisation. A Learning Group has also commenced to focus on intensive sharing of learning around a key theme taken from integrated risk intelligence. The current area of focus for this group is safe handover.

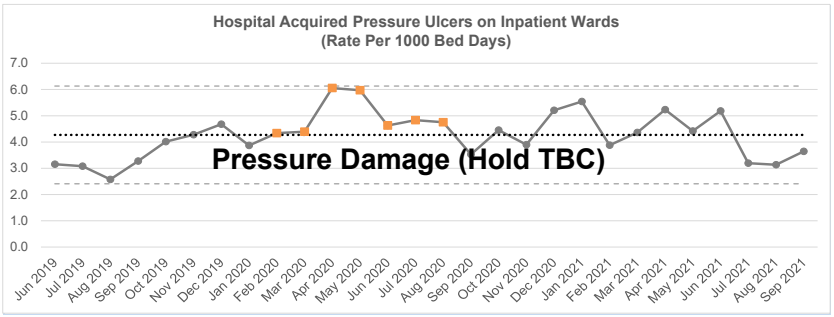
Duty of Candour
The data source is from Ulysses and shows compliance with duty of candour requirements in relation to Serious Incidents only. The Trust's target for this area is 100%. As a result, the Statistical Process Control (SPC) upper control limit is based on the statistical confidence 'rules' and therefore exceeds 100%. In this setting this should be deemed as not applicable in this instance. **Issues/Risks:** There is a requirement to ensure duty of candour is completed for all instances of harm at moderate level or above. There is a gap at present in relation to moderate level harm. Divisions approach to resolve this has been hampered by operational responses to the Covid-19 pandemic. 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. **Actions:** Ongoing oversight and action, working with Divisions to obtain assurance that all moderate (and above) harm instances have duty of candour completed. Completion of 'moderate harm' duty of candour is monitored through SI panel, significant improvements have been noted. **Mitigations:** Ongoing work and focus on with Divisions with support from the central team.



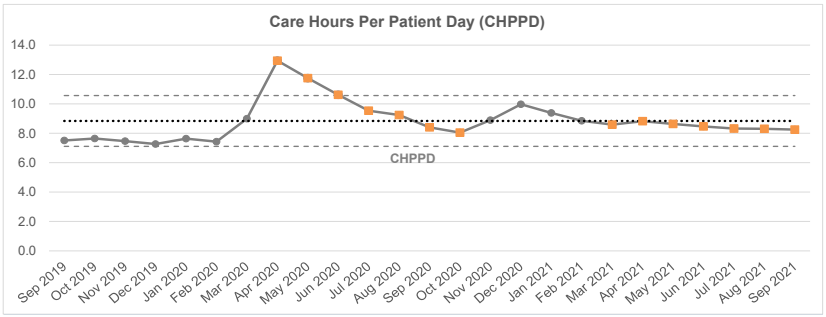
Sep 2021	4.5
Target	No target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Sep 2021	78.2%
Target	95.0%
Variance	Special cause of concerning nature or lower pressure due to lower values
Assurance	Variation indicates consistently failing the target



Sep 2021	3.6
Target	No target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Sep 2021	8.3
Target	No target
Variance	Special cause of concerning nature or lower pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant

Data Analysis:
Falls on Inpatient Wards: The falls rate for September was 4.5%. This is within the expected range of variation and the rate has been gradually reducing since Feb 21 .
VTE Risk Assessment: September saw the tenth month of significantly poorer performance with 78.2% performance against a target of 95%. There has been a consistent improvement in performance over the last 6 months. **Hospital Aquired Pressure Ulcers:** The rate of hospital acquired pressure ulcers was 3.6% for September. This is within the expected range of variation.
Care Hours Per Patient Day: The rate has been declining for seven consecutive months with Setpember being 8.3.

Commentary:
VTE Risk Assessment

This chart demonstrates the number of patients who have been admitted to hospital and that have had a VTE risk assessment. This is 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 older Department of Health (DH) guidance, also form part of the numerator. The chart demonstrates that the Trust's performance has increased slightly from 76.10% in August 2021 to 78.2% in September against the 95%target.

Issues/Risks: VTE risk assessment performance has been impacted upon adversely during the Trust's response to Covid-19. The Trust are still operationally very challenged in response to an increasing demand of Covid-related (or Covidsuspected) acute admissions. The actions being taken now to launch an e-screening tool will not be shown in the data reported within the Integrated Performance Report (IPR) until December 2021, which will focus on performance during the month of October 2021.

The ePMA system is only deployed on inpatient ward areas so excludes A&E. Risk has been identified for 'stranded' patients in A&E, which have been handed over to the medical/surgical teams by the A&E team, but do not have a bed on an inpatient ward yet. These patients require a VTE assessment completed, but because they have yet to be transferred to an inpatient ward, cannot be done on ePMA. This is due to ePMA and linkages to eCAMIS which generates a new inpatient episode of care once the patient is physically on the admissions ward. Once the patient arrives on a ward, the ward staffs are not supported to administer from the paper drug chart and have to wait for the clinician to prescribe the drug chart again on ePMA.

VTE Continued...

Mitigations: Clinical leads identified and actively working to review and update VTE related policy and patient intended information in line with latest guidance from NICE.

Ongoing education work with clinical staff.

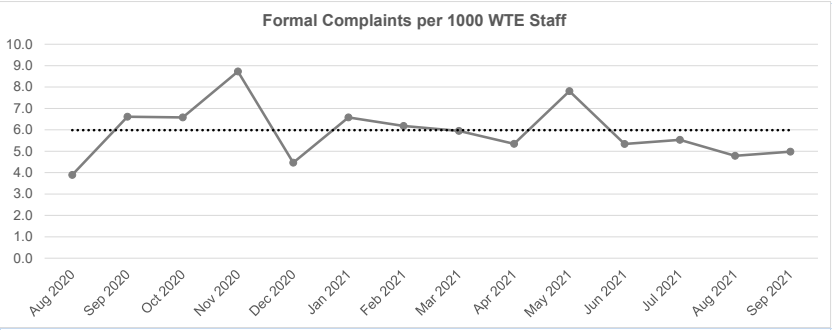
Engagement with trainee grades of medical staff to understand and overcome identified barriers.

Speciality clinicians provided with the ability to prescribe onto ePMA whilst patients are lodged for a bed in ECC.

ECC will not be able to administer from ePMA and so any critical medications to be prescribed onto the ECC card prescription page.

Falls on Inpatient Wards: The falls rate for September was 4.5%. This is within the expected range of variation.

Hospital Acquired Pressure Ulcers: The rate of hospital acquired pressure ulcers was 3.6% for September. This is within the expected range of variation. **Care Hours Per Patient Days:** The care hours per patient day has been falling for the last 9 months, with the latest (September) figure being 8.3



Sep 2021
5.0

Target
No target

Variance

There is currently insufficient data for an SPC chart

Assurance

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

Compliments (to be added if data available)

Complaints Reposnded to on time (To be added if data available)

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Data Analysis:
Formal Complaints: In September there were 5 formal complaints.

Commentary:

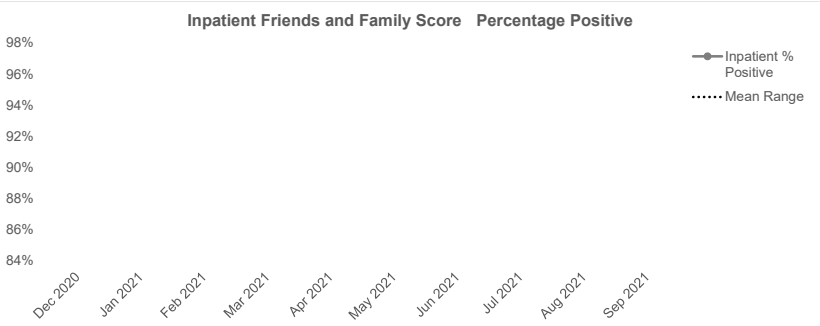
Formal Complaints
Formal complaints are received by the Trust patients or someone on their behalf such as a relative, MP, solicitor or CCG. These are triaged by the Complaints Manager to ensure the correct route of management is undertaken. The current Trust policy aims to respond to formal complaint within 60 working days. This data is not a data set we currently report on and does not demonstrate the complaints performance and quality in a meaningful way. The data set shown represents new formal complaints measured against per 1000 whole time equivalent (WTE) staff. The Trust currently sits towards the mid zone (82nd) when benchmarked against other Trusts (198 total).

Issues/Risks:
SJR continues, within complaints, to need further work to ensure quality and timeliness of review Management of complaint responses within timescale remains a challenge due to divisional capacity Engagement with complaint process at divisional level, culture shift required to prioritise and embed learning from complaints as an opportunity rather than a threat.

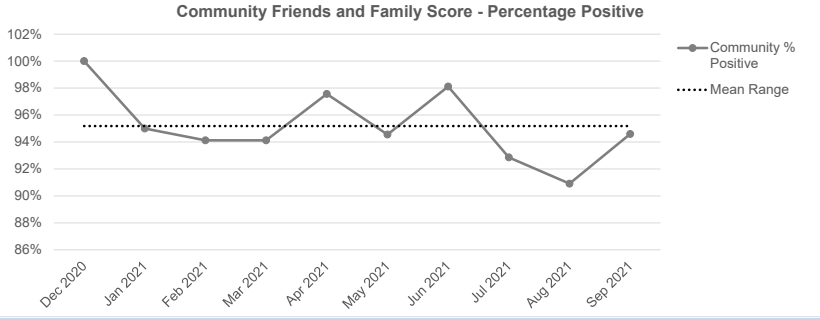
Actions:
> Continued support of lead investigator role
> SJR training for Lead Nurse involved in quality sign off process
> Development of complaint module within new incident system - Ulysses

Formal Complaints Cont/d...

Mitigations:
> Continued work with SJR team , additional weekly oversight on all open SJR, Lead Nurse trained now to undertake SJRs
> Monthly Reporting sent to divisions for good oversight
> Central Team support for all lead investigators and divisions
> Learning Log evident on current incident reporting module
> Support & Challenge Meetings weekly to monitor performance and quality



Sep 2021	Target	Variance	Assurance
94.1%	No target	There is currently insufficient data for an SPC chart	There is currently insufficient data for an SPC chart



Sep 2021	Target	Variance	Assurance
94.6%	No target	There is currently insufficient data for an SPC chart	There is currently insufficient data for an SPC chart

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Sep 2021	Target	Variance	Assurance
59.8%	No target	There is currently insufficient data for an SPC chart	There is currently insufficient data for an SPC chart

Data Analysis:
Inpatient FFT: Performance for September was 94.1% and the average since Dec 2020 is 93.4%
A&E FFT: Performance for September was 59.8% and the average since Dec 2020 is 72.9%
Community FFT: Performance for September was 95.6% and the average since Dec 2020 is 95.8%

Commentary:
The Friends and Family Test is a mandated patient experience measure which enables patient insights to gathered across all services within the Trust. During the Covid pandemic all mandated collection and reporting of data was paused until December 2020. The Trust adopted a soft relaunch at this point due to the second wave of Coronavirus. The Trust has procured an external company to deliver the systems to deliver FFT - the implementation process is still underway due to the impact of Covid 19. Inpatient FFT is delivered via paper/QR/ online. Response rates still require increasing to ensure the patient voice is representative in extracting information from the themes.

Issues and Risks:
> Staff engagement with process resulting in poor response rates
> Delays in stock ordering
> Difficulties using data due to low numbers

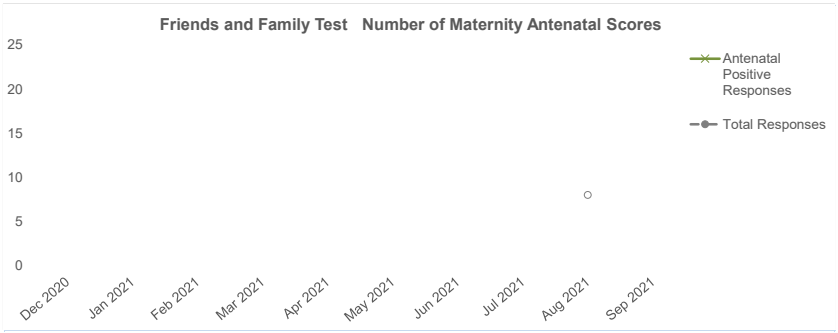
Actions:
> Monthly FFT Oversight Meetings refreshed
> Weekly meetings with IWANTGREATCARE and monthly performance meetings
> Monthly message and data sharing through Nursing & AHP leadership community
> Review of paper solution ordering to esnure good stock levels
> IWANTGREATCARE to support further with staff engagement
> IWANTGREATCARE developing tracker to montior "drop off point " in SmS journey and identify ongoing solution

Mitigations:
> Monthly performance meeting with IWANTGREATCARE from July
> Review of paper processes commenced
> Consistent message to staff to utilise methods available

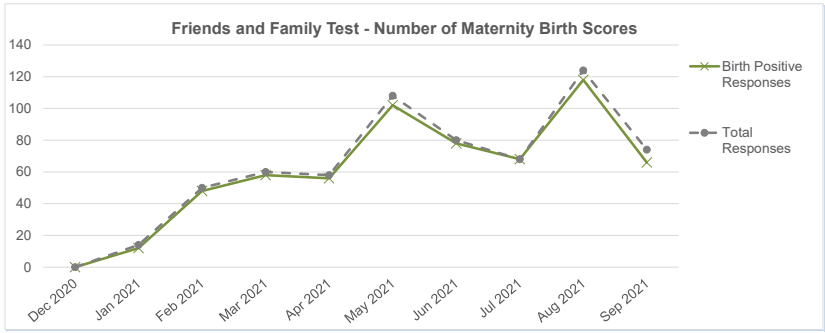
Inpatient FFT
Inpatient FFT is delivered via online/paper/QR.
Nationally the Trust is near the lower centile for inpatient response rates (82 out of 131), however consideration of patient numbers needs to be factored into this level of benchmarking.

A&E FFT
Emergency Care Centre (ECC) FFT is collected via SmS/paper/QR

Community FFT
Community FFT is delivered via online/paper/QR.
Full internal review of community services to create improved collection systems

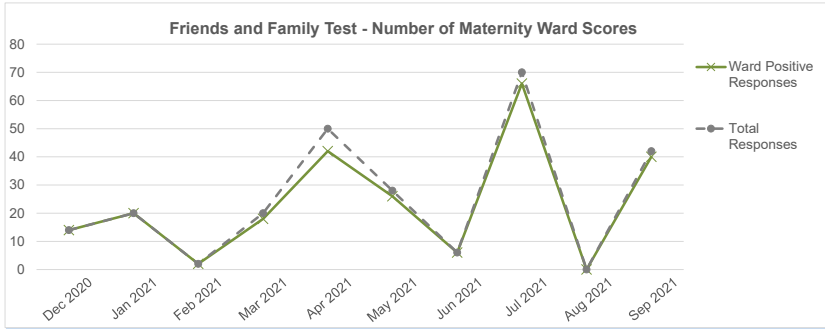


Sep 2021	
12	out of 20
Target	
No target	
Variance	
Insufficient data for an SPC chart	
Assurance	
Insufficient data for an SPC chart	



Sep 2021	
66	out of 74
Target	
No target	
Variance	
Insufficient data for an SPC chart	
Assurance	
Insufficient data for an SPC chart	

Sep 2021	
6	out of 6
Target	
No target	
Variance	
Insufficient data for an SPC chart	
Assurance	
Insufficient data for an SPC chart	



Sep 2021	
40	out of 42
Target	
No target	
Variance	
Insufficient data for an SPC chart	
Assurance	
Insufficient data for an SPC chart	

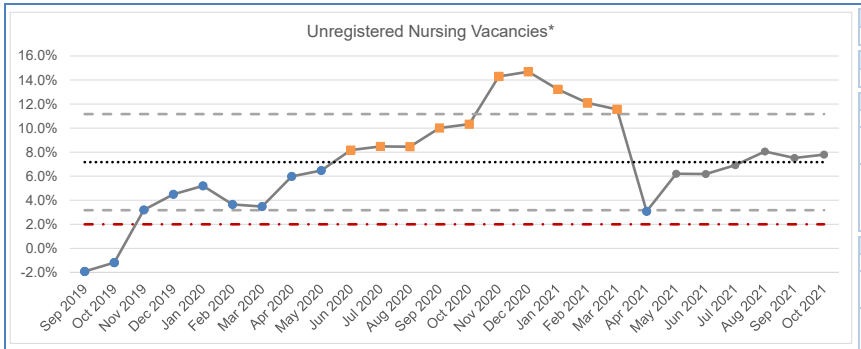
Data Analysis:
Maternity Antenatal FFT: There were 20 responses received in total for August, and 12 were positive.
Maternity Birth FFT: There were 74 responses received in total for August, and 66 were positive.
Maternity Postnatal FFT: There were 6 responses received in total for August, and all were positive.
Maternity Ward FFT: There were 42 responses received for August, and 40 were positive.

Commentary:
The Friends and Family Test is a mandated patient experience measure which enables patient insights to gathered across all services within the Trust. During the Covid pandemic all mandated collection and reporting of data was paused until December 2020. The Trust adopted a soft relaunch at this point due to the second wave of Coronavirus. The Trust has procured an external company to deliver the systems to deliver FFT - the implementation process is still underway due to the impact of Covid 19. Inpatient FFT is delivered via paper/QR/ online. Response rates still require increasing to ensure the patient voice is representative in extracting information from the themes. Maternity FFT is delivered via SmS/paper/QR.

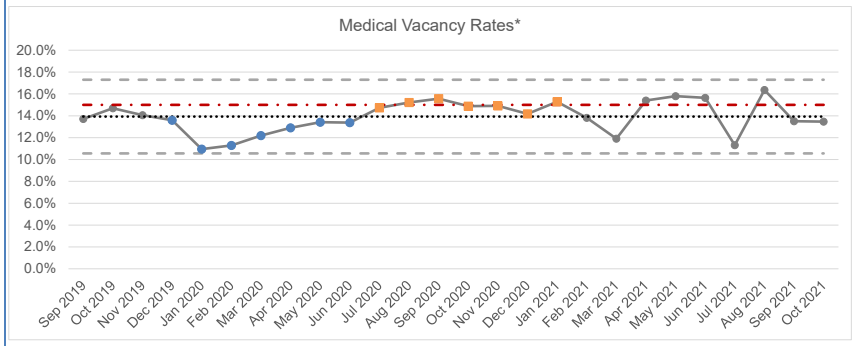
Issues and Risks:-
> Staff engagement with process resulting in poor response rates
> Delays in stock ordering
> Difficulties using data due to low numbers

Actions:-
> Monthly FFT Oversight Meetings refreshed
> Weekly meetings with IWANTGREATCARE and monthly performance meetings
> Monthly message and data sharing through Nursing & AHP leadership community
> Review of paper solution ordering to esnure good stock levels
> IWANTGREATCARE to support further with staff engagement
> IWANTGREATCARE developing tracker to montior "drop off point " in SmS journey and identify ongoing solution

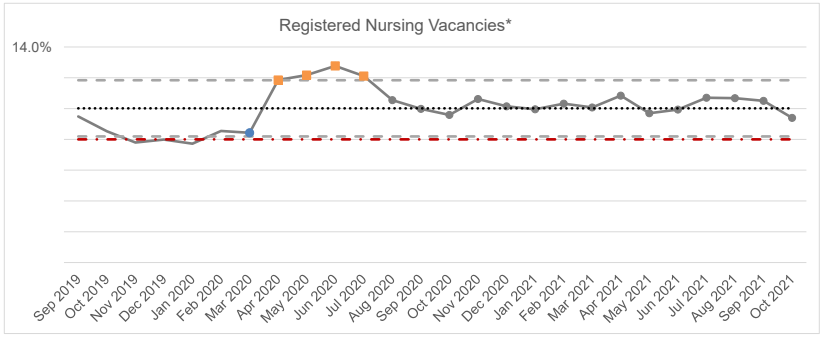
Mitigations:
> Monthly performance meeting with IWANTGREATCARE from July
> Review of paper processes commenced
> Consistent message to staff to utilise methods available



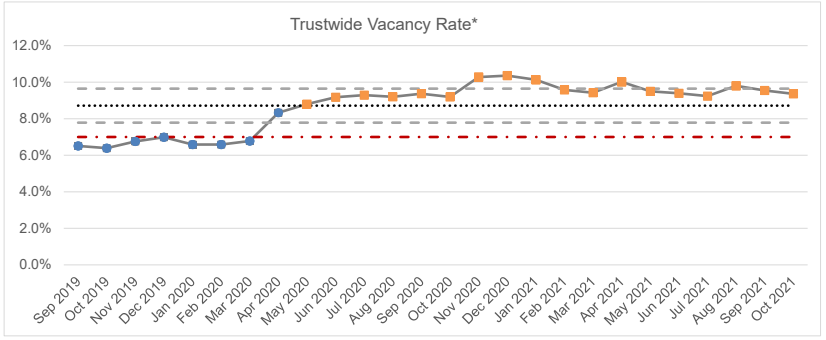
Oct 2021: **7.8%**
Target: **2.0%**
Variance: SPCNoChange
Common cause - no significant change
Assurance: SPCFailing
Variation indicates consistently failing the target



Oct 2021: **13.5%**
Target: **15.0%**
Variance
Common cause - no significant change
Assurance
Variation indicates inconsistently hitting passing and failing the traget



Oct 2021: **9.4%**
Target: **8.0%**
Variance: SPCNoChange
Common cause - no significant change
Assurance: SPCFailing
Variation indicates consistently failing the target



Oct 2021: **9.4%**
Target: **7.0%**
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates consistently failing the target

Data Analysis:
Unregistered Nursing Vacancies*: There has been a significant reduction since April 21 and during this time performance has shown natural variation. The target cannot be achieved without process redesign.
Registered Nursing Vacancies*: The rate has been relatively stable since August 2020. The target cannot be achieved without process redesign.
Medical Vacancy Rate*: Performance has been relatively unstable in recent months. Whilst the target was achieved this month, this can be expected to be hit and missed at random.□
Trustwide Vacancy Rate*: The performance is has been consistently in special cause since June 2020 and will continue to fail the target without process redesign.

Commentary:
Unregistered Nursing Vacancies:
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), however it remains higher than forecast due to large numbers of leavers, with October seeing this rising further to 15 WTE. The current pipeline is 30.61 WTE within the pool. Of these 11 have completed employment checks and will commence in month, 14 have been allocated and are undergoing pre-employment checks and awaiting start dates, and 9 are awaiting allocation and undergoing pre-employment checks. Further advertisements are underway to increase numbers in the pool to meet turnover demands.

Issues/Risks: Retention of HCAs, particularly new starters. Unfamiliarity with the role and expectations of what the role entails influencing decisions to leave.

Mitigations: 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. Update position:

Actions: 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.

Registered Nursing Vacancies:
Regular recruitment activity is underway sourcing candidates from overseas via the internal Talent Acquisition Team, and via an agreement with Yeovil NHS Trust, and regular ongoing activity. Over the last 12 months 99 international nurses have commenced in post.

Issues/Risks: 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. 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.

Actions: Continue sourcing of nursing candidates via the Talent Acquisition Team - Domestic and international. Continued engagement with both Chief Nurse Directorate and Operations to review existing recruitment practices has resulted in the implementation of a new process for selection and allocation. Development of a 3 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.

Mitigations: Ongoing recruitment activity for pre-registered nurses with a very large pool of candidates available. A project group led by the Chief Nurses office to oversee all activities. Newly qualified nurse (NQN) recruitment with 71 confirmed offers. A further 51 international nurses planned for November, December 2020 and January and February 2021. Further bids with NHSi to continue with international nurse recruitment for the duration of 2022.

Commentary Vacancies Cont/d:

Medical Vacancies

The drop in medical vacancies seen in July is due to Foundation 1 trainees commencing shadowing as part of their trainees while existing Foundation 1 trainees were in post. The vacancy factor then rose in August due to a fill rate for trainees of 80.10%.

Issues/Risks: Travel restrictions within red areas are impacting upon some start dates. Availability of accomodation can delay recruitment processes.

Actions: Travel restrictions are impacting upon start dates. Available accomodation can delay recruitment processes.

Mitigations: Recruitment team continuing to engage with candidates. Introduction of Talent Acquisition Team support in sourcing senior hard to fill medical staff posts introduced following a pilot within medicine to explore this methodology for medical staff. A pipeline of 34 medical staff has been established, with plans to start over the next 3 months, and a further 23 in the pipeline appointed for longer term starts. A network of private landlords has been established to support accomodation needs where the Trust is unable to accomodate locally, and work undertaken by the onsite accommodation team to free up onsite accommodation.

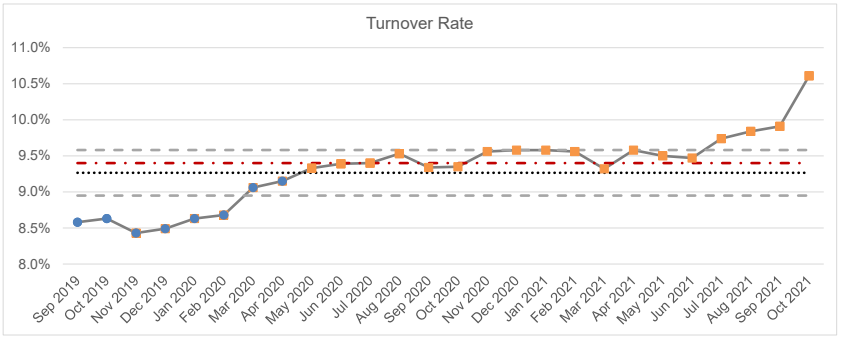
Trustwide Vavancy Rate

The vacancy rate increased in month by 37.61 WTE, this is attributed to the trainee rotation and a slight increase in unregistered nursing vacancies Recruitment at an increased rate is ongoing, with recruitment activity increasing by 19.88% over the last 12 months, sourcing candidates locally, nationally, and internationally.

Issues/Risks: Travel difficulties are delaying starts for some new employees coming from red areas overseas overseas.

Actions: Ongoing recruitment activity across various workstreams, engagement with candidates to reduce withdrawal rates. A full review of the recruitment processes supported by the QI team commenced in August and is currently underway.

Mitigations: Various projects for different staff groups, including international nursing and HCAs. Introduction of Talent Acquisition for senior hard to fill medical staff roles.



Oct 2021
10.6%

Target
9.4%

Variance

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

Assurance

Variation indicates inconsistently hitting passing and failing the traget

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Sep 2021
6.4%

Target
4.1%

Variance

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

Assurance

Variation indicates inconsistently hitting passing and failing the traget

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Data Analysis:
Turnover Rate: The turnover rate has been significantly higher for the past 7 months. In October the rate was the highest (10.6%) it has been over the last 2 years.
Sickness Rate: The sickness rate in September was significantly higher than levels from seen since January. It is extremely unlikely that this target will be achieved without process redesign, as the target line is very close to the lower process limit.

Commentary:
Turnover Rate

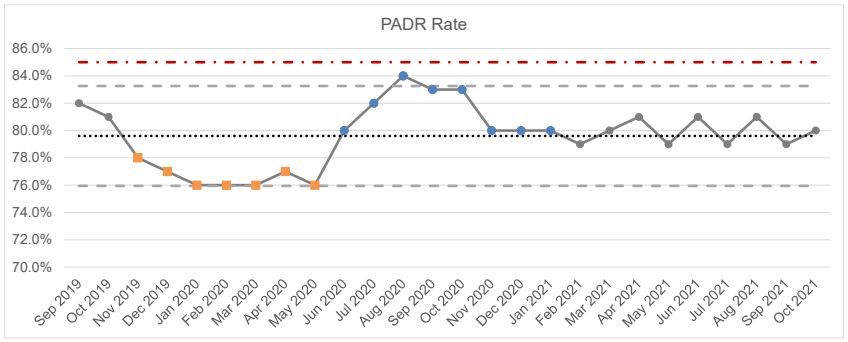
The latest turnover data point (9.84%) is over the Trust target of 9.4% which indicates that the turnover position is not improving or seeing signs of recovery in relation to pre-pandemic levels of turnover of 9%.

Issues/Risks: The risk of increase turnover ahead of recruitment is increased bank and agency costs and potential decrease in quality of patient care.

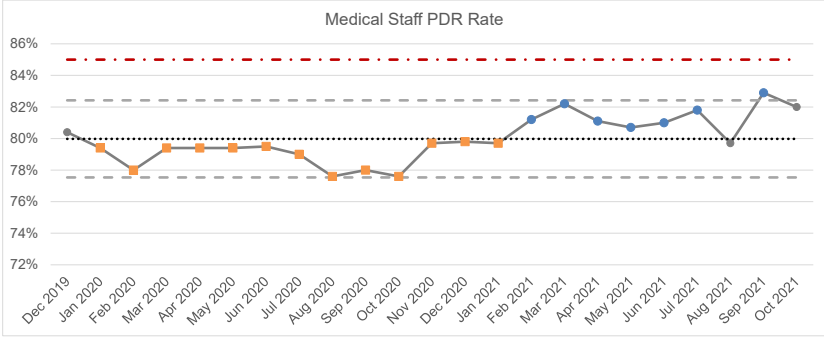
Actions: Greater understanding of leavers data via ESR data and exit questionnaires to understand any trends to form an appropriate response. An increased emphasis on prevention of avoidable leavers by improving culture (mid to long term goal) and strengthening leadership capability and behaviours where required. Creation of talent pools for high frequency leaver areas to ensure a quicker recruitment turnaround. Promote a leadership and career development framework and processes for the identification of high potential, feeding in to talent development and succession planning. Improve quality of PADR and coaching skill in line managers to strengthen engagement; implementation of culture and engagement programme of work focused on proactively improving engagement levels.

Mitigations: Planned earlier intervention in relation to known leavers. Creation of talent pools. Strengthen engagement levels; proactive health and wellbeing plan to address common themes affecting wellbeing-related retention.

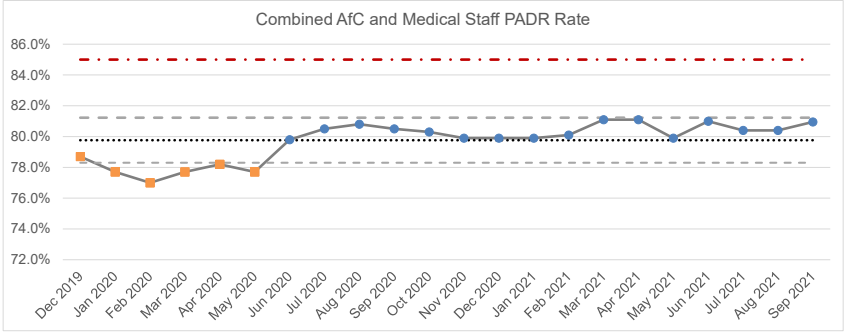
Sickness
Sickness Rate
Following a period of normal variation the sickness level has peaked again at rates simular to that of the November 2020 rates. Please note sickness will always be a month in arrears due to the extraction of information from the Health Roster System.
Issues/Risks: Staff who are isolating 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. Winter pressures combined with seasonal illness and covid are likely to increase levels of sickness both directly because of illness and indirectly because of increased pressures - fatigue, mental resilience and other mental health related issues .
Actions: The Trust has now employed a new Health and Wellbeing business partner to specifically drive the Health and Wellbeing agenda and commenced in post August 21. Daily sickness monitoring has recommenced with ICC and Infection Control lead to monitor specifically covid absences. A revised operational dashboard will be available in October that will allow managers to have a greater level of access to data in relation to sickness which will support the wider management. The Flu campaign has now launched with delivery via the peer vaccinator model with a later link into the covid hubs. The covid booster programme has also now launched with a good uptake from staff in the first month. High levels of vaccination should translate into a reduced sickness level throughout the winter months. Launch of winter incentive programme to support the fill rate of frontline posts.
Mitigations: Continued close monitoring of sickness levels with increased operational reporting - volume, trends & themes. Targeted preventative intervention in known high pressure areas. Greater levels of health and wellbeing resource via PEO and identified external funding. Greater levels of Occupational Health clinician time and on-site face to face counselling now in place. Operational areas responding to levels of sickness through rostering reviews to redeploy staff into areas of greatest need.



Oct 2021	Target	Variance	Assurance
80.0%	85.0%	Common cause - no significant change	Variation indicates consistently failing the target



Oct 2021	Target	Variance	Assurance
82.0%	85.0%	Common cause - no significant change	Variation indicates consistently failing the target



Oct 2021	Target	Variance	Assurance
81.0%	85.0%	Special cause of improving nature or lower pressure due to higher values	Variation indicates consistently failing the target

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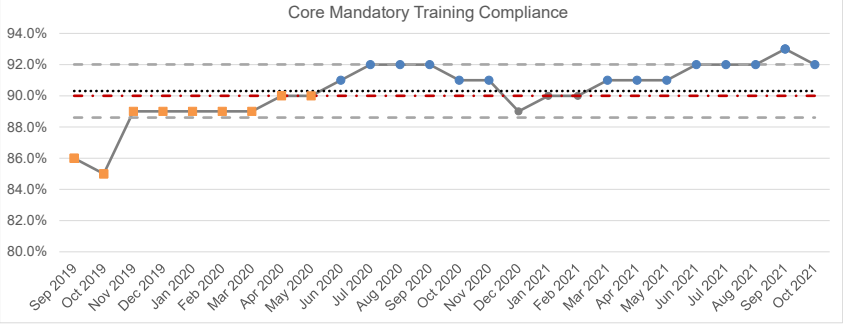
Data Analysis:
PADR Rate: Performance has been stable for the past 9 months. The target cannot be met without process redesign.
Medical Staff PADR Rate: Performance has remained relatively stable since February. Without process re-design performance will continue to fail the target.
Combined AfC and Medical Staff PADR Rate: Performance has remained stable since June 2020. Without process re-design performance will continue to fail the target.

Commentary:
PADR Rate:
The non medical PADR compliance position currently stands at 80% this is below the Trust target of 85% .
Medical Staff PADR Compliance currently stands at 83% as of October 2021.
The combined appraisal complaince currently stands at 81% as of Ocotber 2021.

Issues/Risks: Low PADR compliance will result in the risks moral, performance and demotivation.

Actions: 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.

Mitigations: Historically the trend data shows that the Trust's PADR compliance has decreased for this time of year . It is predicted that the PADR compliance will continue to rise over the next few months.



Oct 2021
92.0%

Target
90.0%

Variance

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

Assurance

Variation indicates inconsistently hitting passing and failing the traget

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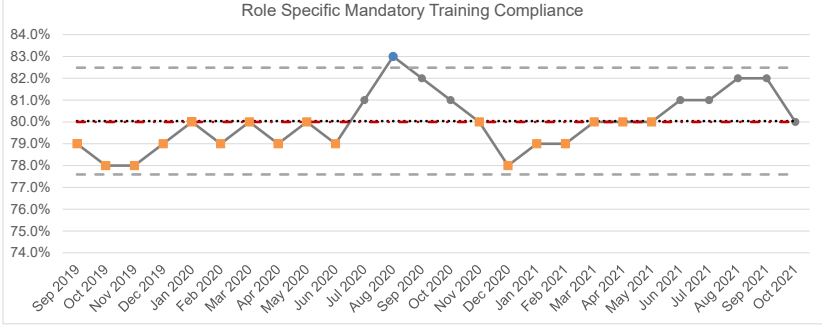

Oct 2021
80.0%

Target
80.0%

Variance

Common cause - no significant change

Assurance

Variation indicates inconsistently hitting passing and failing the traget

This space is intentionally blank

Data Analysis:
Core Mandatory Training: Performance has been significantly better since March and the target consistently achieved.
Role Specific Mandatory Training: Performance since June has recovered following a period of significantly poorer performance. Over the past 2 years, performance has been very volatile. The target will be achieved and not achieved at random.

Commentary:
Core Mandatory Training Compliance
The Core Mandatory Training position currently stands at 92%. This continues to be above the Trust target of 90%, Performance has exceeded the target since Feb 2020.

Issues/Risks: Low MT compliance will result in the risks around safe and effective care.

Actions: 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.

Role Specific Mandatory Training Compliance
The Role Specific Mandatory Training position currently stands at 80% (October 2021). This is continues to be in line with 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 October 2020 the Role Specific Mandatory Training Position was also at 81%.

Issues/Risks: Low MT compliance will result in the risks around safe and effective care.

Actions: The Training and Development Department will continue targeting employees with low compliance by sending out reminders, guidance and workbooks for completion. Auto enrolment has now been switched on in ESR making this easier for staff to complete eLearning modules.

Mitigations: Over the last 3 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.

IPR Appendix - National Benchmarked Centiles

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

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

Source: https://publicview.health as at 22/11/2021

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

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Access & Flow	Planned	% Under 18 Weeks Incomplete RTT Pathways	Oct 2021	66.8%	92.0%	38	106 / 171	* Sep 2021
	Planned	Number of Incomplete RTT pathways 52 weeks	Oct 2021	463	0	60	69 / 170	* Sep 2021
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Sep 2021	31.5%	1.0%	28	116 / 160	* Sep 2021
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Oct 2021	58.1%	85.0%	25	102 / 135	* Sep 2021
	Cancer	Cancer - Request To Test In 14 Days	Oct 2021	83.9%	100.0%	90	15 / 138	* Sept 2021
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Oct 2021	53.0%	95.0%	0	133 / 133	Oct 2021
	Urgent Care	Number Of Emergency Department Attendances	Oct 2021	11,988	No target	47	79 / 147	Oct 2021
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Oct 2021	114	0	13	136 / 156	Oct 2021
	Flow	Bed Occupancy Rate (General & Acute)	Oct 2021	93.9%	92.0%	42	92 / 159	^ Jul/Aug/Sept 21
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Oct 2021	9.6%	No target	26	126 / 171	* Sep 2021
	COVID	Number of COVID patients in ICU beds (Weekly)	Oct 2021	16	No target	14 (All beds)	176 / 204	^ Oct 2021
	COVID	Number of COVID patients in other beds (Weekly)	Oct 2021	52	No target			^ Oct 2021

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**		**Period**
Quality & Safety	Infection Control	Number of MRSA Infections	Sep 2021	0	0	62	53 / 139	*^ Sept 20 - Aug 21
	Infection Control	Number of E Coli Infections	Sep 2021	5	9	52	67 / 139	*^ Sept 20 - Aug 21
	Infection Control	Number of Trust Attributed C-Difficile Infections	Sep 2021	3	3	96	7 / 139	*^ Sept 20 - Aug 21
	Infection Control	Number of MSSA Infections	Sep 2021	4	0	61	55 / 139	*^ Sept 20 - Aug 21
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Apr 2021	108	108.2	15	104 / 122	* Jun 2021
	Safe Care	Number of Serious Incidents Raised in Month	Sept 2021	18	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Sep 2021	8.3	No target	32	126 / 186	* Aug 2021
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Sept 2021	78.2%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Sept 2021	5.0	No target	Old data unsuitable for comparison		
	Patient Experience	Percentage of Positive Inpatient Scores	Sep 2021	94.1%	No target	39	84 / 136	* Sep 2021

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**		**Period**
Workforce	Staffing Levels	Sickness Rate	Sep 2021	6.4%	4.1%	26	160 / 215	* Jul 2021

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DATE OF MEETING	7 December 2021
REPORT FOR	Trust Board of Directors (Please indicate Public or Private)
REPORT FROM	Dr Kate Wood, Medical Director Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Angie Legge, Associate Director for Quality Governance
SUBJECT	Executive Governance Report
BACKGROUND DOCUMENT (if any)	None
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None
EXECUTIVE SUMMARY	The report this month has added Patient Experience. Work continues to address staffing, the fill rate has remained below 95% but 73 newly qualified nurses joined the Trust in September / October.

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)	1. To give great care				
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
CHPPD remains at 8.3 compared to national median of 9.1 and peer median 8.9. Combined fill rate was 92.2% in Sept. Securing temporary staffing remains challenging. Family Services fill rate lowest at 84.5%; drop of 1.7%. Substantive RN fill rates increased for days and nights. 15 wards with RN substantive fill rates on nights below 50%. RN vacancy 10.5%, 176.92wte and HCSW vacancy 7.52%, 63.44wte. 100 red flag staffing incidents were reported in Sept, 41 related to staffing levels.	There is a risk to the quality and safety of care of patients on the wards due to availability of staff and poor bank and agency fill rates (Risk 2421 scored 25)	Safecare Live data reviewed daily at 10am. 3 x daily staffing reviews in place. Staffing red flag incidents monitored and actioned daily. 73 newly qualified nurses joining the Trust in Sept/Oct. International nurse recruitment continues with enhanced training and support. Block booking of regular agency nurses who are familiar with the wards. Winter incentive introduced for bank and substantive staff. CNO ward establishment reviews undertaken – report to TMB in November and Board in December.
	Increased Complaints / PALS due to staffing levels	Family liaison assistants are supporting communication with families which is supporting frontline staff to prioritise bedside care. Additional funding secured to continue over the winter.
	Risk of increased sickness due to stress from pressures of Covid-19 and persistent staffing shortfalls	Trust wellbeing offer. Professional Voice email address. Leadership training is being offered to equip staff with skills to lead through this challenging period. Initiatives to help improve morale being explored & implemented e.g. winter incentives.
Community nurse staffing remains under pressure – slight increase in RN vacancies (9.89%) & decrease in HCSW vacancies. 22 red flag incidents reported in Aug & Sept. 17 were related to staffing levels. Unplanned activity remains high.	There is a risk to the quality and safety of patient care due to demand exceeding capacity, particular risk on evenings and nights (Risk 2921 scored 15)	Work ongoing to fill vacancies with support from the Talent Acquisition Team. Electronic allocation system live from 21.09.21 to assist with allocating work and capacity and demand modelling. Daily huddle and escalation process in place. Participating in national project for safe staffing tool for community.
Midwife: Birth ratio 1:25.4 in Sept (below 1:28 & in line with national guidance). Midwifery red flags increased significantly (n50) due to staffing challenges & increased	Risk to the quality and safety of care as a result of sickness and	Escalation processes and plans are in place with daily oversight from the Head of Midwifery. Active recruitment is on-going as well as agency

IPC

Aim: To minimise cross infection to maintain patient safety

Current Position	Risk	Mitigation
The period of July onwards has seen a dramatic rise in the number of COVID cases admitted being identified, linked to escalation of cases detected in school age children Unfortunately with the local prevalence being above national average there has been a slow increase in probable / definite increase in COVID cases identified in sporadic outbreaks. Some of the cases possibly linked staff – patent transmission. UKHSA issued some updated guidance to manage social distancing, PCR testing, cleaning. .	Prevalence of COVID remains high and above the UK levels. This is a significant issue especially as the effect of the vaccines will begin to wain in vulnerable groups. Increased footfall of patents which may increase risk of cross infection.	National guidance 30 Redirooms for isolation Cubiscreen (shielding curtain) Architectural walls on B3, Ward 23, Ward 28, IAAU SGH Lateral flow testing Vaccination available for16 yrs and over Capital projects to look at refurbishment of ward 25 to create additional isolation capacity. Divisions asked to review low risk procedures that can be switched to LFD testing. C02 monitors purchased to pilot additional patent's in ophthalmology clinics / OPD.
The trust is seeing more double vaccinated COVID-19 cases admitted due to possible vaccine waning.	Given the rise of Delta and Omicron variants, local authorities pushing comms re booster vaccinations.	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
Sustaining positive position of complaints responded to within timescale 75%– 87% closed within timescale ,average of 41 - 50 days open. Noted increase in complex formal complaints and Pals .Current Open complaint position = 70 , 64(91%) in timescale & 6 > 60 WD timescale (Med 3 , SCC 3) Increased numbers of Pals ECC DPOW – collaborative work being undertaken to ensure clear oversight and action weekly. Transition to Ulysses , review of support needed to minimise risks until all pathways established	Complaints >60 working days &Pals > 5 working days (Risk 2659 scored 12) Reputational risk to Trust Continued increased activity in ECC linked to increased Pals -Reputational risk to trust . New complaint/Pals data module requiring dedicated time to establish correct pathways	• Weekly central team Support and Challenge meetings ,with central team escalating issues directly to Divisions & monthly review of all closed complaints >60 days • Central Complaint Team to dedicate 2 hours to ECC DPOW to support management of Pals • Weekly Pals reports to divisions • Complaints position discussed at PRIMs • Monthly report to divisions for governance purposes • Patient Experience Action plan • Review of central complaint team to identify hours needed to support effective transition of Ulysses • Monthly tracking of complaint facilitators caseloads • New Patient Experience manager currently supporting central complaints/Pals teams
Effective communication impacted (telephones not responded to) impact of restricted visiting and activity/acuity on wards/ECC Family Liaison Assistant role only continues until Jan 31st 2022	• Increased in PALS/complaints - reputation risk to Trust	• Family liaison Assistants business case in development • 3 Pt experience officer across 3 sites • Patient Contact Helpline • Sage & Thyme training programme

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 have remained consistent for three months in both the acute and community (October data not available) 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 sickness and vacancy within team • Staffing shortfalls impacting upon patient care	• The backlog of incidents have been allocated across the Divisions. Some incidents remain outstanding due to the ongoing operational pressures. Progress is being monitored regularly. • Training prioritised to higher reporting areas/areas of concern. • Virtual sessions are being utilised to provide training cross-site. • Learning shared via new "Patient Safety in Our Hands" update to Nursing teams to reduce risk • Recruitment to HCA vacancies, use of bank and agency staff. Themes fed in to establishment reviews.
Numbers of reported falls have decreased for two months (October data not available) Ongoing roll-out of Supportive Care and the AFLOAT tool to support decision making and escalation for resource	• There is a risk of falls for all patients coming into hospital which carries the risk of serious harm • Staffing to resource additional shift requirements • Impact of escalation beds further increasing staffing risks	• Documentation fully reviewed to focus on actions to reduce individuals risks with plan to roll-out Trust wide on 22nd November 2021. • Learning shared via new "Patient Safety in Our Hands" update to Nursing teams to reduce risk • Training delivered to higher reporting areas/areas of concern identified through Nursing Metrics Panel • Action plan developed from themes of huddles and serious incidents • Recruitment to HCA vacancies, use of bank . • Roll-out of new falls documentation will include full roll-out of Supportive Care

Safeguarding and Vulnerabilities

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

Current Position	Risk	Mitigation
No changing Places toilet facilities at SGH. Legal requirement for new hospitals	Reputational to the Trust Breach of Equality Act Personal Hygiene and Dignity for users	On risk register (risk 2992-score16) Funding bid with NL Council submitted Sept 21. No further progression Disabled toilet facilities both sites
Increase in attendances of Children and Young people to ECC with a mental health concern	Attendances not reviewed in a timely manner by the Missed opportunity to safeguard children and young people	Raised at NL Safeguarding Children's Partnership. Audit undertaken now for NEL- further review with CCG and other partners for next steps Temporary funding until Jan 22 to support increase Risk 1991, scored 12, Risk 2576, scored 16)
Some levels of Safeguarding training not met trust target of 85%	Missed opportunity to safeguard children and adults/ not following procedures Risk 2910, scored 9)	Training compliance level 2- 84-85% Training compliance level 3- 57-76% Safeguarding team Mon-Fri 9-5 Information on Hub/ Policies and procedures Plans to provide additional methods. Continued promotion Further review of transfer over to CTSF
Liberty Protection Safeguards awaiting draft Code of Practice from the Government	The Trust is not prepared to implement new system Financial implications Training	Anticipated draft code of practice still not available- was due Autumn 2021 MCA lead is linked with local networks/ nationally LPS work stream established in NLAG On risk register (risk 2993-score 8)
Temporary funding in place until Jan 22 for acute LD Liaison nurse (SGH) and Transition Lead Trust wide.	Delay in responding to any unmet heath needs in particular unplanned care	Awaiting Business case approval On risk register (risk 2531- score 12)

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: 34% On track: 42% Delayed: 16% On Hold: 3%	There is a risk that actions may not be fully embedded (Risk 2820 scored 9)	-Each action is monitored with the relevant division regularly. -Current position & progress discussed at divisional PRIM meetings. -Quarterly reviews are in place of all previously closed actions to ensure the monitoring is robust and compliance sustainable.
Off track actions: 5% (8 actions)	-The Trust will not be compliant with mandatory training by the CQC visit (Risk 2898 scored 16) -The trust will not be compliant with appraisals by the CQC visit	-Board have oversight (via sub-committees & TMB). -Commitment from all divisions to continue to give focus, work towards recovery & ensure sustainability. -New BI report in October to allow 'real time' monitoring and breakdown of data to divisions/staff groups/modules to allow identification of areas of concern and allow focused recovery. A number of training modules transferred to online learning to allow greater access. -Specialities asked to prioritise MT modules to ensure patient safety in their specific areas -Associate Director of Culture reviewing Mandatory training in comparison to peer organisations
	Additional resources are needed to meet staffing levels (community nurse staffing specific) (Risk 2921 scored 15)	Controls -Adequate quality metrics, HR and performance monitoring systems in place -Adequate PADR (appraisal), supervision and training systems in place. -Daily safety huddle and newly developed OPEL scoring for community nursing. -Caseload management tool has been developed Mitigation -Block contract reviewed and funding in place to recruit staff -Planned care nursing establishment review process completed -Complete Divisional Workforce Plan -Implemented an electronic allocation system supporting capacity and demand planning -Review of the skill mix and the demand. Plan to increase competencies of HCA. -Recruitment for qualified associate nurses & overseas registered nurses

Maternity & CNST

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

Current Position	Risk	Mitigation
CNST Year four released. Submission date 30 June 2022. Increased requirements in every action	Failure to submit the evidence to provide assurance on safety in maternity units	Leads for Safety Actions allocated. Escalation via PRIM, Exec Review, fortnightly meetings. Recruitment to support work plan.
Ockenden evidence submitted to NHSE/I – feedback received, action plan updated . Action plan – 27 actions met, 22 outstanding with further work necessary	Safety in maternity units	Provision of independent senior advocate role (awaiting further detail). Embedding submission to Trust Board of Serious Incidents. Implementation of LMS oversight being embedded. Further assurance necessary – SOP's, audits re documentation, risk assessments, Dr handover etc
MDT Training - Compliance >90%, average compliance 84.5%	Staff training and working together in emergency situation, ability to release anaesthetists. Must be face to face Jan '22	No. of Obs Drs new to trust. 2022 training programme reviewed, trajectory to comply by June 2022
Saving Babies Lives – revised 5 elements with CNST yr 4. 21/22 Q1 – NLAG 5.6/1000 birth, Q2 – 4.0/1000 stillbirth rate. Region average 4.0.	Managing complex pregnancy and ability to escalate to regional centres(Risk 2918 scored 9, Risk 2765 scored 12, Risk 2855 scored 12)	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
Midwifery staffing challenges	Inability to safely staff maternity units Risk 2960 scored 12)	Agency requests out of trust process (accessing sooner). Utilisation of specialist midwives. Block booked agency midwife however improved fill rate due to bank incentives

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: 94% **Q1 21/22: 93%** **Q2 21/22: 85%** *(Apr 21: 96%; May 21: 93%; Jun 21: 91%; Jul 21: 80%; Aug 21: 88%; Sep 21: 86%)* 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 (Risk 2797 scored 9)	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: 93% **2021/22: 69%** *2020: N= 7 [4: NQB/ 3: Concern]* *2021: N= 31 [19: NQB/ 5: Concern]* There is a backlog of cases not yet reviewed going back to Nov 2020 [Risk 2797; risk rating 8].	Risk of not achieving the 100% of SJR on cases identified from screening, within 6 weeks. (Risk 2797 scored 9) 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.	Mortality SOP revised in line with NHSE/I guidance to reduce number of SJRs being indicated and share cases with community concerns with CCGs via incident reporting instead of NLAG internal review. Escalation to and working with DCD in Medicine; 50+ staff trained in Medicine for SJR by NHSE/I, further external training to be provided.
(Month ending May 21) In hospital SHMI 96, 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 29 points (39 at DPoW and 18 at SGH (was 31 so reduction noted). (Risk 2418 scored 10)	NHSE/I audit completed looking at the management of patients at EOL. Recommendations received by MIG; action plan being 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
27 out 38 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 (Risk 2606 scored 8)	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
89% 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 (Risk 2606 scored 8)	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 Increased challenge through sign off process
Currently 28 overdue actions in total. 7 off track within Medicine and 21 in Surgery. 4 of these are more than than 3 months over due date. Verbal assurance on safety received for all overdue actions	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 vacancy – post has been recruited to with an expected start date by end of Jan 22	Insufficient learning from a Serious Incident	Learning on a Page to all wards and departments SI theming and trend analysis in place Learning Strategy Serious Incident Review Group to look at any further action

Never Events

Aim: Zero Never Events

Current Position	Risk	Mitigation
2021/22 – 3 Never Events: 2 Wrong site Surgery 1 Retained item	There will be further wrong implant or wrong site surgery in Ophthalmology or other specialties linked to poor application of the WHO checklist	Regular WHO Checklist audit on both sites Assessment of the WHO checklist audit by Patient Safety Specialist on both sites Review of induction / competencies for new theatre staff to look at culture Review of evidence and embedding of immediate actions and actions from older SI's via QGG
	There will be further wrong patient procedures linked to complex systems, a lack of digital connectivity and a lack of patient pathway oversight between Trusts	Process mapping as part of investigation to streamline systems and processes Digital solutions to be identified.
	Complicated process for angiograms and unclear route of escalation for Consultants in medicine specialities.	Streamline angiogram pathway and devise clear route of escalation. Cardiology SAT team now fully established.

VTE

Aim: 95% of patients risk assessed for VTE

Current Position	Risk	Mitigation
78.2% VTE Risk assessments completed	VTE risk assessment will continue to fall below the 95% target. VTE risk assessment performance has not recovered to pre-Pandemic performance levels. Risk 2893 scored 12 Risk 2824 scored 12 The ePMA system deployed on inpatient ward areas only (excluding ED). Risk identified for 'stranded' patients when handed over to the medical/surgical teams, but do not have a bed on an inpatient ward. These patients require a VTE assessment completed, but cannot be completed on ePMA until transferred to an inpatient ward. The current denominator to calculate the compliance rate is incorrect as SDEC is included. The risk identified is that the denominator is too great and will provide a lower compliance rate than is actually true.	Clinical leads identified and actively working to review and update VTE related policy and patient intended information in line with latest guidance from NICE. E-screening tool for VTE launched as part of the EPMA system which will make it easier for medical staff to use. Ongoing education work with clinical staff. Engagement with trainee grades of medical staff to understand and overcome identified barriers. Speciality clinicians provided with the ability to prescribe onto ePMA whilst patients are lodged for a bed in ECC. Critical medications in ECC are to be prescribed onto the ECC card prescription page. Use of incorrect denominator escalated through the Information and EPMA teams for resolution.

Quality Priorities

Aim: Delivery of all Trust Quality Priorities

Current Position	Risk	Mitigation
End of Life No. of patients dying within 24 hrs of admission =15 Out of hospital SHMI 128 *(figures remain the same due to National HED SHMI extracts unavailable)* 180 patients had an emergency admission in the last 3 months of life	The out of hospital SHMI will continue to affect the Trust position Risk 2811 scored 12	A project is underway with NHSEI to address the out of hospital SHMI. Local CCGs have established an oversight group Collaborative end to end mortality reviews focusing on two QPs related to deaths within 24 hours of admission and unplanned emergency admissions in last 3 months of life to identify and share learning.
Adult observations within 30 mins =91% Child observations within 30 mins =95% Escalation of NEWS = 3% Sepsis screen = 32% Sepsis screen in those with red flag = 43%	There is a risk that delayed observations and delayed escalation of observations will lead to significant harm to a patient (Risk 2388 scored 15) Risk of delayed availability of e-sepsis screening data via WebV.	Deteriorating Patient and Sepsis Group oversee action plan Changes being made to the sepsis screening tool to provide full assurance that WEB V data is accurate Escalation policy revisited and refreshed with staff Introduction of Nurse Educator role to support staff Confirm and Challenge meetings with Ward Managers.
Recording patient weights on IAAU (actual; patient reported or estimated) = 78% Actual weight recorded = 30% Compliance with medications requiring adjustment for weight = 80%	There is a risk that not adjusting prescribed medicines to a patients weight could lead to harm. Risk 2844 scored 9 Risk 2848 scored 9	To share with Governance group and safer medication group for action/reminders to prescribers. Learning to be shared via Medicines Newsletter Discussion about PDSA cycle to improve performance.
BM in adults when NEWS >1 = 98% BM in paediatrics when PEWS>1 = 80% Diabetes training = 90%	A risk that DKA may be missed in a patient with diabetes Risk 2812 scored 9	Diabetes Task and Finish Group PEN Team in ECC undertake reviews of all children where BM recording was not completed to determine if there are learning lessons opportunity or if this was not undertaken due to the clinical context.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)253

DATE OF MEETING	7 December 2021
REPORT FOR	Trust Board
REPORT FROM	Mike Proctor, Non Executive Chair
CONTACT OFFICER	Angie Legge, Associate Director for Quality Governance
SUBJECT	Quality & Safety Committee highlight report
BACKGROUND DOCUMENT (if any)	Quality & Safety Committee Terms of Reference
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None
EXECUTIVE SUMMARY	

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

Report for Trust Board Meeting on:	7 December 2021
Report From:	Quality & Safety Committee on 19 November 2021

Highlight Report:

October 2021

The Committee discussed a quarterly update on progress against the Quality Priority for Diabetes management. Positive assurance was received in relation to congratulations to the team from both tertiary centres (Sheffield and Leeds) in achieving the best median and mean HbA1C in the region. Of the four KPIs, two have been achieved (insulin errors causing significant harm and diabetes mandatory training). In Diabetes inpatient management, monitoring blood sugar 4 times a day was achieved but the other elements remain below target and work was still underway on ensuring that decision making not to undertake blood sugar in paediatrics was documented.

The Nursing Assurance report gave an updated position on staffing and the continuing work to maintain safety despite staffing pressures. A decrease in inpatient pressure ulcers was noted, and a decrease in falls in Scunthorpe. A lower data set in the FFT was identified as due to a temporarily mislaid courier collection of paper responses, since addressed. Focused work will raise the profile of FFT. Increased Covid rates were noted for August, and low vaccination rates in pregnant women was a concern.

There was one new maternity serious incident highlighted to the Committee, relating to a pregnancy where guidance was followed but the higher risk of the pregnancy had not been taken into account.

The Committee reviewed a paper on the Register of External Agency Visits, and welcomed the news that the process was being strengthened to check the evidence of action completion prior to closure.

In relation to progress against the CQC actions, the Committee was told about the valuable work to complete the self assessments against the CQC key lines of inquiry, and the scrutiny and challenge to these.

The paper on Clinical Harm and Risk Stratification noted that all patients subject to delays had been risk stratified and that the numbers of patients who had been waiting 52 weeks had been reducing for the last 5 months. There were processes in place to manage this and monitor for harm.

Concern was raised at the meeting as to the patient experience relating to delays to be seen in ECC, with a request for assurance on this and patient safety in ECC for the next meeting.

November 2021

The Committee received assurance from Medicine Division on the measures to manage the safety of patients queuing for the Emergency Care Centre and for the care of paediatric patients attending the Emergency Care Centre on both sites, noting the risk mitigation approach taken, including the support from Paediatric

Clinical leadership in Sheffield Teaching Hospitals, the extension of the PEN team hours and the training being undertaken by all ECC nurses. Concern was still expressed for the poor experience of those waiting outside to enter the Emergency Care Centre; it was noted that the introduction of the Urgent Care Centre at SGH had largely removed the queue, and that this measure would be introduced at DPoWH in December.

An update was received in relation to the waiting list for Ophthalmology. While the Committee noted the reduction in the waiting list, concern remained about the lack of assurance that those identified as high risk had all been seen. It was noted the division were tracking high risk appointments but it wasn't clear whether these were all now rebooking or if any were outstanding from the original risk stratification.

A paper was received on the progress towards a Humber single cancer service, which was supported in principle. Assurance was received that the progress made guaranteed equity on location. The Committee asked that the next report notes progress within NLAG on the specific issues cited.

Reports were received from Clinical Support Services and Community and Therapies

Assurance was received in the PROMS report that the previous issue with knee replacements being outside the 95% control limit had been resolved.

The monthly report on Maternity and other key serious incidents was received. There were currently 3 maternity serious incidents under investigation, one with HSIB and two internal to the Trust. The most recent HSIB report findings and learning was shared; it was noted the key finding was misinterpretation of the CTG due to similarities between the fetal heart rate and maternal pulse. Four key lessons were identified:

- The Trust to ensure mothers were given the option of immediate induction of labour following pre labour rupture of membranes
- The Trust to ensure staff were aware and supported to consider the early use of a fetal scalp electrode when the mother and baby's heart rates could not be differentiated on CTG
- The Trust to ensure there was escalation to the obstetric team when the mother's observations were outside the expected range
- The Trust to ensure there was ongoing obstetric oversight of mothers on the delivery suite including a twice daily ward round.

The Committee received the Quality Improvement Strategy and agreed to commend this to the Trust Board.

The Committee heard how the annual safer staffing nursing establishment review was conducted, and the clear methodology in line with national best practice to ensure the right staff with the right skills in the right place at the right time, using the Safer Nursing Care Tool.

The Committee received highlight reports with an annual review of effectiveness from QGG and the Patient Safety Champions Group, and ratified the updated terms of reference based on the annual reviews. In addition the Mortality Improvement Group terms of reference were ratified.

Confirm or Challenge of the Board Assurance Framework:

The highlight summary of the Quality Board Assurance Framework was discussed and agreed.
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. **Mike Proctor** **Non-Executive Director**

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NLG(21)254

DATE OF MEETING	Tuesday 7 December 2021
REPORT FOR	Trust Board
REPORT FROM	Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Ryan Sutton – Associate Director of Quality Improvement
SUBJECT	Quality Improvement Strategy
BACKGROUND DOCUMENT (if any)	NA
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Trust Management Board Quality and Safety Committee
EXECUTIVE SUMMARY	Approval of Quality Improvement Strategy

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**
	✓				

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Quality Improvement Strategy

2021 -2023

Kindness • Courage • Respect

Introduction

Our Quality Improvement (QI) strategy will further support our journey to improve our services for patients and staff, by supporting teams to make the improvements they wish to make and improving the care they provide. This initial strategy, 2021-2023 will guide us in developing a practice of continuous improvement and learning, championing our staff and patients in the improvement of their services. This will be achieved by supporting ideas generations and innovation, underpinned by tool from improvement science, to continually improve and develop our services.

This is our initial strategy to help us shape and develop our QI vision, direction and methodology for the Trust. Over the next 18 months we will focus on achievable outcomes, embedding the culture and role of QI within our organisation, whilst establishing our QI team.

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Foreword

We are delighted to present our Quality Improvement Strategy 2021-2023 which sets out our ambitions for the 18 months.

Here at NLAG improvement is engrained into everything we do, it is not new, as our teams strive each day to develop our services for the patients that we care for.

Over recent years the Trust has been on a journey of improvement to move our CQC rating out of quality special measures, the ongoing work to achieve this is immense and it is the collective efforts of everyone that has allowed us to progress towards our goal.

This strategy builds on the improvement work done to date and details how the Trust will continue to support your improvement efforts as we continue on our journey to continually improve our services for both our patients and staff.

Peter Reading
Chief Executive

Linda Jackson
Interim Chair
& Non-Executive Director

The terms Quality and Improvement can mean many things depending on the context, the CQC define "Quality improvement as an approach to improving service quality, efficiency, realising cost reductions and increasing [staff] morale simultaneously: it achieves this through a collaborative leadership approach underpinned by the methodologies and tools from improvement science" (CQC, 2018).

A Message from the Chief Nurse
(Executive Lead for Quality Improvement)

For a Trust which has been in quality special measures in recent years we need to find ways to continually improve what we do. We also need to find ways to improve how we do things. Every day we will come up against barriers and frustrations, often ones we have seen and faced before.

As we set out our new Quality Improvement approach the goal is to give you some approaches and, as important if not more so, the permission to try new ways of doing things.

One way of doing this is by putting in place a small QI team with processes to support you to make changes to improve things. We have made developing a refreshed Quality Improvement approach part of the Trust's priorities for 2021/23.

We all have two roles within Northern Lincolnshire and Goole NHS Trust: our everyday job and improving how we do that job. Therefore all of us, whatever our job in NLAG, have a role to play in quality improvement and how this relates to the delivery of our clinical quality priorities or daily service improvements.

This initial strategy sets out what NLAG will do to create a culture of quality improvement to equip staff with the skills and support structure so they can improve patient care and experience therefore increasing their job satisfaction.

This initial strategy will allow us to focus on some key areas as we transform the way we improve the services for our staff and our patients. We really want you to be at the centre of the ideas for improvement and provide you with the tools to be able to make these changes yourself.

Teams that have worked with us already using these tools we have given them, the support and resource from our experts are already making a difference and you can too.

Ellie Monkhouse
Chief Nurse

Our Quality Improvement Vision

"To continue to empower all staff to promote a culture of problem solving, ideas generation and testing through a common approach, a common language and common set of QI tools"

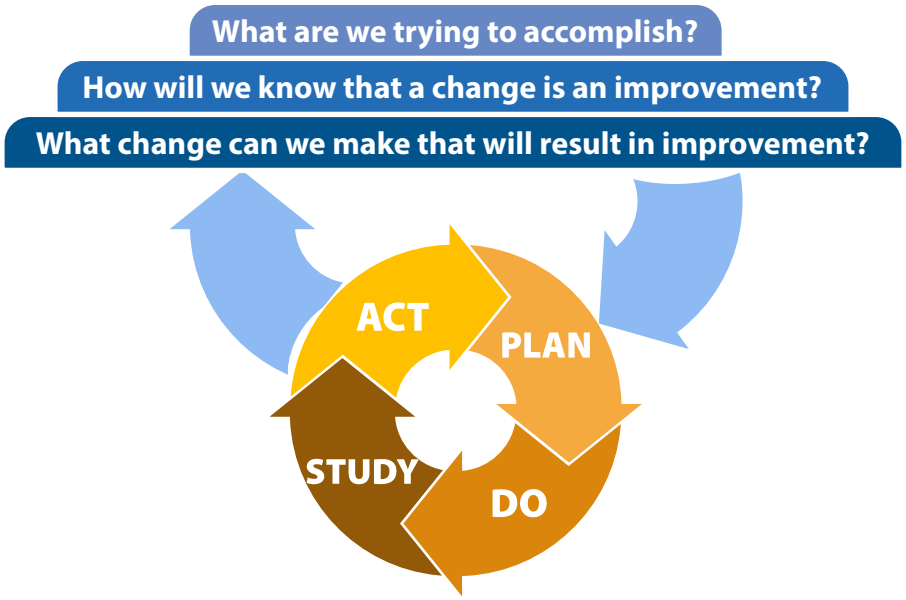
Our Quality Improvement approach

The common language and common approach referred to in our vision is based on NHS Improvements Academy for Change and Transformation (ACT) which promotes the use of "The Model for Improvement" from the Institute of Healthcare Improvement (IHI).

This model is used internationally across healthcare and guides QI work through defining a clear aim, underpinned by measurement, promoting ideas generation and the testing of those ideas using Plan, Do, Study, Act (PDSA).

"The Model for Improvement" is the underpinning model throughout the Trust QI training offered by the Trust, known as QSIR (Quality, Service Improvement and Redesign).

Model for Improvement



To support the trust in the use of the above methodologies the QI team has been formed to provide training, support and facilitation at an individual, team and Trust level.

Supporting Individuals

Our staff and teams are best placed to understand the problems that our services face and generate ideas to help improve our services.

To support their improvement efforts the Trust offers the QSIR QI training with a renewed focus to turn "learning into action" by simultaneously building the QI knowledge of participants whilst providing support to apply these QI tools to the problem they wish to solve or the idea they wish to test.

Supporting Teams – QI Team Facilitation

QI is rarely a solo endeavour and by bringing a team together to share understanding, learning and create solutions from those within a specific area of work is key to engaging our staff in the improvement of their services.

QI facilitation can be used to guide a team through the Model for Improvement, applying tools from improvement science, to a specific problem or idea to achieve the improvements they seek.

Supporting the Trust – QI Collaboratives

Where a problem exists across multiple areas, wards or sites a larger QI initiative maybe required to deliver improvement on scale.

QI Collaboratives can be used to bring together teams from across the Trust to understand the problem and work towards achieving a common goal, whilst ensuring involvement of staff and patients.

Key Actions to deliver our QI strategy

1 To build a fully established QI Team to deliver the Trust's QI ambitions

- Develop a QI team structure
- Recruit experienced and able staff to the QI team
- Align QI team resource and offer to organisational needs

2 Develop a QI brand and profile with a mechanism to show case, celebrate and communicate all QI initiatives across the trust.

- Work with the Trust Communications team to develop mechanism for promoting and celebrating the Trust improvement efforts
- Promote the Model for Improvement as the Trust's methodology for continuous improvement

Key Actions

3 Develop a "QI Dosing Models" to ensure the QI training offer is suitable to the needs of staff

- Develop, embed and deliver a range of training and facilitation offers to suit the needs of individuals, teams and the Trust overall
- Work with NHS Improvement to access specialist subject knowledge where required e.g. Human Factors, Lean etc

4 Work with external partners across the ICS to share QI knowledge and resources

- Develop a network of QI relationship across the ICS, including primary, secondary and tertiary care
- Establish connections with the Yorkshire and Humber Improvement Academy and Academic Health Networks

Key Actions

5 Implement an approach to capture ideas from across the Trust to promote and capture "ground up" ideas

- Establish divisional engagement to facilitate, support and develop "ground up" ideas
- Embed a process and facility for staff to identify and raise ideas
- Empower and encourage staff to deliver improvements based on "ground up" ideas.

6 Build a network of QI forums to provide peer support for staff ideas and build our NLAG QI community

- Engage with staff previously involved in QI work or training
- Establish QI forums to support staff ideas and QI efforts, with triangulation to both divisional and Trust governance structures
- Provide support, development and knowledge/training for staff in the QI community

Key Actions

7 **Promote and showcase the features and benefits of the Life QI system in supporting QI efforts, with the ambition of using in one Division as an initial exemplar**

- Identify division (and specific work areas) to pilot system
- Link system to improvement work streams
- Train and support staff to utilise system effectively and evaluate benefits

Key Actions

8 **Hold a QI Conference (April 2022) to showcase the Trust's improvement work and celebrate the efforts of staff**

- Build portfolio of QI work and successes to showcase on the day
- Establish interactive and engaging approach for the day, including speakers, workshops etc
- Give opportunity to all Trust staff to showcase their QI work

Key Actions

9 Explore other improvement initiatives (Always events, LEAN, Flow Academy etc) to develop the QI teams knowledge and in turn offering to support the organisation

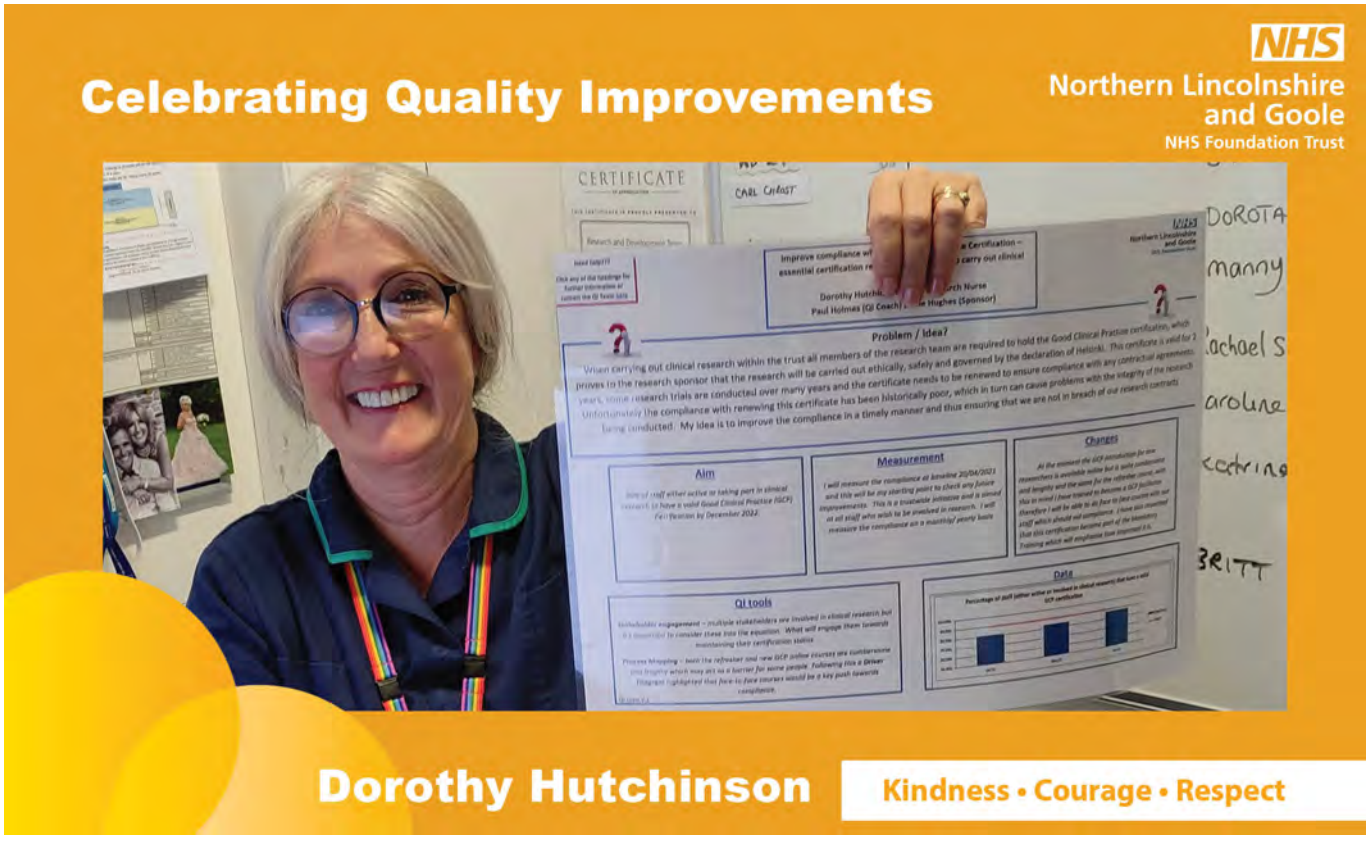
- Understand alternative approaches, models and initiatives to support quality improvement
- Build and expand the QI teams knowledge and skillset
- Develop suite of packages enabling a wide range of approaches to supporting improvement

10 Work with the Business Planning team for 2022 to incorporate QI initiatives to support delivery of Divisional priorities

- Explore how QI can support the Divisional and service objectives through the Business Planning cycle
- Develop annual schedule of QI improvement work to support Divisional and organisational improvement ambitions

How will we deliver this?

- The QI strategy 2021-2023 will be achieved by identified workstreams and action plans overseen by the Associate Director of Quality Improvement.
- Progress will be monitored by the Associate Director of Quality Improvement supported by the Clinical, Nursing and AHP leads for QI.
- The Chief Nurse will review and challenge progress on a bi-monthly basis as part of the Trust's new QI council.
- An update of the current position of ongoing QI projects and metrics of QI training outputs will be reported at the bi-monthly Trust's QI council, this will include any risks to delivery.
- An annual review will take place, with a refresh of our action plans to ensure continuous improvement.
- We will hold our first QI conference to showcase the Trust's QI work across all divisions and professional groups.
- We will work hard to ensure we promote the work of the Trust, individuals and professionals working within the organisation across local, regional and national forums.
- We will work to support improvements and innovation by embedding a culture of QI across our all of our developments and innovations.

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Celebrating Quality Improvements
Certificate of Achievement
This is to certify that
Karen Horne
Has successfully completed their QSIR Virtual
Karen Horne
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Contact Us:

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Visit: **www.nlg.nhs.uk**

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NLG(21)255

DATE OF MEETING	Tuesday 7 December 2021
REPORT FOR	Trust Board
REPORT FROM	Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Jenny Hinchliffe, Deputy Chief Nurse
SUBJECT	Annual Safer Staffing Nursing Establishment Review
BACKGROUND DOCUMENT (if any)	Establishment review 2019 Bed base review 2021 – Operations Team
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Trust Management Board Quality & Safety Committee
EXECUTIVE SUMMARY	As part of the National Quality Board (2016) requirements around the monitoring of sustainable safe staffing levels on inpatient wards, the Board are required to receive an annual review and approve any changes to nursing establishments. From April 2019 NHS providers area also assesses against new guidance: Workforce Safeguards Guidance (NHSI 2018) to support the application of workforce planning and safe staffing decisions. The nurse staffing review was undertaken using methodology described by the NQB guidance for thirty-one wards across the trust for adult and children inpatients. Although this formal review has been delayed due to the Covid 19 pandemic, a rolling process is in place to ensure that six monthly reviews take place to reflect potential seasonal changes. The next adult and children inpatient SNCT data collection is due to commence in November 2021. At the time of the review the SNCT tool was not available for use in ED, however the departments had been reviewed by ECIST and a review of ED is included. The ED SNCT tool has now been published and the Trust is awaiting receipt of the tool. It is recommended that further review of ED is undertaken, using the new NICE tool, when the footprint of the new departments can be walked. (we have included the review for information and transparency) A review of maternity staffing was undertaken by the Chief Nurse in March 2021 and is included; however, a further review using BirthRate+ is now underway. *We have also included the Community Nursing Review which took place in 2020 as an appendix for information.*

	The review was conducted following the re-basing of the bed base by the Chief Operating Officer in April 2021, and the establishment review is done on these bed base numbers. A review of staffing required for escalation areas has been completed but is not included in this paper presented to board. The review undertaken in adult and children inpatient areas considered a triangulation of data for each ward and included a celebration of what is going well. Consistent themes from ward managers included vacancies and managing short term sickness. Improvements were noted in mandatory training and appraisal rates. Themes identified included: • Patient acuity has increased since the last review. • Activity was still taking place on the wards after staffing had reduced for night shifts. Although the twilight shift has been successful on some wards, on others it was either unfilled or moved to cover shortfalls in the afternoon or night shifts thus continuing to leave a shortfall when activity and patient movement remains high. • The staffing levels on nights do not support the high activity and patient movement that continues over the evening and into the night across the acute sites. • Issues with training requirement and uplift as the budgeted uplift does not cover the 22.6% headroom as the sickness and all other leave (maternity, paternity and carer allowance) are not included in the recruitable establishments. • The process for reviewing and signing off rosters well in advance is not yet fully embedded. • No additional funding has been included for the 1 to 1 supportive care requirements. • Number of medical outliers and escalation beds not within divisional budgets. • Movement of staff, particularly out of hours, remains an issue and is impacting on morale. • Skill mix not meeting national guidance. • Family Liaison Assistant role has been received very positively and further work could be undertaken to quantify nursing time realised to care. • High dependency areas would benefit from a supernumerary shift lead/ coordinator and this would have the added benefit of being able to provide flexibility to support the CCOT and NIV patients on the wards due to Covid. • Two days of supervisory time for the ward managers is insufficient.

	Recommendations: 1. Review how headroom is being set based on workforce profile and guidance and then as annual review, recognising that some areas e.g. maternity, paediatrics, NICU have high levels of mandatory training requirements. 2. To consider the inclusion of a supportive observation in the headroom or how this can be funded. 3. Substantive recruitment to maternity leave. 4. Stabilisation of ward and bed base to support further data analysis and assurance and review plans for staffing and funding escalation beds. 5. Consider review of HSA support and supervision to ensure consistency and standards. 6. Continue to work on length of stay of our patients and discharge planning, looking more to develop nurse led discharge and protocols. 7. Uplift the Ward Managers time to lead to 30 hours per week. 8. Continue to embed use of Safecare Live to support safe deployment of staff. 9. Continue to monitor E-rostering levels of attainment against standards through the Safe Staffing and Effective Rostering Group. 10. Collate and review SNCT data every 6 months andpresent mid-year review to the Board. 11. Align the rosters, budgets and establishments with a 'sense check' at each ward review. The outputs of the SNCT data and Clinical reviews have been risk assessed and are included on page 39 of the report. ✓ The immediate concerns were implemented at the time of the clinical review based on Patient and staff safety. These are currently being managed through bank and agency as a cost pressure. It is recommended that these are funded substantively with immediate effect and the establishments amended. ✓ It is also recommended that the ED Clinical Educators are recruited to substantively. ✓ The assessment is then split into medium and low risk. Making this risk assessment helps the board and finance teams mitigate and plan for the cost of the review, this does not defer from the outcomes of the review and the implementation of those recommendations which are still required. The methodology and outcomes have been presented to the Quality and Safety Committee in November 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)	N/A				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Annual Safer Staffing and Establishment Review – June 2021

1. Introduction

The purpose of this paper is to provide the Board with the annual nurse safe staffing review in line with the guidance and requirements as cited by the National Quality Board (NQB) (July 2016) and Developing Workforce Safeguards (NHSI 2018).

As part of the NQB requirements around the monitoring of sustainable safe staffing levels on inpatient wards, the Board are required to receive an annual review and approve any changes to nursing establishments. The guidance:

- Sets out the key principles and tools that provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable and productive services, including introducing the care hours per patient day (CHPPD) metric
- Identifies three updated NQB expectations that form a 'triangulated' approach (Right Staff, Right Skills, Right Place and Time) to staffing decisions.

2. Context

Developing Workforce Safeguards (NHSI 2018) supports previous documents and requirements, building on the triangulated approach to safe staffing needs as described by the NQB guidance from 2016. It is based on patients' needs, acuity, dependency and risks. A safe staffing review should be reported to the Board twice a year, based on evidence-based tools, outcomes and clinical judgements (figure 1). Compliance will be assessed through the Single Oversight Framework and through a statement provided in the Trust's Annual Governance Statement.

Figure 1 Principles of safe staffing (NHSI 2018)

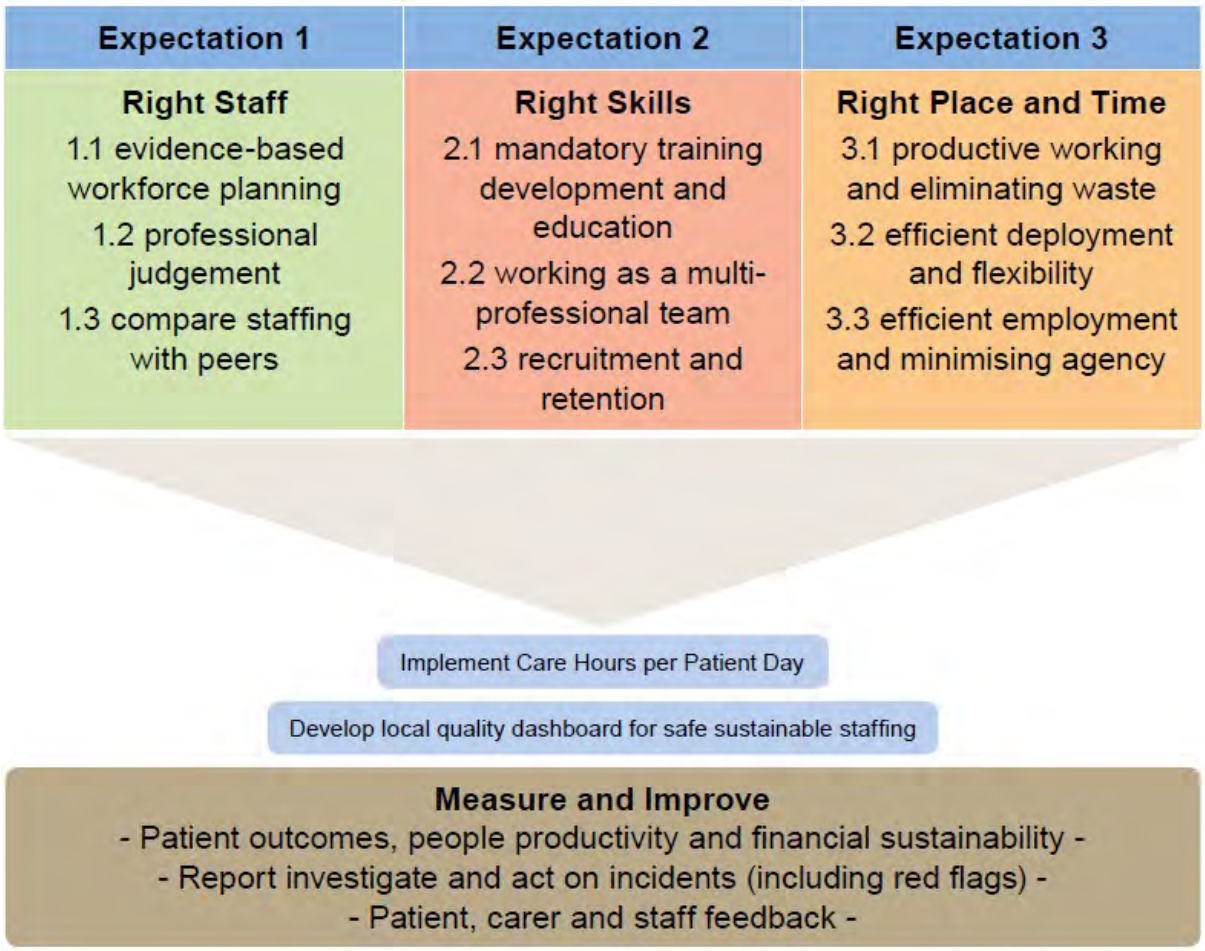
Using this methodology will ensure that the Board can be assured that establishments are based on patient safety and acuity data in line with CQC fundamental standards and use of resources, therefore fulfilling the Boards statutory requirements.

NQB (2016) guidance states providers:

- Must deploy sufficient suitable qualified, competent, skilled and experienced staff to meet treatment needs of patients safely and effectively
- Should have a systematic approach to determining the number of staff and range of skills required and keep them safe at all times
- MUST use an approach the reflects current legislation

The requirements of the Safe Staffing review and what must be considered as part of this review are outlined below in figure 2.

Figure 2 Triangulated approach to staffing decisions (NQB 2016)



The guidance also advises that boards must have a local dashboard that cross checks quality metrics and this should be reported monthly. The Chief Nurse has developed a nursing dashboard and a Nursing Metrics Panel which informs the nursing assurance report submitted monthly to the Quality and Safety Committee to support these requirements.

'The nursing workforce is the most important factor in the provision of safe, effective, high quality compassionate care in a timely, cost-effective and sustainable manner' (Royal College of Nursing (RCN) 2021). In May 2021 the RCN published Nursing Workforce Standards and Standard 1 states that:

> 'Executive nurses are responsible for setting nursing workforce establishments and staffing levels. All members of the corporate board of any organisation are accountable for the decisions they make and the actions they do or do not take to ensure the safety and effectiveness of service provision.'

This paper forms the annual report to Board and there will be a mid-year review. Over time this will allow the Trust to develop more understanding of seasonal trends or workforce patterns, and will also allow us to ensure there is a continuous review of safe staffing against patient acuity and dependency.

The reviews included:

- The Safer Nursing Care Tool (SNCT)
- NICE Guidance (2014) Safe Staffing for Nursing in Adult Acute Wards in Acute Hospitals
- Clinical / professional judgement
- Model Hospital data

- Review of staffing red flags and staffing incidents
- Triangulation of nursing metrics or nurse sensitive indicators through the nursing dashboard and nursing metric panel
- Mandatory training, appraisals and professional development data
- Recruitment and retention information
- Roster management
- Budget management and staffing costs
- Temporary staffing and fill rates
- Safecare Live

This paper will identify how the review meets all of the expectations identified within the Developing Workforce Safeguards Guidance NHSI (2018).

3. Covid 19 Pandemic and annual establishment review for 2020

During the pandemic the Chief Nurse has continued to provide oversight to the Quality and Safety Committee and Board on nursing and safe staffing. Throughout this time there were continuous changes to the bed base, ward reconfigurations and zoning. The establishment has been under constant review as we have moved through the various stages of the pandemic. During this time we have not been able to apply the methodology described above with use of the Safer Nursing Care Tool (SNCT), so we have had to use and work to other principles that support the safer staffing methodology: clinical judgement, nursing metrics, Safecare Live data and triangulation of complaints and incidents.

The staffing for Green, Yellow and Red zones were reviewed and set by the Chief Nurse in discussion and agreement with the respective Heads of Nursing. Throughout this process we have worked with individual ward managers and matrons to adjust staffing as we navigated our way through the pandemic and the changing needs of our patients and clinical teams. A Daily COVID-19 Short Term Nurse Staffing Standard Operating Procedure was developed and a Surge Plan for Moving to Surge Capacity and Safe Staffing Levels was set in April 2020 by the Chief Nurse and has been reviewed as activity has changed. Safecare Live was introduced in April 2020 and provides information regarding patient acuity, dependency and staffing in real time to support decision making regarding deployment of staff to maintain patient safety on the in-patient wards. Daily 10.00 hour safe staffing meetings were introduced in September 2020 for Matrons and are chaired by the Deputy Chief Nurse, Head of Nurse Staffing or a Head of Nursing to review nurse staffing and Safecare Live information, and agree any additional actions or escalation required to mitigate risks and maintain patient safety.

At the beginning of the pandemic we needed to upskill staff and provide enough staff to be able to care for zoned patients and critically ill patients. In this later surge we are seeing an increase in patients with long term conditions, later stages of illness and more fragility. This means we have needed to review our staffing needs, and this will be discussed further in the need and provision for 1:1 supportive care.

It is worth noting that ward reconfigurations and changes to bed bases will affect any Model Hospital metrics comparisons and should therefore be viewed with caution.

In 2020, the wards were supported by Year 3 final placement student nurses who were employed as Band 4 Aspiring Nurses, and Year 2 student nurses who accepted paid placements on Band 2 contracts to support the pandemic and progression through their training programme. The addition of student nurses to the paid workforce helped to maintain Healthcare Assistant shift fill rates during the pandemic, however, this support is no longer available which is leaving our ward areas more vulnerable.

Although the bed base continues to be reviewed as we manage the third wave, the Chief Operating Officer commenced work in April to reset the bed base to support a formal establishment review. The 'new' bed base was formally approved in July, however there have been ongoing challenges with increased non-elective activity, high number of admissions, and increased cases of Covid resulting in increased use of unestablished escalation beds, and further ward changes have been made since the data was collected in May therefore this needs to be considered when reviewing SNCT data.

4. Review of the Adult and Children Inpatient Ward Establishment Review 2019

The last formal nurse staffing review was carried out in 2019 using the methodology described above for thirty-one wards across all hospital sites for adult and children inpatients. ED was reviewed by NHSI and was included in the review (SNCT was not used as ED SNCT not published at the time of the review). All adult inpatient wards had 2 rounds of SNCT data collected to inform ward establishment reviews held by the Chief Nurse.

The reviews undertaken in adult and children inpatient areas considered a triangulation of elements for each ward. A consistent theme from the ward managers included vacancies, managing short term sickness and ability to cover rosters within the ward establishments, as well as issues with training requirements and uplift. Despite this, improvement was noted in statutory and mandatory training and appraisal rates. A concern highlighted was the recurring theme across the teams regarding high patient activity and transfer out of hours.

4.1 Review findings

- Reduced nursing cover on a night shift with continued high patient activity
- Variation in shift patterns
- Some discrepancies with ward budgets not being calculated to cover a 24 hour period so wards at full establishment were not always able to cover a roster
- More consistency in reviewing and signing off rosters well in advance
- Budget meetings inconsistent in some ward areas
- Ward clerks not being part of the nursing team and not working later into evening hours and at weekends
- Inconsistency of care navigators and clinical ward sisters on wards
- SNCT data demonstrating that on some wards staffing RN establishment level was low
- CHPPD was low on more general wards at 4.5 for RN and 3 for HCAs against peers at 4.6 and 3.3 and the national average of 4.7 and 3.3 respectively
- Skill mix was in the majority outside national limits, identified as a 60/40 ratio.

4.2 Recommendations and outcome

Key recommendations
Move staff towards the later part of the day to support the early evening to night time period. Most of the investment requested was to support this patient safety requirement.
Review how headroom is being set based on workforce profile and guidance and then review annually as part of this review.
Substantive recruitment to cover maternity leave
Reinstate monthly ward budget meetings with ward managers.
Consider the review of the Patient Care Navigators and how they are budgeted to the wards. In some areas they were included within the HCA numbers and in other areas they were separate. Some areas did not have care navigators.
Implement SafeCare to allow real time staffing management.
Consider a review of Ward Clerk support to endure this is consistent across ward in and out of hours.
Consider the inclusion of a supportive observation budgeted uplift in the headroom, or top slice budgets to cover this cost.
Consider the divisions being funded for the apprenticeship backfill.
Uplift the Ward Managers time to lead to 15 hours per week and 7.5 hours per week in January, February and August.
Align the rosters, budgets and establishments, with a ‘sense check’ at each ward review.
Increase the number of flow coordinators in ED to improve flow and recruit two band 7 clinical educators in ED on both sites (in line with CQC recommendations).
Consider the procurement of the community productivity tool.

The review was initially presented to the Trust Board in early August 2019 followed by a formal paper in September. In principle all of the recommendations were supported, however identification of financial support was needed. The first phase of funding was subsequently secured from October 2019 for those areas identified as having the greatest need based on the review (very high risk), with funding for high risk areas subsequently being secured from April 2020.

Very High Risk to organisation Risk to patient safety and outcomes Risk to performance Risk to CQC regulation for Safe Staffing	Immediate	➢ Investment across 9 wards for the twilight shift (B5) to be introduced 7.5 hour shift to reduce patient safety risk and match ED activity and flow (B4, C7 Stroke DPoW, 16, 17, 24, B7, 23, 24 and Amethyst (intensive support position)). ➢ Increase RN (B5) establishment on C6 and C7 Stroke at weekends to be the same as weekday. ➢ Increase RN (B5) 12.5 on 22 due to poor skill mix. ➢ Increase RN (B5) 7.5 hours on ED 7 days per week. ➢ band 7 on nights to support the senior decision maker in ED.
High	In next 2 months	➢ Procurement of Community Nursing software to enable a productivity review ➢ Investment across 8 wards for the twilight shift (B5) to be introduced 7.5 hour shift to reduce patient safety risk and match ED activity and flow (AMU, B3, B6, C2, C5, C6, CDU, 25). ➢ Increase RN x1 (B5) 12.5 on B2, due to poor skill mix. ➢ Care Navigator role consistent across wards, although this would contribute to discharge planning, LOS and release nursing time.
Medium		➢ Increase RN (B5) x1 ward 25 Mon-Fri to support with theatre activity ➢ Increase HCSW on nights for wards 16 and 17 due to acuity of patients ➢ Increase RN (B5) a 1 ward 25 nights 7 days per week. ➢ Increase ward managers time to lead to 15 hours per week except for Dec, Jan, Feb and August where it would be reduced to 7.5
Low		➢ Uplift band 5 to 6 for 2 ward areas NRC and CCU to make consistent across organisation ➢ Increase number of Flow co-ordinators to cover 10 am to midnight ➢ 2 clinical educators for ED in line with CQC guidance

Medicine Division:

Very high and high risk areas were funded. Recruitment to cover maternity leave remains a challenge for the Division and the requirement for the clinical educator posts in ED is now viewed as high priority to support patient safety. Ward Manager increased time to lead has not been funded and remains at 7.5 hours per week.

Surgery Division:

Very high, high risk and medium risk areas funded with the exception of the Twilight shift on B3 (funded from ward 25 Twilight funding) and the RN early shift 5 days per week on ward 25. 4th RN 7 days per week on ward 25 was funded as per additional review recommendations in February 2020.

All surgical wards were funded for 15 hours supernumerary time to lead B7 hours plus 7.5 hours every 2 weeks supernumerary for B6 deputy following the review in February 2020.

Community & Therapies Division

Investment secured to purchase a scheduling system to support review of productivity. Procurement of the system has been delayed due to the requirement for Smartphones to support the system, however this has been resolved and the system is now being procured. Recruitment to cover maternity leave remains a challenge for the Division.

Children's Wards

No very high or high areas identified in review. Ward Mangers on Paediatric wards are supernumerary, ward managers increased time to lead was not funded on neonatal wards.

4.3 Summary

Very high, high and some medium risk recommendations were funded. More recently the 2 Clinical Educator posts in ED (low risk recommendations) have been funded temporarily to support the improvement work required in our emergency departments. This needs to be funded recurrently to support the development and safety of our staff and patients.

In summary, several areas remain unfunded from the 2019 review:

- Recurrent funding for ED Clinical Educators
- Increase for ward managers time to lead to 15 hours for Medicine and Neonatal Units

5. Review of the Adult and Children Inpatient Ward Establishment Review 2021

5.1 Methodology

The Safer Nursing Care Tool (SNCT) is defined as:

> *"An evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/ dependency terms".*

The process involves using the SNCT over a period of 20 days on each area to establish patient need and dependency. This tool is based on 4 levels of care, defined by national guidance (see Appendix 1*).* Data is then collected around levels of patient dependency and patient movements, including discharges, transfers, admissions, direct and indirect care, and occupancy.

Refresher training was provided to all Ward Leaders, Matrons and other Senior Nurses across the Trust in the use of the SNCT. This included a clinical competency element based on the levels of care, including an assessment by those who received the training by NHSI experts. The Trust collected the data via SurveyMonkey from w/c 26.04.21 to w/c 17.05.21 inclusive. The data was then run through the appropriate software, using specific SNCT calculations seen in Appendix 2. Once this data processing was completed, the ward review process commenced.

5.2 Ward Review Process

As part of the new annual review, thirty-two wards across all hospital sites for adult and children inpatients were reviewed. In addition, both Emergency Departments were reviewed, however it should be noted that the SNCT tool is not yet available for ED. A rolling process has been put in place by the Chief Nurse to ensure a six monthly review, in normal circumstances, takes place to reflect potential seasonal changes or demographic changes to wards.

The ward review group consisted of the Ward Manager, Chief Nurse, Deputy Chief Nurse, Head of Nurse Staffing, Divisional Head of Nursing, Matron and Finance Business Partner. It is essential to include the clinical manager in the ward review process as they are the accountable leader and meetings were arranged to accommodate their attendance. The ward review considered a triangulation of elements for each ward, including a financial review. An example of the template used is included in Appendix 3.

Information was taken from a 3 month review of the nursing dashboard, but also included:

- Information from the SNCT review
- A review of ward budgets and establishments, with a clear breakdown of staffing budgets at each band
- Agency and bank use

- Roster management
- HR benchmarks including vacancy, sickness, appraisals, training and development
- National benchmarking of CHPPD data using the Model Hospital

The review included a celebration of what is going well on the ward areas which highlighted good practice and exceptional leadership. A consistent theme from the ward managers included:

- RN vacancies
- Increased acuity and dependency of patients on the wards
- Movement of patients out of hours
- Significant number of medical outliers in many specialties
- Use of unestablished escalation beds
- Movement of staff and the impact of the pandemic on the health and wellbeing of staff
- Covering maternity leave
- Insufficient ward manager supervisory time
- Issues with training requirement and uplift in areas with increased mandatory training requirements (NICU, paediatrics and ED)

There had generally been a significant increase in statutory and mandatory training and appraisal rates, with most wards advising that they are near completion. All ward managers with a Family Liaison Assistant in their team talked very highly of the role and the positive impact on patients, relatives and staff.

At the end of each ward review a discussion was held and decision made on the recommendations that would be put forward so the entire panel was in agreement.

5.3 Review of Results

5.3.1 SNCT Results

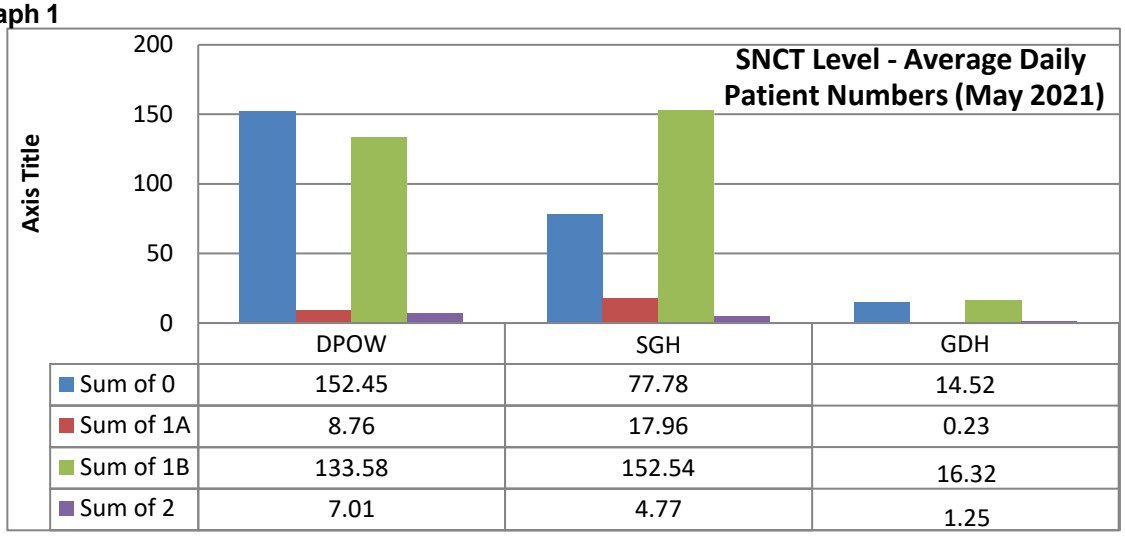
The SNCT allows managers and practitioners to challenge historical staffing and address inequities. The care levels and multipliers facilitate judgements and are an integral part of the Chief Nurse's toolkit. The SNCT multipliers are based on empirical data and the national best-practice dependency/acuity database. The Trust used licensed software to gain this information. The SNCT takes into account headroom of 22%. It is advised that the SNCT is not used on small units of less than 10 beds.

Graphs 1 (average daily patient numbers) and 2 (average patient daily patient %) below show a breakdown across the hospital sites of the SNCT levels of acuity of patients.

SNCT Levels of Care:

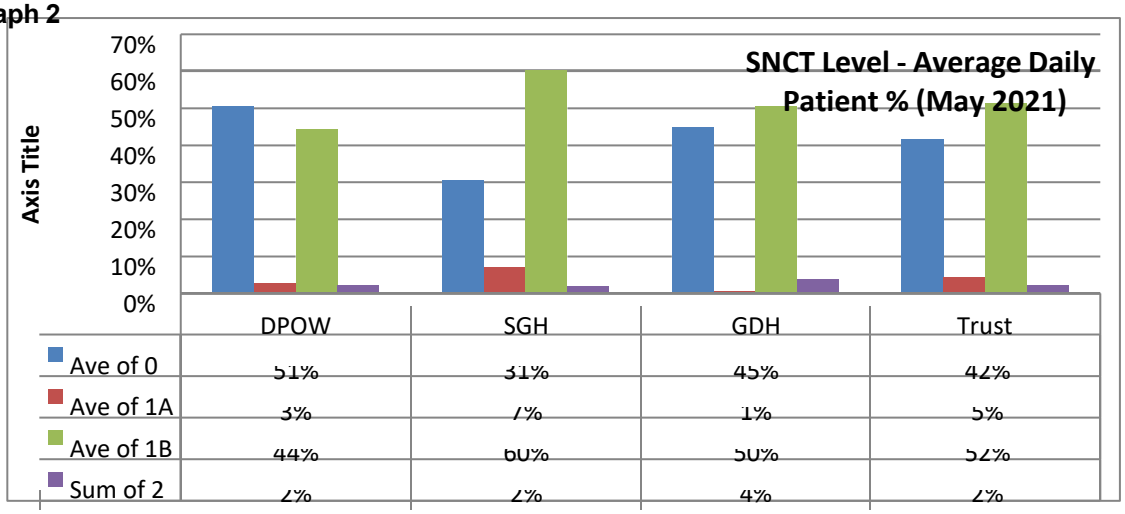
Level 0	*Patient requires hospitalisation. Needs met by provision of normal ward cares.*
Level 1a	*Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.*
Level 1b	*Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living.*
Level 2	*May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility /unit.*
Level 3	*Patients needing advanced respiratory support and/or therapeutic support of multiple organs.*

Graph 1



	DPOW	SGH	GDH
Sum of 0	152.45	77.78	14.52
Sum of 1A	8.76	17.96	0.23
Sum of 1B	133.58	152.54	16.32
Sum of 2	7.01	4.77	1.25

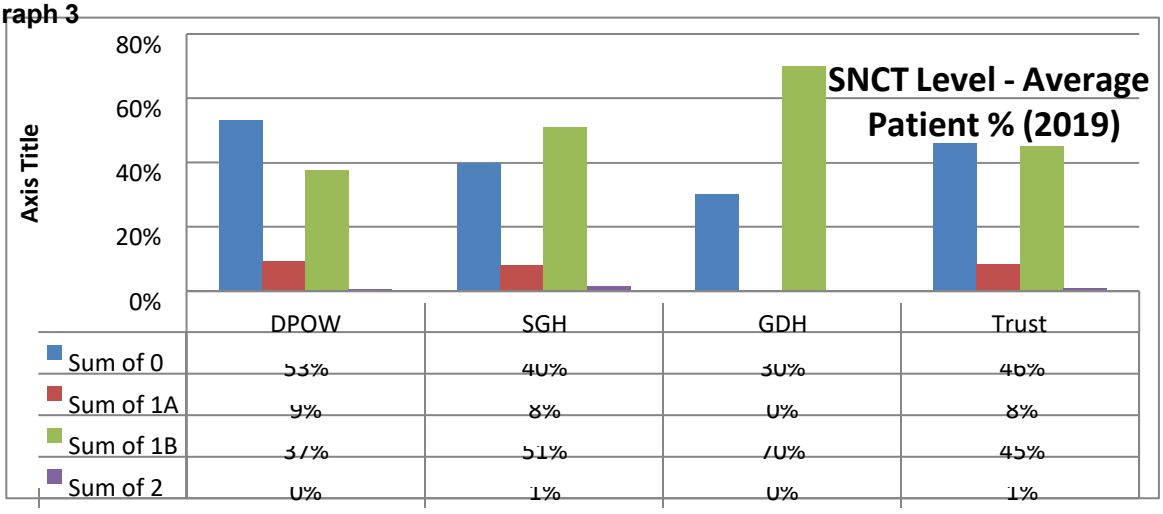
Graph 2



	DPOW	SGH	GDH	Trust
Ave of 0	51%	31%	45%	42%
Ave of 1A	3%	7%	1%	5%
Ave of 1B	44%	60%	50%	52%
Sum of 2	2%	2%	4%	2%

For comparison, SNCT data collated in 2019 is shown in graph 3 below.

Graph 3



	DPOW	SGH	GDH	Trust
Sum of 0	53%	40%	30%	46%
Sum of 1A	9%	8%	0%	8%
Sum of 1B	37%	51%	70%	45%
Sum of 2	0%	1%	0%	1%

SNCT data reflects feedback from the Ward Managers and teams that the % of level 1b patients has increased on both the SGH and DPOW sites since 2019. SGH continues to have the highest % of level 1b patients at 60%. The % of level 2 patients has increased on all sites and is reflective of the impact of Covid with more patients requiring CPAP and NIV. The level 2 patient at GDH reflects one patient with a

tracheostomy on NRC and is in line with national rehabilitation ward benchmark data. Level 1a patients have decreased on both the DPOW and SGH sites.

The reduced number of level 0 patients reflects the development and success of same day emergency model on both acute sites, however with the reduction in beds this has resulted in a higher proportion of those patients at the higher acuity and dependency level on the wards.

SNCT data (appendices 4 and 6) should be reviewed with caution due to subsequent ward moves (e.g. switch of C1 and C5), differences in open beds verses the plan, and use of unestablished escalation beds. It should be noted that no adjustments were made to the SNCT calculations to account for the increased time required for donning and doffing PPE and for increased breaks when full PPE is being worn, both of which have increased significantly since the beginning of the pandemic, however the impact of this must not be underestimated and has been retrospectively shown and added to the SNCT calculation (appendix 4). Additionally, SNCT output does not include time for transfer/escort activity which is particularly high on assessment units. As transfer time data was collated this is also shown and has also been added to HCA SNCT data.

The table below shows wards with SNCT data showing deficits of more than 3 RNs.

Table 1 Wards showing deficits of more than 3 RNs

Site	Division	Ward	Beds	Esc beds	Ops Bed Plan	Ops Plan esc beds	RN (Est)	Average beds SNCT	RN (SNCT)	Donning RN WTE	Total RN (SNCT)
DPoW	Medicine	C5	24		24		16.17	23.4	23.9	1.08	24.98
DPoW	Medicine	C2	27		27		16.53	26.6	22.5		22.5
DPoW	Medicine	Stroke Unit	25		25		16.53	24.2	21.1		21.1
SGH	Medicine	16	23		23		15.63	22.8	21.6		21.6
SGH	Medicine	22 (ward 17 staff)	27		27		15.41	27	25		25
SGH	Medicine	Ward 25 (ward 18 staff)	28		14	14	12.15	28	25.6		25.6
SGH	Medicine	IAAU (B)	21		9	12	15.41	18.9	20.3	1.4	21.7
DPoW	Surgery	B6	22		22		15.41	21.6	18.6		18.6
DPoW	Surgery	B7	18		14	4	15.41	21.7	18.9		18.9

It should be noted that wards 22 and 25 have the highest difference in RN establishments however the establishments for both of these wards were for a much lower number of beds. Ward 17, now ward 22, is established for 23 beds and at the time of the review had an average of 27 occupied beds. Ward 18, now ward 25, is established for 14 beds and at the time of the review there were an average of 28 occupied beds. IAAU is budgeted for 9 beds however the escalation beds are generally in use with an average of 18.9 occupied beds when the data was collected.

These areas have high levels of acuity and can be triangulated to the areas which have triggered various nursing metrics and high temporary staffing, for example:

- Ward 22 had 75% level 1b patients compared to the benchmark of 48% for medicine and 66% for medical elderly, RN night fill rate of 61.3%, Care Hours Per Patient Day (CHPPF) for qualified staff of 2.9 and 8.9 falls per occupied bed day.

- Ward 25 had 73% of level 1b patients compared to the benchmark of 48% for medicine, increasing numbers of 1:1 supportive care requests, high temporary staffing use, CHPPD for qualified staff of 2.9 and 5.0 falls per occupied bed days.

- Ward 16 had 80% of level 1b patients compared to the benchmark of 66% for medical elderly, CHPPD for qualified staff of 3.1 and increased falls overnight.

It is also noted that on a number of wards the SNCT recommended ‘Staff per shift’ is considerably lower on nights than days. An example of this can be seen on ward A1 acute assessment unit:

A1 SNCT data

	SNCT Element	Your ward	Your ward	Benchmark
4	Level 0 patients (daily average)?	7.2	44%	42%
5	Level 1a patients (daily average)?	0.0	0%	26%
6	Level 1b patients (daily average)?	9.1	56%	31%
7	Level 2 patients (daily average)?	0.0	0%	1%
8	Level 3 patients (daily average)?	0.0	0%	0%
9	Patients	16.3	100%	1556
10	Preferred time-out?	22.0%		
11	Preferred RforA time?	9.7%		
12	Preferred RN proportion?	60%		
13	Level 0 multiplier	1.27		
14	Level 1a multiplier	1.66		
15	Level 1b multiplier	2.08		
16	Level 2 multiplier	2.26		
17	Level 3 multiplier	5.96		
18	RNs required	16.8		
19	HCAs required	11.2		
20	Total FTEs required	28.0		

Staff per shift			
Three Shifts		*Two Shifts*	
Early	7.1	Day	7.0
Late	5.1	Night	3.0
Night	3.1		
Includes twilight/shift workers			

In this example it is assumed that 44% of patients will sleep most of the night requiring little nursing interventions. However, in reality it would not be safe to reduce the number of staff on duty to three on nights on ward A1, not only because of the layout of the ward and high number of single rooms, but given the high number of discharges, admissions and patient movement that continue during the evening and early into the morning. This is the case across the Trust and applicable to all of our ward areas.

Analysis of SNCT data and establishments can be found in appendices 4, 5 and 6.

5.3.2 Care Hours Per Patient Day (CHPPD) Data and Model Hospital

CHPPD data has been collected for acute and acute specialist providers since April 2016 and for community and mental health Trusts since April 2018 following publication of Lord Carter's report on their productivity.

As a result of this:

- All Trusts must submit CHPPD data via the Strategic Data Collection Service (SDCS)
- CHPPD is a measure of workforce deployment that can be used at ward level and service level or aggregated to Trust level
- To calculate CHPPD, monthly returns for safe staffing and the daily patient count at midnight, which is the total number of patients on the ward at 23.59, are aggregated for the month

The Chief Nurse has been using the Model Hospital to compare our CHPPD metrics against national peers since November 2018. It should be noted that due to the Covid pandemic and numerous ward reconfigurations, many of the ward definitions have changed and overall Trust data of CHPPD should be viewed with caution. It does not take into consideration elements within our model of delivery and benchmarking against the nominated peers list does not always provide a good comparator. The parameters of our peers are also not clear as they include single site smaller Trusts, with less acute services provided. It is therefore more useful to look at ward demographics.

Things for our Trust to consider include:

- Changes to our reconfigurations of wards are impacting on the Trust overall data
- Lower occupancy on Children's wards
- The acuity of the service delivery model at the Trust is currently not taken into account, i.e. escalation beds
- Our ward demographics are not classified correctly given the multiple ward reconfigurations and moves throughout the pandemic

- Goole site due to low occupancy/activity levels and impact on the overall Trust CHPPD. (It would be useful to be able to review the Trust data removing the Goole element to give a more realistic picture of the Trust wide CHPPD data.)

The latest Model Hospital data from May 2021 shows the total Trust CHPPD value of 8.6 compared to the Peer median of 8.9 and national median of 9.1.

Figure 3 CHPPD – Total Nursing and Midwifery staff

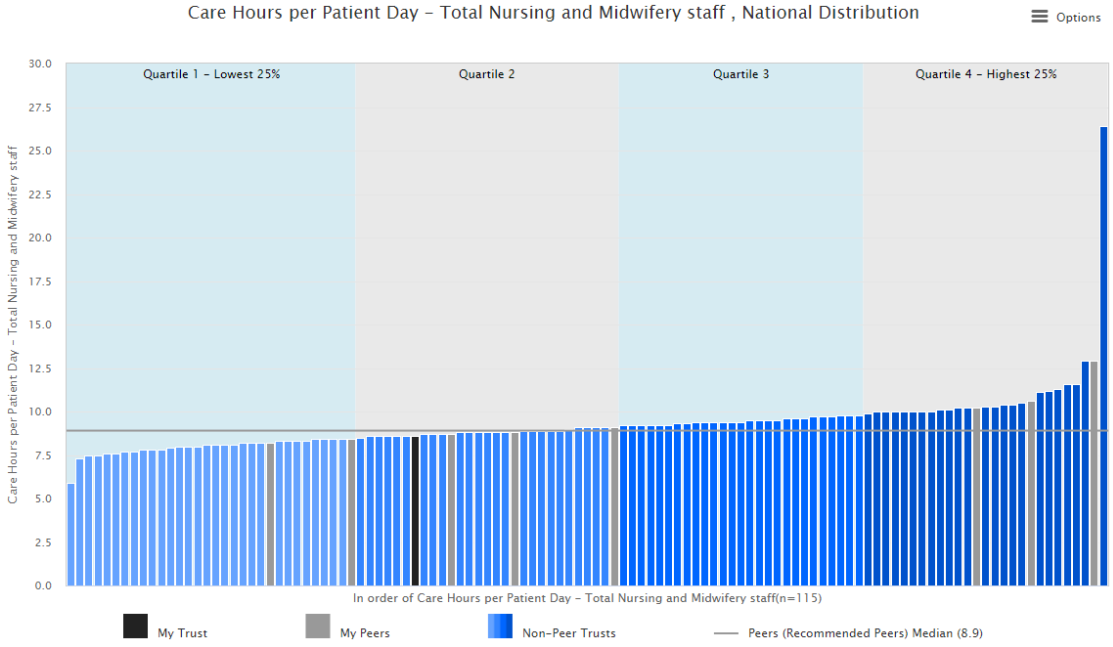


Figure 4 CHPPD – Registered Nurses and Healthcare Support Workers

CHPPD	Data period	Trust value	Performance band description	Peer median	National median
Care Hours per Patient Day - Total Nursing, Midwifery and AHP staff	May 2021	8.6	In quartile 2 - Mid-Low 25% (blue)	8.9	9.1
Care Hours per Patient Day - Total Nursing and Midwifery staff	May 2021	8.6	In quartile 2 - Mid-Low 25% (blue)	8.9	9.1
• Care Hours per Patient Day - Registered Nurses and Midwives	May 2021	5.2	In quartile 2 - Mid-Low 25% (blue)	5.1	5.3
• Care Hours per Patient Day - Healthcare Support Workers	May 2021	3.3	In quartile 1 - Lowest 25% (blue)	4.0	3.5

Trust CHPPD value for Registered Nurses and Midwives is 5.2 and in quartile 2 compared to a peer median of 5.1 and national median of 5.3. CHPPD for Healthcare Support Workers was 3.3 and in the lowest 25% of Trusts, quartile 1, compared to the peer median of 4.0 and national median of 3.5.

Cost per Care Hour data is only available for Q4 2018/19 however is considerably lower than both the peer and national median.

Figure 5 Cost per Care Hour

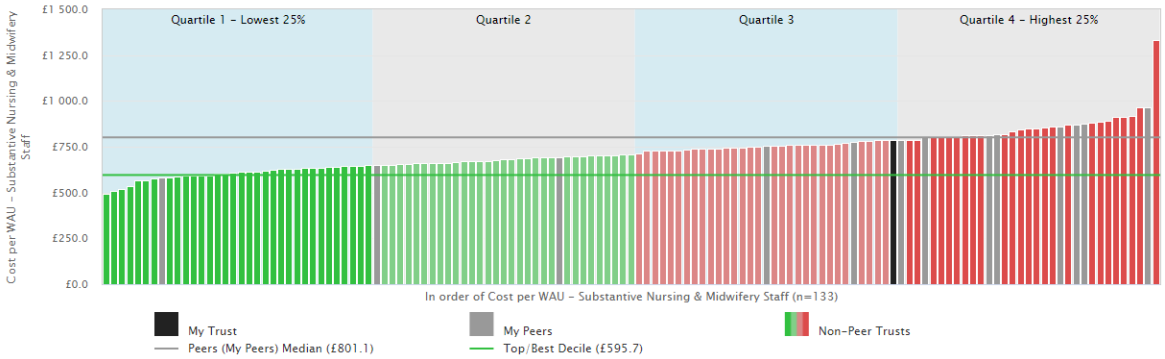
Cost per Care Hour - Total Nursing and Midwifery staff	Q4 2018/19	£20.3	£24.0	£23.6	
Cost per Patient Day - Total Nursing and Midwifery staff	Q4 2018/19	£153.3	£181.6	£189.6	

The Weighted Activity Unit (WAU) is a 'common currency' to describe an amount of clinical activity, with a weighting applied that takes account of case mix and complexity. The cost per WAU for nursing and midwifery staff is quartile 3, a significant improvement on the quartile 4 position in 2018/19.

Figure 6 Nursing staff cost per WAU

Money & Resources	Data period	Trust value	Peer median	National median	Chart
Total Nurses Health Visitors and Midwifery (FTE)	Q1 2021/22	2,399.9	2,201.3	2,609.6	
Average Staff Cost - All Nursing Health Visitors and Midwifery Staff	2019/20	£37,666	£38,924	£39,664	
Nursing staff cost per WAU	2019/20	£1,003	£1,007	£948	

Figure 7 Cost per WAU for Substantive Nursing Staff 2019/20



Nursing staff cost per WAU	2019/20	£1,003	£977	£948	
Nurses, Operating Department Clinical Staff and Healthcare Support cost per WAU	2019/20	£943	£937	£890	
Specialist Nurses, Advanced Nurse Practitioners cost per WAU	2019/20	£61	£55	£49	

Although temporary staffing premium costs are not paid for HCAs, the Trust has been paying a bank incentive over recent years which could account for higher cost. We have also been supplementing some trained nurses for HCAs and the use of 1:1 supportive care for some of our level 1b patients which we can see from the SNCT results. Although the Trust WAU for RNs is slightly higher than the national average, we do compare with our peers favourably. It is interesting to note that our cost of care per hour benchmarks better than the national median and peer organisations. This could be representative of low productivity in activity rather than high nursing costs and suggests that the focus should be on productivity and efficiency rather than reducing nursing costs, for example, increasing day case rates and theatre productivity would

reduce the nurse cost per WAU, however the Trust has a high nursing agency spend and work is ongoing to reduce this.

Moreover, this might suggest that the Trust's activity levels could be slightly higher as opposed to paying too much for its nursing and midwifery workforce. As discussed in the next section, our skill mix is lower on some wards that that in many Trusts, so may also be contributing to our lower costs given temporary staffing use.

5.3.3 Skill Mix

As part of the ward review process, a review of ward skill mix was undertaken as seen in Appendix 4.

The public inquiry into the Mid Staffordshire NHS Trust pointed to fundamental flaws in the structure and culture of the NHS, and how these had led to serious care failures. In relation to nurse staffing, the inquiry highlighted poor decision-making, a failure to undertake risk assessment when changing levels or skill-mix, privileging financial matters over quality and safety, failures of leadership, not taking senior nursing advice, and failure to act in the face of evidence (Francis 2013).

The supply of registered nurse staffing has not matched increases in demand; staffing levels in Trusts are falling below the level identified as being needed. There is evidence that there has been a downward shift in skill mix; support staff numbers have increased at a faster rate than RNs. Whilst in the short term this may appear to offer a solution to the 'balancing act', research evidence to date suggests that substitution of RNs with less well trained staff is unlikely to represent an efficient or effective solution (Ball et al 2019).

Higher registered nurse staffing levels are associated with lower mortality, and the fact that fewer vital sign observations are missed is the most likely explanation for this. Increasing registered nursing staff by an hour for each patient per day could reduce the risk of death by 3%. If the ratio of healthcare assistants to nurses gets too high, the data also suggest that rates of missed vital sign observations and mortality increase in line with the extra registered nurse time spent supervising other staff (Aitkin et al 2016). Variation in hospital nurse skill mix in NHS hospitals in England varies from a high of 79% professional nurses in some hospitals to a low of 47% in others (Ball et al. 2014). Increases in nursing skill mix, by having proportionately more registered nurses, may be cost-effective for improving patient safety. The relationship between staffing, safety or workload is complex which should only be dismissed with caution (Leary and Punshon (2019).

In 2019 the establishment review identified that the RN: HSCW skill mix on day shift was below 50% on 18 wards, with 7 of those areas between 43% and 49% RN rate. 13 areas were above 60% however these were in high dependency, assessment and paediatric areas. On night shift, 13 areas were at 50% or below RN: HCA ratio as most wards ran on 2 Registered Nurses with the exception of assessment areas, high dependency and paediatrics.

Improvements are seen with the RN: HCA skill mix on days:

- 6 wards between 43 and 50% RN skill mix
- 13 areas are above 60% but these are in high dependency, assessment and paediatric areas

Areas with the lowest RN ratios are Ward C6, Stroke Unit in DPoW, Ward 16, Ward 17, Ward 22 with areas having an average of 43:57 ratio, and Neuro Rehabilitation Centre having an average of 40:60 ratio which are below RCN guidance and best practice.

On nights 14 areas are at a 50% or below RN ratio this is because generally these wards run on 2 RNs with a twilight shift that was added following the last review to mitigate some of the risk overnight (with the exception of A1 DPOW and IAAU SGH), however the review panel heard that where a twilight shift is in place it may not always be filled as the staff member is used to fill last minute gaps in the day and night shifts.

Increases in nursing skill mix, by having proportionately more registered nurses, may be cost-effective for improving patient safety. The relationship between staffing, safety or workload is complex which should only be dismissed with caution (Leary and Punshon (2019).

5.3.4 Staffing Incidents

Staffing incidents and red flags are reviewed at the monthly Nursing Metrics Panel. The majority of the staffing incidents are reported to occur out of hours. The staffing red flags were refreshed and relaunched in June 2021 and, for ease of reporting, can now be reported on Safecare Live which will in part account for the increased incidents being reported (appendix 7).

Of the 103 incidents reported via Datix on September, 23 were reported as nursing red flags on inpatient wards, an additional 77 red flags were reported on Safecare Live. There were a total of 100 red flags reported in September 2021. Table 2 shows the types of red flag incidents reported.

Table 2 Red flag types

Red flag type	September	Wards
Delay in administration of IV medications by 1 hour to more than 3 patients	4	C2, C3(2),ward 25
Delay in medicine rounds by 1 hour	8	ECC DPoW, Blueberry ward, C3, Ward 22, Ward 23(2), Ward 24, Ward 28
Delay of more than 30 minutes to provide acute pain relief	2	C2, Ward 28
More than 50% of staff under 12 months qualified	1	Ward 17
Less than 2 trained nurses on a clinical area	5	IAAU B SGH, Stroke unit SGH(2), ward 3 GDH, SDU SGH
Trained nurse less than 12 months qualified, or still in preceptorship left in charge	2	B3, ward 6
Less than 50% substantive staff on a shift	17	EC SGH, B3, C2 (4), Stoke ward DPOW,HOBS ward 28, Maternity Theatre DPOW, ward 23, ward 17, ward 28 (2)
Below safe staffing levels	41	A1, B6(2), C2(7), C3(2), HDU(3), ITU(1), Rainforest (4), Stroke unit DPOW (5), AAU B , ward 16(3), ward 17(2), ward 23(4), ward 24(6), ward 25, ward 29(2), ward 6
Patient Transfer 2200-0600 for due to bed pressures	2	C3(2
Co-ordintors Non Supernumerary	9	C2, ITU (4), ICU SGH(3), CDS SGH
Covid-19 +ve pts on ward	8	HDU(6), ITU(2)
Failure to deliver one to one care	3	C2, C3, ward 23
Missed or delayed care	1	C2
Delayed action on abnormal vital signs	1	Ward 23

A review of falls data shows that over 50% of patient falls occur at night when activity across the Trust remains high and staffing reduced. Serious incident reports for falls with harm from April 2020 to March 2021 have been reviewed. The following themes and trends were identified from the contributory causes:

- The patient was confused in three of the incidents
- Mental capacity was not assessed in two of the incidents
- The assessment was not completed by a Registered Nurse in two of the incidents
- Staffing shortfalls impacted upon the observation of the patient in two of the incidents

Night shifts predominantly commence at 7pm or 7:30pm for a twelve hour period and at this time flow and activity are still high throughout the Trust. The transfer of patients and movement of staff was a clear feature of ward review discussions as the majority of this took place out of hours. The movement of patients continues to be an issue in the out of hours period.

5.3.5 1:1 Supportive Care

A supportive care assessment tool (AFLOAT) has been introduced to identify the appropriate level of care and observation needed to maintain patient safety and to ensure resources are appropriately allocated through a robust assessment and escalation process. Many ward managers reported a higher number of patients with cognitive impairment, confused/agitated/aggressive patients, and patients assessed as a high risk of falls resulting in harm. This is reflected in the SNCT results with high levels of level 1b patients and is reflective of the increase in supportive care HCA bank shift requests as there is no allowance in establishments to support this additional care when needed. Wards C2, 16, B6, 29, B7, Stroke Unit DPoW, Amethyst and A1 have all seen a high level of needs for supportive care, and at the time of the review C1, B2 and ward 28 reported a considerable increase in the need for supportive care shifts (see below).

Figure 8

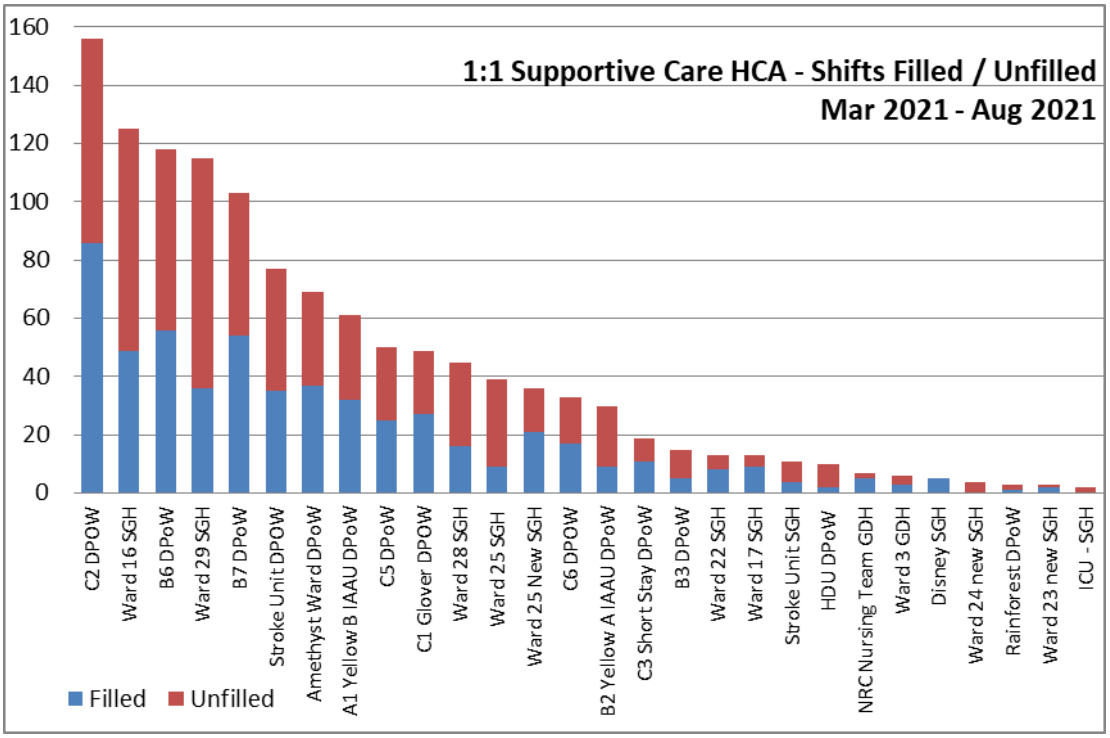


Table 3 1:1 Supportive Care – shifts filled/ unfilled Mar 2021-Aug 2021

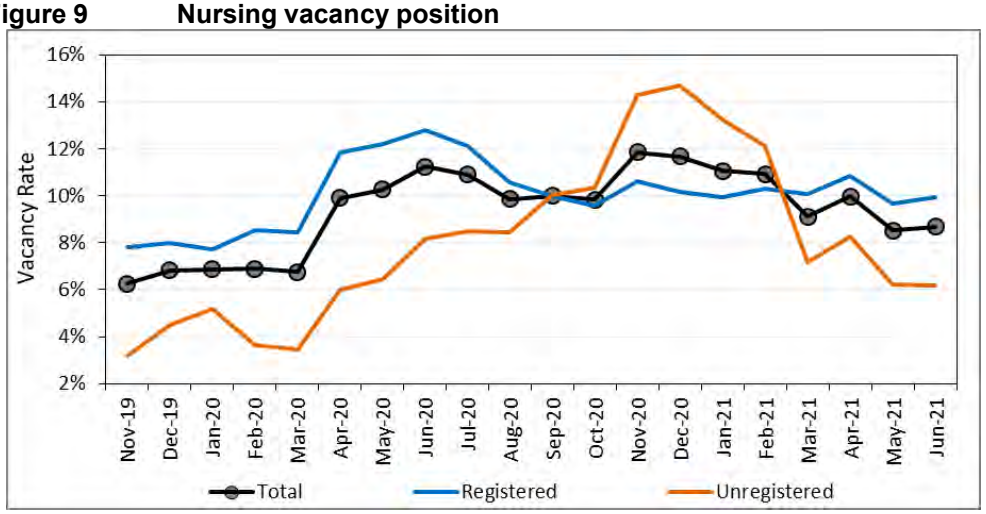
Ward	Filled	Unfilled	Grand Total	% Filled
C2 DPOW	86	70	156	55%
Ward 16 SGH	49	76	125	39%
B6 DPoW	56	62	118	47%
Ward 29 SGH	36	79	115	31%
B7 DPoW	54	49	103	52%
Stroke Unit DPOW	35	42	77	45%
Amethyst Ward DPoW	37	32	69	54%
A1 Yellow B IAAU DPoW	32	29	61	52%
C5 DPoW	25	25	50	50%
C1 Glover DPOW	27	22	49	55%
Ward 28 SGH	16	29	45	36%
Ward 25 SGH	9	30	39	23%
Ward 25 New SGH	21	15	36	58%
C6 DPOW	17	16	33	52%
B2 Yellow A IAAU DPoW	9	21	30	30%
C3 Short Stay DPoW	11	8	19	58%
B3 DPoW	5	10	15	33%
Ward 22 SGH	8	5	13	62%
Ward 17 SGH	9	4	13	69%
Stroke Unit SGH	4	7	11	36%
HDU DPoW	2	8	10	20%
NRC Nursing Team GDH	5	2	7	71%
Ward 3 GDH	3	3	6	50%
Disney SGH	5		5	100%
Ward 24 new SGH		4	4	0%
Rainforest DPoW	1	2	3	33%
Ward 23 new SGH	2	1	3	67%
ICU - SGH		2	2	0%
Grand Total	564	653	1217	46%

Consideration needs to be given to how enhanced care can be delivered going forward as ward establishments do not cover this additional demand, and the bank HCA fill rate is an average of 46%. Some Trusts have set up a central supportive care team and this option should be considered along with the alternative of some allowance within budgets as part of headroom review in the future.

5.3.6 Temporary Staffing

Work has recently been undertaken to reduce the number of HCA vacancies however the RN vacancies remain high in the Trust as can be seen below.

Figure 9 Nursing vacancy position



Recent international nurse recruitment is starting to have an impact on the RN vacancy position and the appointment of the newly qualified nurses in the autumn will have a further impact along with ongoing planned international nurse recruitment. A RN vacancy forecast has been developed which takes into account average turnover and planned recruitment, and is currently indicating a 16.99 FTE B5 RN vacancy position by April 2022. Additionally, work is ongoing to attract return to practice nurses.

The graphs below demonstrate that the bank and agency fill rates remain fairly static, even when there is an increase in demand. RN requests increased dramatically in December 2020 and although have subsequently reduced, remain higher than in the first half of 2020. The reasons for the December increase are unclear and may be related to roster planning which will be reviewed through the Safe Staffing and Effective Rostering Group. Sickness has been higher throughout the pandemic due to Covid related illness, shielding and self-isolation which is affecting the availability of staff and continued high demand and spend for temporary staffing.

Figure 10 Temporary staffing RN fill 2020

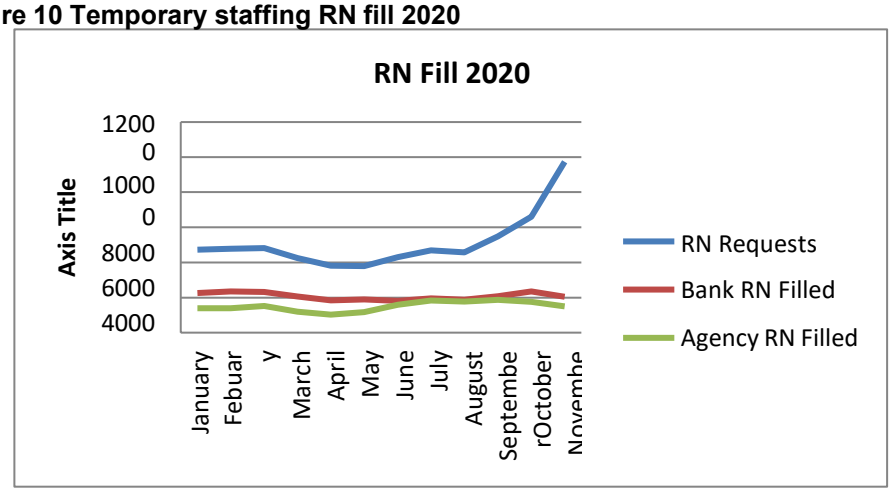


Figure 11 Temporary staffing RN fill 2021

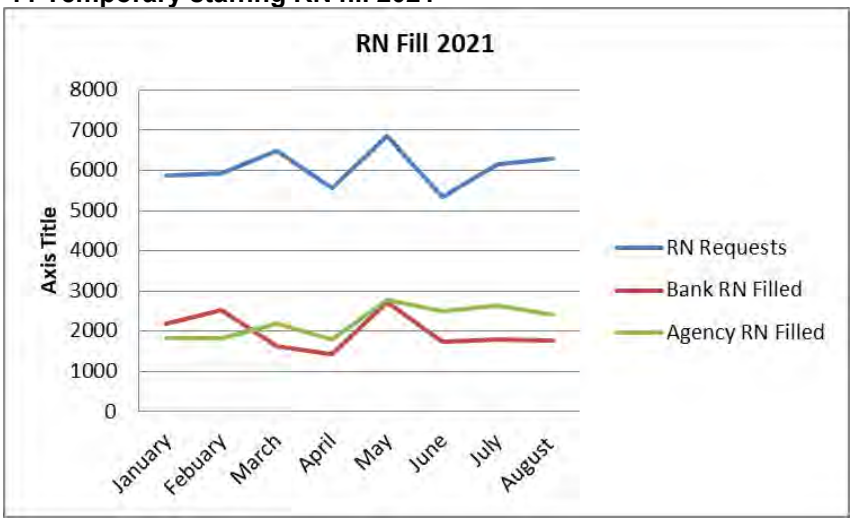
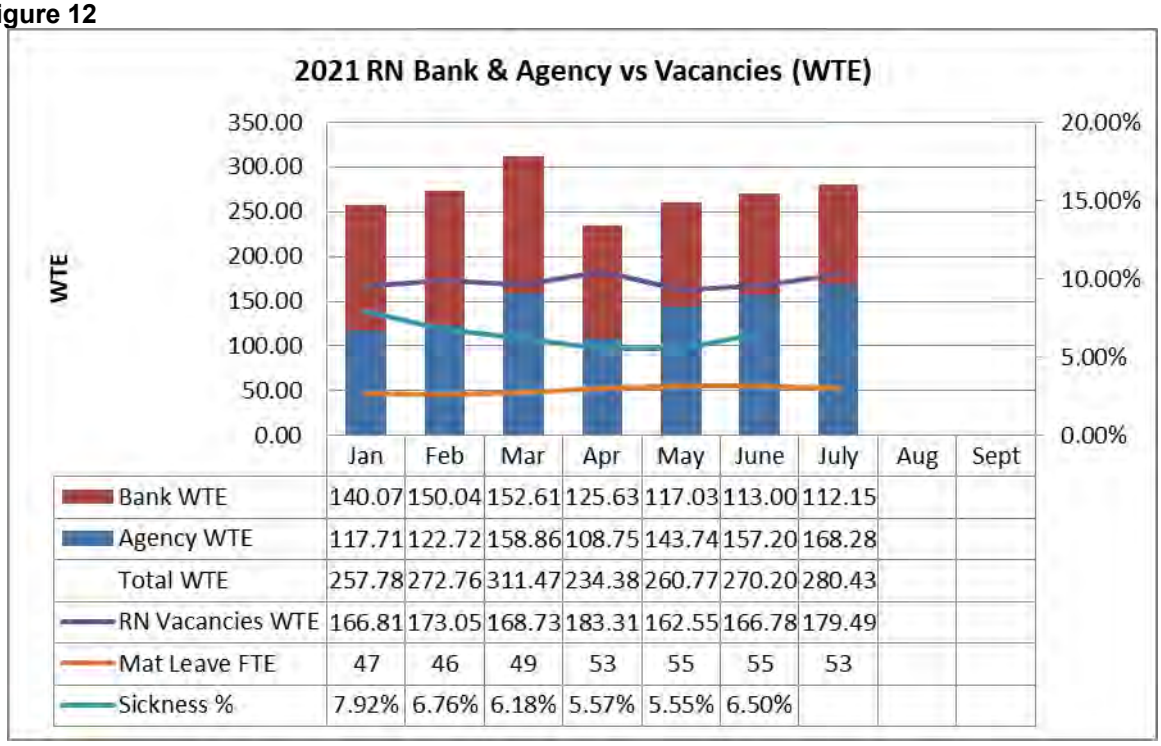


Figure 12 below shows the overall bank and agency usage against RN vacancies and sickness.

Figure 12



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Bank WTE	140.07	150.04	152.61	125.63	117.03	113.00	112.15		
Agency WTE	117.71	122.72	158.86	108.75	143.74	157.20	168.28		
Total WTE	257.78	272.76	311.47	234.38	260.77	270.20	280.43		
RN Vacancies WTE	166.81	173.05	168.73	183.31	162.55	166.78	179.49		
Mat Leave FTE	47	46	49	53	55	55	53		
Sickness %	7.92%	6.76%	6.18%	5.57%	5.55%	6.50%			

Figure 13 Pay Expenditure over the last five financial years

Staff Group (£K)	16/17 Full Year	17/18 Full Year	18/19 Full Year	19/20 Full Year	20/21 Full Year	21/22 Quarter 1
Nursing Staff	**88,896.95**	**92,335.10**	**97,249.04**	**105,657.31**	**116,302.47**	**28,937.71**
Agency	3,357.70	6,281.32	7,558.18	7,389.23	9,076.62	3,089.56
Bank	6,135.65	7,435.83	8,420.99	9,632.28	13,112.24	3,192.50
Substantive	79,403.61	78,617.95	81,269.86	88,635.80	94,113.60	22,655.65

5.3.7 Headroom

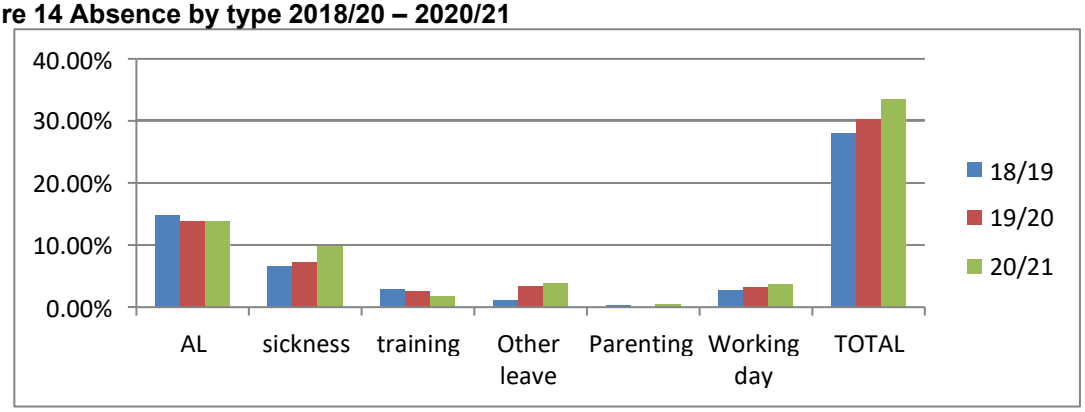
The Auditor General (2002), Hurst (2003), Healthcare Commission (2005) and RCN (2006) all recommend flexible headroom allowances ranging from 22% to 25%. The SNCT tool has 22% time out allowance included in the multipliers and establishment. The Carter review (2016) recommended between 22% - 24%. Headroom is a judgement about allowing clinical staff time away from the clinical area to complete their professional and mandatory training requirements. The electronic rosters are set up to allow a 22% allowance.

A review of headroom has identified that the budgeted uplift headroom is 22.6% as outlined in the table below. However, the sickness and all other leave (maternity, paternity and carer allowance) are not included in the recruitable establishments but provided for in a bank budget as it has previously been deemed unplanned and variable (5.7%). Therefore the actual marginal headroom for annual leave and training is 16.9%.

Component	Number of days allocated per annum	Percentage mark up on net establishment
Annual Leave (AfC average)	31	11.90%
Bank Holidays (in-year)	8	3.10%
Sickness allowance	11	4.20%
Maternity & Other Absence*	4	1.50%
Education and Training requirements	5	1.90%
Total allowance per wte	59	22.60%

Our average actual combined percentage for annual leave and training over the last 3 years has been between 15.61% and 17.85% (see table below). Training has been lower in the last year as much of it was cancelled as we managed the pandemic. This is against the headroom of 16.9%.

Figure 14 Absence by type 2018/20 – 2020/21



Type of Absence	18/19	19/20	20/21
AL	14.7%	13.76%	13.85%
Sickness	6.5%	7.2%	9.8%
Training	2.85%	2.54%	1.76%
Other leave (e.g. carer leave, special leave, time owing)	1.1%	3.3%	3.85%
Parenting (e.g. maternity and parental leave)	0.25%	0.17%	0.5%
Working day (e.g. phased return supernumerary, management time)	2.63%	3.19%	3.63%
TOTAL	**28.03%**	**30.16%**	**33.39%**

Review of the month 4 vacancy report indicates that the bank budget is 4.39% of the budgeted WTE (inc bank) and not the unplanned and variable 5.7% anticipated. Therefore, the nursing budget does not cover the 22.6% headroom.

VACANCY REPORT AS AT 31ST JULY 2021 M04

Vacancies by staff group

Staff Groups	*Budgeted Exc bank WTE	Budgeted Bank WTE	Budgeted Inc bank WTE	Contracted WTE	Vacancies WTE	Vacancy Factor
Registered	1677.51	73.69	1751.20	1498.02	179.49	10.70%
Unregistered	842.12	41.91	884.03	783.82	58.30	6.92%
Total Nursing	**2519.63**	**115.60**	**2635.23**	**2281.84**	**237.79**	**9.44%**

The impact of the budgeting this way is that the wards are only able to recruit up to their funded establishment. In essence, they can only fill 19 out of every 20 posts with the 20th post in a temporary staffing budget. With the bank and agency fill rates being as they are, this exposes the wards to clinical risks and high temporary staffing spend.

The potential advantage of funding this through a bank budget is that it give the Divisions flexibility to bring in bank staff to cover where the sickness occurs, however the disadvantage is that the Trust is not recruiting substantive nursing staff to fill ward establishments, and covering unexpected sickness could be supported by moving substantive staff around with the associated flexibility and benefits to quality and patient safety.

Work has been ongoing to ensure there is improved control over planned leave (annual leave and training, and better allocation of unused hours. This is monitored monthly by the Safe Staffing and Effective Rostering Group which is chaired by the Deputy Chief Nurse.

It is recommended that recruitment takes place up to establishment including the budgeted uplift headroom of 22.6%.

5.3.8 Ward Manager Supervisory Time/ Time to Lead

NLAG ward managers historically had 9.25 hours per week management team. This was increased in 2019 to 15 hours per week and 7.5 hours per week in January, February and August following multiple concerns raised to the Chief Nurse through the establishment reviews.

Although grateful for this additional time, ward managers remain concerned they have insufficient time to effectively complete their role, with many reporting working at home and staying late, unpaid, to complete important parts of their role.

The importance of supervisory time for the ward manager cannot be underestimated. The Francis Report (2013) called for a strengthening of the ward sister's role, recommending that they should operate in a supervisory capacity and should not be office bound. It also advised that a ward leaders role is pivotal in:

- Managing services
- Improving Patient Outcomes
- Effective team working

The Ward Leaders handbook, NHSI 2018, states ‘there is not another clinical role where a single person’s leadership can be felt by both staff and patients’

Effective ward leadership has been recognised as being vital to high-quality patient care and experience. This was also cited in much of the evidence reviewed (Nursing Notes 2019, Nursing Times March 2013, RCN 2016, Regan and Shillitoes 2017).

This is supported in the NHS guidance, ‘How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability’ (2013), which advises that a realistic assessment of the time required by the lead sister / charge nurse or team leader to

assume supervisory status should be undertaken and that many Trusts have supported these staff to be supervisory full time.

One example of a Trust that has taken the approach to have full time supervisory ward managers is Macclesfield District General Hospital. They report this has enabled their ward managers to spend more time overseeing their wards, and since this change the number of patients who received assessments has improved markedly. Falls assessments rose from 75% to 94%, nutrition from 62% 95% and pain assessment from 74% to 91%. This has an impact on patient safety, care planning and outcomes. Strong and clear leadership is key to the delivery of high quality care and to ensuring that staff are well led and motivated.

There is growing evidence that nursing leadership is crucial to patient outcomes and standards at the point of care. Ward Managers need to be given time to lead, they need to have time to develop and support, as well as to manage their staff. Our ward managers have articulated some of the benefits of increasing their supervisory time which are summarised in the table below.

As we have increased our student clinical placements by nearly 100 in the last 2 years, and have an ongoing healthy pipeline of International nurses, the role of the ward manager becomes even more crucial in our trust in helping with supervision, oversight and sign off of competencies.

The Chief Nursing Officer for England from 2021 wants to develop the role of restorative Clinical Supervision through formal channels and the introduction of specialist roles that have had training, we have a number of these roles within our trust already. As part of the Nursing, Midwifery and AHP strategy we are looking to develop a more structured supervision process and the ward managers are a key to this. This is particularly important following the pandemic to help with fatigue and wellbeing, and our leaders need time to work with their teams and supervise the professional standards of the teams they are accountable for.

It is recommended that ward manager supervisory time is increased to 30 hours per week. KPIs would be developed and agreed to include % reduction in sickness, % PADR and mandatory training % reduction in hospital required pressure ulcers, demonstrable improvement in patient experience, sustained achievement of >95% for nursing metrics scores, and sustained nursing staffing to agreed levels and working to keep vacancies at a manageable level. The impact of increasing ward managers time on improving patient care/ staff retention would be evidenced and measured going forward and through the nursing assurance dashboard. Additionally, increased supervisory time would increase flexibility to cover last minute sickness and escalation beds.

‘The role of the ward manager is ideally situated to supervise clinical care, oversee quality and safety standards, co-ordinate patient care and promote leadership and mentoring.’ RCN, 2016.

Table 4 Ward Manager feedback regarding benefits of increased supervisory time

Admin • Timely investigate & completion of datix (6) • Timely completion of PUFFINs (Pressure ulcer investigations) • To complete audits (5) • Answer PALS in designated timeframes(3) • Ability to give complaints the time and consideration they require • E roster submitted in a timely manner (2) • Timely sorting out of student placement hours • Timely completion of PADRs and clinical supervision which will help targets to be achieved (7) • Sickness/performance monitoring (5) • More rapid authorisation of annual leave • Update guidelines and patient information leaflets in a timely manner	**Training** • Improved clinical hours in unit as currently having to use clinical time to catch up in the office • More time to support staff in completing mandatory training to help achieve set targets(5) • More time to supervise staff to ensure Step competencies have been met and signed off • Use my management days to allow junior staff to experience leadership shifts on the ward with the comfort of them knowing that I am with them for support and guidance • More time to develop staff particularly new starters.(4) • Help develop the deputy role (4) • Invest in time with staff to improve retention of staff • Able to free up other staff, link nurses to provide on the ward training • Enabling the development of staff • Allocate some of time to clinical sister (5)
Wellbeing • Reduction in hours owed due to having to stay late to catch up • Sickness review meeting dealt with in a timely manner • Feeling of being overwhelmed would be reduced as so much non clinical has now been put to the ward managers i.e. recruitment, having to complete establishment control and inputting trac, updating risk register, updating ESR etc. • More time to have wellness conversations with staff • Increased senior visibility on ward to drive standards(2) • Would also reduce my own personal stress as I am constantly asked to sort out problems whilst working clinically which compromises safety (2) • Reduce the risk of me making a mistake as during my clinical work I am continually pulled away from my patient to deal with staffing issues/complaints. This is on top of taking a fair clinical workload alongside of my colleagues • Negate the 'unpaid working from home' I frequently perform (approx. 4-7 hours per week on average) (2) • Be proactive rather than reactive to situations such as issues with	**Organisation** • The unit would run even more smoothly and organised! • Attend meetings (3) • More time to make sure the ward environment was clean, tidy and welcoming • Fully devote my time to maintaining a safe environment by addressing any concerns in a more timely manner • Ability to actually move the ward forward with positive changes • Improve processes and procedures • Spend time with service users to see where they feel that we could improve • Be seen as a manager whom is leading the team rather than being a part of the team • More visibility for both patients and relatives, resolving any issues promptly • Gives the ability when other avenues have been exhausted for the manager to step in to support the department by working clinically, thus reduction in and cancellation of appointments and care • If more time available managers are able to demonstrate a true

staffing or a staff member's practice/behaviour • Have one to one meetings with staff for individual support (2) • Support the staff and ward more effectively • Reduced stress and anxiety of managers as more time available to complete managerial responsibilities thus possible reduction in sickness/absence • I do not feel any extra office time is needed beyond the 15hrs I get but if I were in a supervisory role for the other 15 hrs I could support the team in very difficult times, pressure wise, but also I have a lot of fairly new staff, overseas staff that need extra support which is difficult when we are running daily on reduced levels	commitment to being involved in QI projects which will support the safety and improvement of the division. This may also over time demonstrate a cost saving capability (2) • Sometimes it can be hard to make changes on the ward due to lack of time, for example, rearranging the store room to be more user friendly or spending time working with staff on a 1:1 basis so you can make sure they are working at the expected standard

5.3.9 Family Liaison Advisor roles

Family Liaison Advisor roles help provide effective communication between families, patients and ward areas during continued visiting restrictions and staffing challenges. Through proactive communication to families, a reduction in concerns regarding poor communication and related calls to the Patient Contact Helpline has been seen, with associated positive feedback and improved Trust reputation.

A key element of this role is to enhance the quality of patient care, impacted on by the challenges to the nursing workforce across the Trust, through releasing valuable nursing time. This can be through delivery of emotional and mental wellbeing support, in the form of time spent talking to patients, positive interactions through meaningful activities, and early escalation to nursing staff of any issues. With the high paced activity that occurs in ward areas, the role may be central to early identification of changes in patients' condition and can be a consistent presence within ward areas staffed with high ratios of bank and agency staff.

The role has yet to be fully evaluated, however the continued workforce challenges mean that the Family Liaison Assistant role would influence patient safety and reduce patient harms through increased bedside interactions and time spent with vulnerable patients who are often those most at risk.

5.3.10 NICU

A review was carried out by the British Association of Perinatal Medicine (BAPM) in May 2020 reviewing 2019/20 data using the 2011 (latest) BAPM categories of care methodology.

Table 5 General Definitions (BAPM 2011)

Level of Care	*General Principle*	*Patient to Staff Ratio*
Intensive Care (ICU):	*This is care provided for babies who are the most unwell or unstable and have the greatest needs in relation to staff skills and staff to patient ratios*	*1:1*
High Dependency Care (HDU)	*This is care provided for babies who require highly skilled staff but where the ratio of nurse to patient ratio is less than ICU*	*1:2*
Special Care (SCBU)	*Special care is provided for babies who require additional care delivered by the neonatal service but do not require either intensive care or high dependency care*	*1:4*
Transitional Care (TC)	*Transitional care can be delivered in two service models, within a dedicated transitional care ward or within a post-natal ward. In either case the mother must be resident with her baby and providing care. Care that is needed normally is provided by the mother with support from a midwife / healthcare professional who needs no specialist neonatal training*	*Usually 1:4*

5.3.10.1 NICU DPOW

NICU at DPOW has 8 x level 1 cots, 4 x level 2 cots and 4 transitional care cots.

The BAPM review 2019/20 showed NICU was under established for registered nurses (7.29 FTE), but over established for HCAs (6.9 FTE) (Table 6).

Table 6 Diana Princess of Wales NICU

ANNUAL CARE LEVEL DAYS	BAPM 2O11	HRG 2016 Days - Split	
NICU	242	HRG 1	242
HDU	758	HRG 2	758(1000)
SCBU	2142	HRG 3	1615
		HRG 4	420
		HRG 5	107

DPOW CURRENT UNIT STAFFING: DIRECT CARE ONLY

		WTE BUDGET	WTE IN POST	BAPM 2011	Increase/ Decrease (WRT Budget)
BAND 7		0.6	0.6	1.56	0.96
BAND 6		9.58	9.52	10.49	0.91
BAND 5 QIS		3.58	3.58	9.33	5.75
BAND 5		6.75	6.77	6.42	-0.33
BAND 4		0	0	3.43	3.43
BAND 3		10.33	8.84	0.00	-10.33
TOTAL NUMBER OF NURSES		30.84	29.31	31.23	0.39
Total HCA		10.33	8.84	3.43	-6.9
Total Registered Nurses		20.51	20.47	27.8	7.29

OCCUPANCY AGAINST DECLARED COTS 2019/20

	NICU	HDU	SCBU	TOTAL
BAPM 2011	22.10%	207.67%	73.36%	71.74%

This review included the transitional care cots. In the NLaG model of care the transitional cots are covered by NICU HCA staff with support from a NICU RN, however not all of the cots are located on the neonatal unit and the tool does not account for location of care.

BAPM standards say the HCAs should be Band 4. Within DPOW they are band 3.

The Neonatal Nursing Workforce Tool was used by the network to review activity and staffing in 2020. Staffing requirements are based on activity and BAPM nurse to baby ratios, for nurses providing direct care only, and excluding additional roles e.g. management and education. Transitional care activity is included with HRG 3 (special care) activity (Table 7).

Table 7 DPOW Neonatal Nursing Workforce 2020 (neonatal workforce approved tool)

Neonatal Nursing Workforce Tool (2020): Grimsby

Input unit details	
Trust	NLAG NHSFT
Unit	Grimsby
Designation	LNU
Completed by	
Date completed	
Activity period	

Input activity (HRG 2016)	Activity	Declared cots
HRG 1 (IC)	299	3
HRG 2 (HD)	574	1
HRG 3 (SC)	2,355	8
Total	**3,228**	**12**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY	Budget	In post
Total QIS	16.74	16.60
Total Non QIS	4.17	4.94
Total Non Reg	10.33	9.34
Total	**31.24**	**30.88**

Activity (HRG 2016)	Activity	For calculations: 80% of daily activity	For calculations: WTE (6.07 / BAPM)	Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
HRG 1	299	*1.0*	*6.07*	3	27.31%	2	1
HRG 2	574	*2.0*	*3.04*	1	157.26%	1	0
HRG 3	2,355	*8.1*	*1.52*	8	80.65%	9	-1
Total	**3,228**			**12**	**73.70%**	**12**	**0**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY	Current position: Budget	Current position: In post	Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
NB total nurse staffing required to staff declared cots = 39.46, of which 27.62 (70%) should be QIS					
Total nursing staff	31.24	30.88	30.49	0.75	0.39
Total reg nurses	20.91	21.54	26.82	-5.91	-5.28
Total QIS	16.74	16.60	18.77	-2.03	-2.17
Total non-QIS	4.17	4.94	8.05	-3.88	-3.11
Total non-reg	10.33	9.34	3.67	6.66	5.67
Reg nurses as % nursing staff	66.9%	69.8%	88.0%		
QIS as % reg nurses	80.1%	77.1%	70.0%		

This again shows a shortfall of RNs (5.91 FTE) and over establishment of HCAs (6.66 FTE).

The neonatal commissioning reports in tables 8 and 9 below (data taken from Badgernet [Neonatal activity/acuity database]) shows a reduction in activity for 2020/21 (total 3130 days) when compared to 2019/20 (total 3941 days) which may be a natural fluctuation or an impact of the pandemic and will be monitored going forward. This data included transitional care, which for April 2020 to March 2021 shows a total of 799 transitional care days which usually require the same staffing ratio as a special care cot however can be covered by a HCA, usually band 4.

Table 8 Neonatal Commissioning Report 2019/20

Neonatal Commissioning Report - HRG Care Days by Location

Set Parameters

Selected Parameters:

Care Locations
Grimsby, Diana Princess of Wales
Admit Date From
01 Apr 19 00:00
Admit Date To
31 Mar 20 23:59

Neonatal Commissioning Report - HRG days by location

CareLocation	HRG 1	HRG 2	HRG 3	HRG 4	HRG 5	Unknown	Total
nnu	411	610	1731	377	3	9	3141
obs	1	0	0	1	0	0	2
tc	1	5	12	771	5	4	798
Total	413	615	1743	1149	8	13	3941

Neonatal Commissioning Report - HRG care days by Unit

CareLocation	HRG 1	HRG 2	HRG 3	HRG 4	HRG 5	Unknown
Grimsby, Diana Princess of Wales	413	615	1743	1149	8	13
Total	413	615	1743	1149	8	13

Table 9 Neonatal Commissioning Report 2020/21

Neonatal Commissioning Report - HRG (2016) Care Days by Location

Set Parameters

Selected Parameters:

Care Locations
Grimsby, Diana Princess of Wales
Admit Date From
01 Apr 20 00:00
Admit Date To
31 Mar 21 23:59

Neonatal Commissioning Report - HRG (2016) days by location

CareLocation	HRG 1	HRG 2	HRG 3	HRG 4	HRG 5	Not a period of neonatal care	Unknown	Total
nnu	178	506	1494	93	57	0	0	2328
obs	0	0	1	2	0	0	0	3
tc	0	1	4	707	3	84	0	799
Total	178	507	1499	802	60	84	0	3130

Neonatal Commissioning Report - HRG (2016) care days by Unit

CareLocation	HRG 1	HRG 2	HRG 3	HRG 4	HRG 5	Not a period of neonatal care	Unknown	Total
Grimsby, Diana Princess of Wales	178	507	1499	802	60	84	0	3130
Total	178	507	1499	802	60	84	0	3130

Possible data recording errors

HRG 1 XA01Z Neonatal Critical Care, Intensive Care
HRG 2 XA02Z Neonatal Critical Care, High Dependency Care
HRG 3 XA03Z Neonatal Critical Care, Special Care, Carer not resident alongside baby
HRG 4 XA04Z Neonatal Critical Care , Special Care, Carer Resident at cot side and caring for baby
HRG 5 XA05Z Neonatal Critical Care, Normal Care (i.e. Phototherapy in NICU)

A drop in births were seen in 2020 and early 2021, and although full year effect predictions suggest that this will be case in 2020/21, neonatal activity has been high over recent weeks as we see pregnant women being admitted with complications of Covid.

Table 10 Births 2019/20 – 2021/22

Sum of Number of Births	1 Year 1 Year		25 weeks	
Row Labels	2019/20	2020/21	2021/22	20/21 FYE
Goole and District Hospital	9	9	7	15
Grimsby Maternity Hospital	2457	2204	1067	2219
Scunthorpe General Hospital	1626	1534	731	1520
Grand Total	**4092**	**3747**	**1805**	3754

DPOW Findings:

The current cot configuration is flexible, especially between ICU and HDU cots. The report from the neonatal nurse workforce tool calculates the nursing requirements directly from the activity undertaken from each financial year, therefore staffing has to be balanced between the commissioned cot base and the actual acuity. All of the above is based on 80% occupancy and occupancy is generally about 75%.

The neonatal toolkit recommends the unit manager is supernumerary and that each transitional care unit requires a specific RN lead. The current B7 unit manager has only 15 hours supervisory time per week. This post should be supernumerary to cover the neonatal unit and transitional care lead roles.

On each shift the nurse in charge should be supernumerary as is required to lead and coordinate the shift and oversee the HCA working in transitional care.

Ideally the transitional care service will be delivered by a band 4, however a band 3 with suitable training and competencies delivers this service. The practitioner works under the supervision from the nurse in charge on the neonatal unit with overall oversight from the transitional care lead. Consideration should be given to upskilling the B3 HCAs to B4.

There is no clinical educator support in the unit.

The unit currently runs at approximately 75% capacity which would require 5 RNs (2 x band 6 and 3 x Band 5) to mitigate immediate risks.

5.3.10.2 NICU SGH

NICU at SGH has 6 x level 1 cots, 4 x level 2 cots and 4 x transitional care cots.

The BAPM review 2019/20 showed NICU SGH was under established for registered nurses (9.16 FTE), but over established for HCAs (7.01 FTE) (Table 10).

Table 11 Scunthorpe General Hospital NICU

ANNUAL CARE LEVEL DAYS	BAPM 2O11	HRG 2016 Days - Split	
NICU	225	HRG 1	225
HDU	511	HRG 2	511(736)
SCBU	2073	HRG 3	1592
		HRG 4	367
		HRG 5	114

CURRENT UNIT STAFFING: DIRECT CARE ONLY					
		WTE BUDGET	WTE IN POST	BAPM 2011	Increase/ Decrease (WRT Budget)
BAND 7		0.6	0.6	1.34	0.74
BAND 6		9.58	9.49	9.69	0.11
BAND 5 QIS		1.56	1.56	7.77	6.21
BAND 5		3.61	3.86	5.70	2.09
BAND 4		0	0	3.32	3.32
BAND 3		10.33	10.05	0.00	-10.33
TOTAL NUMBER OF NURSES		25.68	25.56	27.82	2.14
Total HCA		10.33	10.05	3.32	-7.01
Total Registered Nurse		15.35	15.51	24.51	9.16

OCCUPANCY AGAINST DECLARED COTS 2019/20

	NICU	HDU	SCBU	TOTAL
BAPM 2011	30.82%	70.00%	94.66%	76.96%

This review included the transitional care cots. As previously discussed, in the NLaG model of care the transitional cots are covered by NICU HCA staff with support from a NICU RN, however not all of the cots are located on the neonatal unit and the tool does not account for location of care.

The Neonatal Nursing Workforce Tool was used by the network to review activity and staffing in 2020. Staffing requirements are based on activity and BAPM nurse to baby ratios, for nurses providing direct care only, and excluding additional roles e.g. management and education. Transitional care staffing and activity is included with HRG3 (special care) activity (Table 11).

Table 12 SGH Neonatal Nursing Workforce 2020 (neonatal workforce approved tool)

Neonatal Nursing Workforce Tool (2020): Scunthorpe

Input unit details	
Trust	NLAG NHS FT
Unit	Scunthorpe
Designation	LNU
Completed by	
Date completed	
Activity period	

Input activity (HRG 2016)		
	Activity	Declared cots
HRG 1 (IC)	203	2
HRG 2 (HD)	407	2
HRG 3 (SC)	1,997	6
Total	**2,607**	**10**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	13.08	13.07
Total Non QIS	2.67	2.92
Total Non Reg	10.33	10.27
Total	**26.08**	**26.26**

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	203	*0.7*	*6.07*	2	27.81%	1	1
HRG 2	407	*1.4*	*3.04*	2	55.75%	2	0
HRG 3	1,997	*6.8*	*1.52*	6	91.19%	6	0
Total	**2,607**			**10**	**71.42%**	**9**	**1**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 33.39, of which 23.37 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	26.08	26.26	24.90	1.18	1.36
Total reg nurses	15.75	15.99	21.78	-6.03	-5.79
Total QIS	13.08	13.07	15.25	-2.17	-2.18
Total non-QIS	2.67	2.92	6.54	-3.87	-3.62
Total non-reg	10.33	10.27	3.11	7.22	7.16
Reg nurses as % nursing staff	60.4%	60.9%	87.5%		
QIS as % reg nurses	83.0%	81.7%	70.0%		

This again shows a shortfall of RNs of 6.03 FTE and over establishment of HCAs of 7.22 FTE.

The neonatal commissioning reports (data taken from Badgernet) in tables 13 and 114 below show a reduction in activity for 2020/21 (total 3092 days) when compared to 2019/20 (total 3486 days) which may be a natural fluctuation and will be monitored going forward. This data included transitional care which for April 2020 to March 2021 shows a total of 544 transitional care days which usually require the same staffing ratio as a SCBU cot however can be covered by a HCA, usually band 4.

Table 13 Neonatal Commissioning Report 2019/20

Neonatal Commissioning Report - HRG Care Days by Location

Set Parameters

Selected Parameters:

Care Locations

Scunthorpe General Hospital

Admit Date From

01 Apr 19 00:00

Admit Date To

31 Mar 20 23:59

Neonatal Commissioning Report - HRG days by location

CareLocation	HRG 1	HRG 2	HRG 3	HRG 4	HRG 5	Unknown	Total
nnu	324	416	1694	372	4	1	2811
obs	0	0	0	1	0	0	1
pnw	0	0	0	1	0	0	1
tc	1	1	6	665	0	0	673
Total	325	417	1700	1039	4	1	3486

Neonatal Commissioning Report - HRG care days by Unit

CareLocation	HRG 1	HRG 2	HRG 3	HRG 4	HRG 5	Unknown
Scunthorpe General Hospital	325	417	1700	1039	4	1
Total	325	417	1700	1039	4	1

Table 14 Neonatal Commissioning Report 2019/20

Neonatal Commissioning Report - HRG (2016) Care Days by Location

Set Parameters

Selected Parameters:

Care Locations

Scunthorpe General Hospital

Admit Date From

01 Apr 20 00:00

Admit Date To

31 Mar 21 23:59

Neonatal Commissioning Report - HRG (2016) days by location

CareLocation	HRG 1	HRG 2	HRG 3	HRG 4	HRG 5	Not a period of neonatal care	Unknown	Total
nnu	240	399	1493	321	95	0	0	2548
tc	0	0	9	483	9	43	0	544
Total	240	399	1502	804	104	43	0	3092

Neonatal Commissioning Report - HRG (2016) care days by Unit

CareLocation	HRG 1	HRG 2	HRG 3	HRG 4	HRG 5	Not a period of neonatal care	Unknown	Total
Scunthorpe General Hospital	240	399	1502	804	104	43	0	3092
Total	240	399	1502	804	104	43	0	3092

Possible data recording errors

SGH Findings:

Again, the cot configuration is flexible, especially between ICU and HDU cots.

The neonatal toolkit recommends the unit manager is supernumerary and that each transitional care unit requires a specific lead. The current B7 unit manager has only 15 hours supervisory time per week. This post should be supernumerary to cover the neonatal unit and transitional care lead roles.

On each shift the nurse in charge should be supernumerary as is required to lead the shift and oversee the HCA working in transitional care.

Again, consideration should be given to upskilling the B3 HCAs to B4.

5.3.10.3 NICU overall recommendations and further considerations

- The Humber Acute Services Review is ongoing and the impact on maternity, neonatal and paediatric services is unknown at this time therefore consideration should be given to employing new starters on a Trust wide contract. This would also provide service flexibility in the future.
- The HCA role and potential for the Nursing Associate role should be considered on both sites. Consideration should not be given to reducing the HCA establishment until the RN establishment is increased and B3 role reviewed.
- The BAPM review May 2020 recommended a significant change in the ward nursing establishments – with an uplift of 7.29 RN (DPoW) and 9.15 RN (SGH) with the majority requiring to be Qualified in Service.
- At the time of writing this paper it has not been possible to triangulate the data over time to understand the changes in activity levels related to the fluctuation in birth rate during 2020/21.

5.3.11 Themes from inpatient ward establishment reviews

- Patient acuity has increased since the last review.
- Staff working in full PPE require additional breaks and donning and doffing time should be considered.
- During the last review it was identified that a change of shift patterns was required across the Trust to backfill towards the end of the day, therefore a need for a twilight shift was highlighted as heightened activity was still taking place on the wards after staffing had reduced for night shifts. Although this has been successful on some wards, on others it was either unfilled or moved to cover shortfalls in the afternoon or night shifts thus continuing to leave a shortfall when activity and patient movement remains high.
- The staffing levels on nights do not support the high activity and patient movement that continues over the evening and into the night across the acute sites.
- The budgeted uplift does not cover the 22.6% headroom as the sickness and all other leave (maternity, paternity and carer allowance) are not included in the recruitable establishments.
- Only 1.9% is allocated in the uplifts for training and following a review of all the face to face mandatory requirements this means that the uplift is not sufficient to cover any additional training and new professional requirements about access to continuous professional development (CPD), which is funded and needs to be evidenced.
- The process for reviewing and signing off rosters well in advance is not yet fully embedded and will be monitored through the Safe Staffing and Effective Rostering Group.
- No additional funding has been included for the 1 to 1 supportive care requirements.
- Number of medical outliers and escalation beds not within divisional budgets.
- Movement of staff, particularly out of hours, remains an issue and is impacting on morale.
- There are risks in relation to RN recruitment that is a national issue, however this should not detract from the RN establishment required.
- Skill mix not meeting national guidance.
- Family Liaison Assistant role has been received very positively and further work could be undertaken to quantify nursing time realised to care.
- High dependency areas would benefit from a supernumerary shift lead/ coordinator and this would have the added benefit of being able to provide flexibility to support the CCOT and NIV patients on the wards due to Covid.
- Two days of supervisory time for the ward managers is insufficient.

5.3.12 Recommendations

1. Review how headroom is being set based on workforce profile and guidance and then as annual review, recognising that some areas e.g. maternity, paediatrics, NICU have high levels of mandatory training requirements.
2. To consider the inclusion of a supportive observation in the headroom or how this can be funded.
3. Substantive recruitment to maternity leave.
4. Stabilisation of ward and bed base to support further data analysis and assurance and review plans for staffing and funding escalation beds.
5. Consider review of HSA support and supervision to ensure consistency and standards.
6. Continue to work on length of stay of our patients and discharge planning, looking more to develop nurse led discharge and protocols.
7. Uplift the Ward Managers time to lead to 30 hours per week.
8. Continue to embed use of Safecare Live to support safe deployment of staff.
9. Continue to monitor E-rostering levels of attainment against standards through the Safe Staffing and Effective Rostering Group.
10. Collate and review SNCT data every 6 months and present mid-year review to the Board.
11. Align the rosters, budgets and establishments with a 'sense check' at each ward review.

5.3.13 Ward staffing recommendations (Appendix 5)

A number of immediate safe staffing and patient safety risks were identified during the reviews and the Chief Nurse advised immediate actions to mitigate the risks. These were:

- **B7 - swap the Twilight shift to a night shift RN and add a RN long day.**
  This area is very low on CHPPD, has a high acuity due to being medical ward and staffed for surgery and benchmarks nationally against an elderly medical ward.
- **NICU DPOW - increase the establishments to 5 RNs 24/7.**
  Concerned about the lack of a co-ordinator and alongside the other critical care units in the Trust the band 7 is not supernumerary.
- **Stroke SGH - increase stroke responder service to include a HCA between the hours of 10-10.** Significant safety concern within stroke services as they are unable to care for patients and manage the pathways.
- **A1 - increase x1 HCA Night shift**.
  Acuity of patients, movement of patients and ward layout are a risk.
- **C5 – change RN twilight to night shift.**
  High number of level 1b patients and level 2 patients being nursed in cubicles due to Covid.
- **C2 – increase x1 HCA on late, change RN twilight to night and increase x1 HCA on nights.**
  High acuity, patients requiring 1:1 supportive care, ward layout poor.

It should be noted that actual costs associated with the immediate staffing risks will be higher as RN gaps will be filled with temporary staff whilst appointments are made.

In addition, the following recommendations are made:

- C5 - Increase x1 RN on late, x1 HCA early, x2 HCA late and x1 HCA nights
- C2 - Increase x1 RN on late
- C3 - Increase x1 HCA 24/7, increase x1 RN shift coordinator 24/7 ***(IAAU model escalation bed cost)***
- Amethyst – increase HCA by 2 hours per day, swap twilight RN to night
- A1 – increase x1 RN night, 1 HCA long day,
- 16 – Increase x1 RN long day, swap twilight RN to night, increase x1 HCA night
- 17 – fund 5th RN on night (CQC recommendation)

- 22 – Fund 3rd HCA on night, increase x1 RN long day, swap twilight RN to night
- 23 – increase x1 RN or NA on night
- 25 – increase 1 HCA on night
- IAAU – establish for the 12 escalation beds to support current activity ***(IAAU model escalation bed cost)***
- Stroke Unit SGH – uplift B5 to Clinical Sister in line with other wards
- B3 – swap RN twilight to night, increase x1 HCA long day for HOBS
- B6 – increase x1 RN long day, switch twilight RN to night, increase x1 HCA on night
- ICU DPOW – increase x1 HCA 24/7 whilst managing Covid ***(Covid cost)***
- HDU – increase x1 RN long day, increase x1 HCA night
- 29 – increase x1 HCA 24/7
- 28 – increase x1 RN long day, remove x1 HCA long day
- ICU SGH – increase HCA from early to long day
- NICU DPOW – ward manager supernumerary 5 days
  Phase 2 - supernumerary B6 shift lead 24/7, B6 Clinical Educator post for the Trust
- Rainforest and Disney – increase x1 RN 24/7 over winter ***(Potential for winter funding)***
- NICU SGH – supernumerary shift lead 24/7, ward manager supernumerary 5 days
  Phase 2 - supernumerary B6 shift lead 24/7
- NRC – increase x1 HCA 24/7

Additionally it is recommended that the ward manager time to lead is increased to 30 hours per week.

Costs for in-patient ward increases from this review based on WTE:

Ward requirements excluding escalation beds = **41.41wte band 5 RN + 44.60wte B2 HCSW** (*inclusive of 22.6% uplift*) + **uplift 1 x B5 to B6**

Bases on Point 18 of the Band 5 Scale is £27.78k plus on costs for NI and Pension makes it £34.3k basic cost to the Trust. Then weekend and night enhancements is an average 18% so total cost £40.7k cost for 41.41 RNs is **£1,685,387 + uplift of B5 to B6 x1**

Point 5 of the Band 2 Scale is £19.92k plus on costs for NI and Pension makes it £24.2k basic cost to the Trust. Then weekend and night enhancements is an average 18% so total cost £28.8k cost for 44.60 HCA is **£1,284,480**

Ward total = £2,969,867

Ward Manager time to lead = £550.5k for Band 5 RN backfill

5.4 Emergency Departments

In September 2020 the Emergency Care Improvement Support Team (ECIST) were invited into NLAG in response to concerns regarding deterioration in the Emergency Care access standards, particularly with reference to the effectiveness of the current streaming process and increasing ambulance handover times; these issues had already been identified on the Emergency Care Centre/Divisional risk register. Working closely with the ECC matrons it was quickly established that there were fundamental gaps in relation to education, training and workforce which, if not addressed, will continue to prevent any further improvements and advancement in the services such as streaming services within the ECCs. This gap has been highlighted previously by the Care Quality Commission (CQC) during the 2018 and then further 2019 inspection which resulted in the ECCs at both sites being rated as 'requires improvement'. The report aimed to provide a thorough, evidence based and robust strategy to deliver improvements in education, competencies, and professional development, coupled with matching staffing capacity to demand.

For the capacity and demand work, attendance data (taken from the 80th percentile) was analysed and compared to the current staffing to determine how workload can be best matched from the current establishment and what will be required from the organisation to ensure this alignment can be achieved. A mismatch in staffing capacity versus demand particularly during the busiest part of the day, 12:00 – 20:00/22:00 was found in both departments. ECIST advised that work is needed to review the current staffing model in matching capacity to demand, require a formal establishment review.

Furthermore, the team has extensively reviewed the training and development required for all registered staff, demonstrating a significant gap in education and competencies against national requirements for emergency nurses, and will require an initial investment then maintenance funding to maintain a steady state. These findings include: the need to invest in a clinical educator for each site as a core factor in the success of the career development plans, recruitment and retention of the emergency nursing workforce. This paper demonstrated that although investment is required in educational provision, this is not extensively above the costs already being incurred through the above establishment workforce currently in place and, demonstrates that the required skills and competency can be achieved within the current study leave provision.

Key recommendations outlined in the paper were to:

- Implement the emergency nursing career development pathway
- Appoint a Band 7 Clinical Educator for both departments to lead, in conjunction with the Matrons, in developing and delivering the educational career pathway
- Secure investment to deliver the emergency nursing career development pathway to bridge the initial gap and maintain a steady state for the next 5 years
- Review current staffing model in terms of matching capacity to demand using detail provided which may require an establishment review
- Introduce tests of change in relation to matching the staffing profile across 24 hours in both departments with objective and subjective outcome measures

An SNCT tool has been developed for EDs and is expected to be published in the autumn therefore a desktop review was undertaken which reviewed ECIS recommendations, demand and nursing metrics. A review using the ED SNCT will be undertaken once published and it should be noted that the impact of the new builds on staffing requirements has yet to be determined.

Themes identified included:

- High number of vacancies and low morale, particularly at SGH
- Low mandatory training and PADR compliance
- High sickness levels
- No flexibility to e.g. extend streaming capacity when department under pressure
- Higher number of PALS in both departments

- Increased demand for ED services

ED staffing recommendations:

- DPOW
    - Additional B6 24/7
    - Additional B5 12.00-24.00 7 days
    - Establish ENPs to 12 hours (increase of 1 hour per shift) to match SGH
    - WSW B2 7.5 hours per day for 7 days
    - Fund B7 CE post substantively
    - Increase B2 24/7
    - **Phase 2 -** Consider 10% increase in establishment to support winter and increased resus & department activity
- SGH
    - Increase B5 RN 10-10
    - Increase B6 24/7
    - Increase HCA on N (used since 2018)
    - Fund B7 CE substantively
    - **Phase 2 -** Consider 10% increase in establishment to support winter and increased resus & department activity

It is recommended that requirements are reviewed once the ED SNCT tool is available to the Trust and the new ED department footprints can be walked.

5.5 Midwifery Establishment Review

The Trust has a duty to ensure that Midwifery staffing levels are adequate and that women are cared for safely by appropriately qualified and experienced staff. This is incorporated within the NHS Constitution (2013) and the Health and Social Care Act (2012). NICE (2015) states of the Trust Board that it 'should ensure that the budget for maternity services covers the required midwifery staffing establishment for all settings'**.**

In addition, within Safety Action 5 of the Clinical Negligence Scheme for Trusts (Maternity incentive scheme, NHS Resolution 2021) there is a requirement for Trusts to conduct a systematic, evidence-based process to calculate midwifery staffing establishments and submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year.

A full establishment review using BirthRate+ data was conducted in November 2019 following concerns being raised about a gap between establishments and BirthRate+ calculations. Staffing shortfalls were identified and the recommendations fully funded.

A further review using BirthRate+ has been procured however will be undertaken Q2/3 2021 due to availability of the national team and internal resources to collate the large data pack, therefore a review of workforce, activity and patient safety data was undertaken by the Chief Nurse in March 2021 for the maternity wards, delivery suites and community services.

The paper in appendix 9 provides the Board with the full report of the safe staffing review of maternity staffing in line with the above guidance and requirements.

The following recommendations were made:

Clinical area	Recommendations
Antenatal SGH	Increase 1 WTE band 7 diabetic specialist midwife – cross-site post Cost £51.1k (secured via Ockenden funding)
Central Delivery Suite SGH	No change
Ward 26	No change
Community Midwifery SGH	Increase MSW x 1 at a weekend 09.00-17.00 hours – 0.48 WTE **Cost £13.2k**
Antenatal DPOW	No change (See above re 1 wte Band 7 Diabetic Specialist Midwife – cross-site post)
Blueberry/Holly DPOW	Increase RM x 1 weekend Saturday and Sunday – 0.79 WTE Cost 41.1k (secured via Ockenden funding)
Jasmine/Honeysuckle	No change
Community Midwifery DPOW	No change

All recommendations for registered midwives were funded through the Ockenden funding. The additional Midwifery Support Worker for the community midwifery team at SGH is outstanding at a **cost of £13.2k**. Additionally, the outcome of the BirthRate Plus review is awaited.

5.6 Community Nurse Staffing Establishment Review

Processes for determining safe caseload staffing in the community are complex and a robust dependency classification system is not currently available for district nursing services. However, a community SNCT tool is being developed nationally and our community nursing teams are participating in this development work. Patients cared for by the community nursing services often have complex needs with the care environment adding to the complexity. The Covid pandemic has added additional complexities for our community teams with activity increasing, particularly unplanned activity, following the initial decrease when patients did not want staff to enter their home. Additionally there is currently no increased capacity for the additional time taken to don and doff PPE.

Funding was secured by the Chief Nurse in the Trust establishment review undertaken in 2019 to purchase an intelligent scheduling system to support the allocation of visits in the community. The Malinko Scheduling System has been procured and installed and will be live from mid-September 2021.

A review of safe caseload staffing of the community nursing services in North Lincolnshire was undertaken by the Chief Nurse in October 2020 and identified insufficient nursing staff to safely manage activity. A business case was subsequently produced to secure funding for 10.33 WTE additional B5 RNs.

To date this has not been funded however a bespoke recruitment campaign is underway to fill existing RN vacancies and all successful candidates will be offered a post. Additionally and for the first time, our international recruitment programme is looking to attract community nurses from overseas.

5.7 Risks and benefits

There are several risks and benefits identified with this review which need to be considered.

Risks

- Ongoing changes to the bed base and use of unestablished beds will have an impact on required establishments
- Ability to staff a large number of unestablished escalation beds on a number of wards
- An increase in establishments will lead to an increase is costs and may lead to an increase in vacancies
- It may lead to an increase in temporary staffing use in the short term, however, having more flexibility may help with the short term management of sickness and deployment of staff, this is currently an area incurring high cost
- A more robust recruitment and retention plan is needed to include apprenticeships

Benefits

- Improved morale of nursing teams
- Enhance patient experience, safety and quality of care.
- Better use of resources by having flexibility within the Trust to redeploy staff for supportive care, manage short term sickness at short notice and staff unestablished escalation beds.
- Investment in leadership and staffing enhances reputation to attract staff.

5.8 Conclusion

- Most of the uplift to establishment is to support staffing into the early evening and overnight.

- It is recommended that ward manager supervisory time is increased to 30 hours per week. KPIs should be developed and agreed to include % reduction in sickness, % reduction in hospital required pressure ulcers, demonstrable improvement in patient experience, sustained achievement of >95% for nursing metrics scores, and sustained nursing staffing to agreed levels. The impact of increasing ward managers time on improving patient care/ staff retention should be evidenced and measured going forward and through the nursing assurance dashboard.

- Consideration needs to be given to how enhanced care can be delivered going forward as ward establishments do not cover this additional demand.

- It is recommended that consideration is given to recruitment taking place up to establishment including the budgeted uplift headroom of 22.6% going forward.

Risk assessed recommendations:

Very high – immediate risk	• **B7 - swap the Twilight shift to a night shift RN and add a RN long day.** This area is very low on CHPPD, has a high acuity due to being medical ward and staffed for surgery and benchmarks nationally against an elderly medical ward. • **NICU DPOW - increase the establishments to 5 RNs 24/7.** Concerned about the lack of a co-ordinator and alongside the other critical care units in the Trust the band 7 is not supernumerary. • **Stroke SGH - increase stroke responder service to include a HCA between the hours of 10-10.** Significant safety concern within stroke services as they are unable to care for patients and manage the pathways. • **A1 - increase x1 HCA Night shift**. Acuity of patients, movement of patients and ward layout are a risk. • **C5 – change RN twilight to night shift.** High number of level 1b patients and level 2 patients being nursed in cubicles due to Covid. • **C2 – increase x1 HCA on late, change RN twilight to night and increase x1 HCA on nights.** High acuity, patients requiring 1:1 supportive care, ward layout poor. • **Ward 17 – fund 5th RN on night shift.** Risk has increased due to ong Covid pressures (CQC recommendation)
High	• **ED – fund 2 Clinical Educator post substantively** in line with CQC ECIST recommendations • **C5** - Increase x1 RN on late, x1 HCA early, x2 HCA late and x1 HCA nights • **C2** - Increase x1 RN on late • **Amethyst** – increase HCA by 2 hours per day, swap twilight RN to night • **A1** – increase x1 RN night, 1 HCA long day • **16** – Increase x1 RN long day, swap twilight RN to night, increase x1 HCA night • **22** – Fund 3rd HCA on night, increase x1 RN long day, swap twilight RN to night • **23** – increase x1 RN or NA on night • **25** – increase 1 HCA on night • **B3** – swap RN twilight to night, increase x1 HCA long day for HOBS • **B6** – increase x1 RN long day, switch twilight RN to night, increase x1 HCA on night • **HDU** – increase x1 RN long day, increase x1 HCA night • **29** – increase x1 HCA 24/7 • **28** – increase x1 RN long day, remove x1 HCA long day • **ICU SGH** – increase HCA from early to long day • **NICU SGH & DPOW** - ward manager supernumerary 5 days • **NRC** – increase x1 HCA 24/7
Medium	➢ **Stroke Unit SGH** – uplift B5 to Clinical Sister in line with other wards ➢ Increase ward manager time to lead to 30 hours per week
Low	Phase 2 recommendations: ➢ NICU DPOW - supernumerary B6 shift lead 24/7, B6 Clinical Educator post for the Trust ➢ NICU SGH - supernumerary B6 shift lead 24/7

Financial Costings to re- set establishments:

Total "No"	-2,284,174
Total "Yes"	-1,281,300
Total "Partly"	-266,800
	-3,832,274

Risk Rating	Area	Already Started (Yes/No/Partly)?	Additional Cost if Substantive (£)
Grey - very high	B7	Yes	-153,600
Grey - very high	NICU DPOW	No	-236,100
Grey - very high	Stroke SGH	Yes	-76,700
Grey - very high	A1	Yes	-91,000
Grey - very high	C5	Yes	-125,000
Grey - very high	C2	Yes	-184,300
Grey - very high	Ward 17	Yes	-119,700
Red - high	ED	No	-60,600
Red - high	C5	No	-115,100
Red - high	C2	Partly	-66,900
Red - high	Amethyst	No	-57,400
Red - high	A1	Partly	-199,900
Red - high	16	No	-239,500
Red - high	22	Yes	-245,800
Red - high	23	Yes	-119,600
Red - high	25	No	-90,900
Red - high	B3	No	-127,655
Red - high	B6	No	-489,579
Red - high	HDU	Yes	-86,400
Red - high	29	No	-204,440
Red - high	28	Yes	-79,200
Red - high	ICU SGH	No	-32,820
Red - high	NICU SGH & DPOW	No	-76,000
Red - high	NRC	No	-192,980
Amber - medium	Stroke Unit SGH	No	-14,200
Amber - medium	Ward manager time	No	-305,700
Green - low	NICU DPOW	No	-41,200
Green - low	NICU SGH	Yes	0
			-3,832,274

September 2021
Ellie Monkhouse, Chief Nurse
Jenny Hinchliffe, Deputy Chief Nurse
Di Hughes, Head of Nurse Staffing

Appendix 1

The Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (*Comprehensive Critical Care, DH 2000*). These classifications have been adapted to support measurement across a range of wards/specialties. The full SNCT is outlined below.

Safer Nursing Care Tool (SNCT)

Levels of Care	Descriptor
Level 0 (Multiplier =0.99*) Patient requires hospitalisation Needs met by provision of normal ward cares.	**Care requirements may include the following** • Elective medical or surgical admission • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative/post-procedure care - observations recorded half hourly initially then 4-hourly • Regular observations 2 - 4 hourly • **Early Warning Score** is within normal threshold. • ECG monitoring • Fluid management • Oxygen therapy less than 35% • Patient controlled analgesia • Nerve block • Single chest drain • Confused patients not at risk • Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence
Level 1a (Multiplier =1.39*) Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	**Care requirements may include the following** • Increased level of observations and therapeutic interventions • **Early Warning Score** - trigger point reached and requiring escalation. • Post-operative care following complex surgery • Emergency admissions requiring immediate therapeutic intervention. • Instability requiring continual observation/invasive monitoring • Oxygen therapy greater than 35% +/- chest physiotherapy 2-6 hourly • Arterial blood gas analysis - intermittent • Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains • Severe infection or sepsis

Levels of Care	Descriptor
Level 1b (Multiplier = 1.72*) Patients who are in a STABLE condition but are dependant on nursing care to meet most or all of the activities of daily living.	**Care requirements may include the following** • Complex wound management requiring more than one nurse or takes more than one hour to complete. • VAC therapy where ward-based nurses undertake the treatment • Patients with spinal instability / spinal cord injury • Mobility or repositioning difficulties requiring the assistance of two people • Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory/administration / post-administration care) • Patient and / or carers requiring enhanced psychological support due to poor disease prognosis or clinical outcome • Patients on End of Life Care Pathway • Confused patients who are at risk or requiring constant supervision • Requires assistance with most or all activities of daily living • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse
Level 2 (Multiplier = 1.97*) May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit	• Deteriorating / compromised single organ system • Post operative optimisation (pre-op invasive monitoring)/extended post-op care. • Patients requiring non-invasive ventilation/respiratory support; CPAP / BiPAP in acute respiratory failure • First 24 hours following tracheostomy insertion • Requires a range of therapeutic interventions including: • Greater than 50% oxygen continuously • Continuous cardiac monitoring and invasive pressure monitoring • Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium • Pain management - intrathecal analgesia • CNS depression of airway **and** protective reflexes • Invasive neurological monitoring
Level 3 (Multiplier = 5.96*) Patients needing advanced respiratory support and / or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ / systems • Respiratory or CNS depression/compromise requires mechanical / invasive ventilation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage/sepsis or neuro protection

* this multiplier allows a 22% uplift for annual leave/study leave etc.
Software is being developed that will allow this to be adjusted and will be added to this site when available.

Appendix 2 SNCT – Calculation assumptions

Uplifts (sickness / AL / SL)

Definition "Enter your local time-out uplift (sickness, annual and study leave, etc.) the default, 22.6%, which is an average of 1700 wards."

NLAG - This has been left at the default level of 22.6%.

Ready for action time (RforA time)

Definition - The 9.7% (for Adult inpatient & AAU) and 11% (Children and Young people) means that we are deducting almost 10% ready-for-action time (the average from 1700 wards in the nursing database). Think carefully about raising or lowering the RfA time before you change it.

NLAG – This has been left at the default of 9.7% (Adult / AAU) / 11% (CYP)

RN proportion

Definition – "RN to SW ratio - the default is a 66:34 RN to SW ratio; i.e. two thirds will be RNs."

NLAG – 60% RN to 40% HCA has been applied.

Benchmarking

Definition "The percentages are the average SNCT level in 14 specialties so that you can benchmark your percentages for your ward. "

NLAG - wards are mixed speciality ward and therefore it will not be easy to apply these bench marks but are a useful reference point

SNCT score	Cardiolog	CCU	Children's	ENT	Med Eld	Medicine	Neurolog	Onc/Haem	Orthopdc	Rehabltn	Renal	Stroke	Surgery	Trauma
Level 0	53%	52%	38%	73%	32%	40%	31%	38%	42%	38%	33%	21%	62%	34%
Level 1a	18%	19%	25%	12%	2%	10%	26%	26%	22%	7%	6%	7%	15%	5%
Level 1b	17%	15%	24%	7%	66%	48%	42%	35%	34%	52%	59%	67%	22%	57%
Level 2	6%	12%	9%	3%	0%	1%	1%	2%	1%	4%	3%	6%	1%	2%
Level 3	6%	2%	4%	6%	0%	2%	0%	0%	0%	0%	0%	0%	0%	3%
Number of patients in benchmark	1937	433	11500	173	1973	12162	2837	3761	2311	937	1741	2335	13334	2109

Note - Definitions provided by the SNCT 2019 calculators.

Appendix 3 Example template

Nursing establishment review June 2021

Date	
Present	
Number of beds (escalation bed)	
Speciality	
Ward changes since last review	

SNCT DATA

Insert

Average transfer time per day hours

Comments collated from SNCT Survey

Insert

Supportive care shifts			
Month	Requested	Filled	Unfilled
March			
April			
May			

Staffing levels per shift

See spreadsheet

15 Steps Assurance Visit Outcomes

Sickness/other leave (roster perform data)

Vacancy report/Budget Month 01

Ledge CC Name	Cost Centre Code	Subjective Name	Sum of WTE Budget	Sum of WTE Contracted	Vacancies WTE	Vacancy Factor

Quality Dashboard Metrics

Insert 3 months of workforce and quality and safety metrics from dashboard

Complaints/Pals

Month	No. Of PALs	Description	No. of complaints	Description
April 21				
March 21				

Discussion

Recommendations

Appendix 4 SNCT master ward data

Site	Division	Ward	Beds	Esc beds	Ops Bed Plan	Ops Plan esc beds	RN (Est)	HCA (Est)	RN & HCA Total (Est)	E	L	N	Beds SNCT	RN (SNCT)	Donning RN WTE	Total RN (SNCT)	HCA (SNCT)	Transfers HCA (SNCT)	Donning HCA WTE	Total HCA (SNCT)	RN & HCA Total (SNCT)	Occupancy	CHPPD	E	L	N	E (Prop)	L (Prop)	N (Prop)	RN (Prop)	HCA (Prop)	Total (Prop)
DPoW	Medicine	C5	24		24		16.17	15.57	31.74	57/43	60/40	50/50	23.4	23.9	1.08	24.98	15.9	0.28	1.08	17.26	42.24	98.1	6.3	4+3+CN	3+2+TL	2+2	4+4+CN	4+4	3+3			0
DPoW	Medicine	C2	27		27		16.53	15.8	32.33	50/50	50/50	40/60	26.6	22.5		22.5	15	0.4		15.4	37.9	100.4	5.7	4+4+CN	3+3+TL	2+3	4+4+CN	4+4	3+3			0
DPoW	Medicine	C3 Short Stay	30		30	9	28.77	16.81	45.58	67/33	67/33	63/37	31.9↑	22.9		22.9	15.2	0.37		15.57	38.47	85.2	9.1	5+1+3+CN	5+1+3	4+1+3	6+1+4	6+1+4	5+1+4			0
DPoW	Medicine	B2 IAAU (A)	24		24	8	26.87	23.88	50.75	56/44	56/44	56/44	24.1	22.1		22.1	14.8	7.95		22.75	44.85	62.7	12.9	5+4+CN	5+4	5+4	5+4+CN	5+4	5+4			0
DPoW	Medicine	C1 (Glover)	26		26		23.72	14.35	38.07	67/33	67/33	67/33	26.3	17		17	11.3	0.37		11.67	28.67	88.2	7.6	5+3+CN	5+3	4+2	5+3+CN	5+3	4+2			0
DPoW	Medicine	C6	22		22		16.53	19.84	36.37	50/50	43/57	40/60	21.6	18.8		18.8	12.6	0.37		12.97	31.77	94.6	7.1	4+4+CN	3+4+TL	2+3	4+4+CN	3+4+TL	2+3			0
DPoW	Medicine	Stroke Unit	25		25		16.53	19.84	36.37	50/50	43/57	40/60	24.2	21.1		21.1	14	0.38		14.38	35.48	82.1	8.6	4+4+CN	3+4+TL	2+3	4+4+CN	3+4+TL	2+3			0
DPoW	Medicine	Amethyst	23		23		25.92	20.57	46.49	57/43	67/33	50/50	22	16.8		16.8	11.2	0.38		11.58	28.38	82.8	6.2	4+3+CN	4+2+ TL	2+2	4+3+CN	4+3	3+2			0
DPoW	Medicine	A1 (AAU B) (B4 staff)	18		18		18.89	17.14	36.03	57/43	57/43	50/50	16.3	16.8	1.08	17.88	11.2	0.4	1.08	12.68	30.56	81.2	10.9	4+3+CN	4+3	3+3	4+4+CN	4+4	4+4			0
SGH	Medicine	16	23		23		15.63	17.03	32.66	43/57	43/57	50/50	22.8	21.6		21.6	14.4	0.88		15.28	36.88	98.6	5.8	3+4+CN	3+4+TL	2+2	4+4+CN	4+4	3+3			0
SGH	Medicine	17 (ward 22 staff)	19		19		20.05	17.37	37.42	43/57	43/57	60/40	22	20.7	1.15	21.85	13.8	0.5	1.24	15.54	37.39	69	10.6	3+4+CN	3+4	3+2	3+4+CN	3+4	3+2			0
SGH	Medicine	RHOBS	4		4					100/0	100/0	100/0				0				0	0			2+0	2+0	2+0	2+0	2+0	2+0			0
SGH	Medicine	22 (ward 17 staff)	27		27		15.41	17.37	32.78	43/57	43/57	40/60	27	25		25	16.7	0.72		17.42	42.42	96.9	5.6	3+4+CN	3+4+TL	2+3	4+4+CN	4+4	3+3			0
SGH	Medicine	Ward 23 SS	26		26	2	29.22	17.14	46.36	67/33	67/33	63/37	24.8	22.1		22.1	14.7	0.72		15.42	37.52	103.6	8.9	6+3+CN	6+3	5+3	6+3+CN	6+3	5+1+3			0
SGH	Medicine	24 AAU (A)	24		23		26.87	22.31	49.18	50/50	50/50	63/37	19.9	20.7		20.7	13.8	1.58		15.38	36.08	84.6	9.5	5+5+CN	5+5	5+3	5+5+CN	5+5	5+3			0
SGH	Medicine	Ward 25 (ward 18 staff)	28		14	14	12.15	7.36	19.51	60/40	50/50	66/33	28	25.6		25.6	17.1	0.37		17.47	43.07	104.6	5.7	3+2	2+2	2+1	4+5+CN	4+5	3+3			0
SGH	Medicine	IAAU (B)	21		9	12	15.41	17.37	32.78	50/50	50/50	50/50	18.9	20.3	1.4	21.7	13.5	0.74	0.93	15.17	36.87	80.2	9.3	2+2+CN	2+2	2+2	5+3	5+3	4+3			0
SGH	Medicine	Stroke Unit	15		15		29.21	14.93	44.14	67/33	50/50	66/33	20.6	19.6		19.6	13.1	0.74		13.84	33.44	84.1	7.6	4+2	2+2	2+1	4+2	2+2	2+1			0
SGH	Medicine	HASU	6		6					66/33	66/33	66/33				0				0	0			2+1	2+1	2+1	2+1	2+1	2+1			0
DPoW	Surgery	B3	20		20		25.7	14.73	40.43	50/50	50/50	50/50	21.3	17.8		17.8	11.8	0.3		12.1	29.9	76	7.9	3+3+CN	3+3	2+2+TL	3+3+CN	3+3	3+2			0
DPoW	Surgery	B3 HOBS	6		6					100/0	100/0	100/0				0				0	0			2+0	2+0	2+0	2+1	2+1	2+0			0
DPoW	Surgery	B6	22		22		15.41	14.43	29.84	50/50	50/50	50/50	21.6	18.6		18.6	12.4	0.47		12.87	31.47	93.2	6.2	3+3+CN	3+3+TL	2+2	4+3+CN	4+3	3+3			0
DPoW	Surgery	B7	18		14	4	15.41	14.43	29.84	50/50	50/50	50/50	21.7	18.9		18.9	12.6	0.6		13.2	32.1	90.3	6	3+3+CN	3+3	2+2+TL	2+2+CN	2+2	2+2			0
DPoW	Surgery	B7 HOBS	4		4											0				0	0						2+1	2+1	2+0			0
DPoW	Surgery	ICU	6		6		36.4	2.58	38.98	87/13	87/13	100/0		NA	2.16		NA		0.15		0	83.9	30	7+1	7+1	7+0	7+2	7+2	7+1			0
DPoW	Surgery	HDU	7		7		20.86	2.92	23.78	80/20	80/20	100/0		Na	1.4		NA		0.31		0	61.9	23.5	4+1	4+1	4+0	5+1	5+1	4+1			0
SGH	Surgery	Ward 28	24		24		19.66	17.6	37.26	56/44	56/44	71/29	25.7	21.4		21.4	14.3	0.31		14.61	36.01	85.6	5.1	5+4+CN	5+4	5+2	4+3 +CN	4+3	3+2			0
SGH	Surgery	Ward 28 HOBS	4		4											0				0	0						2+0	2+0	2+0			0
SGH	Surgery	Ward 29	25		25		18.89	15.12	34.01	57/43	57/43	60/40	25.2	20.7		20.7	13.8	1.33		15.13	35.83	93.7	8.2	4+3+CN	4+3	3+2	4+4+CN	4+4	3+3			0
SGH	Surgery	Ward 19	6		4	4	14.62	16.06	30.68	50/50	50/50	50/50	7.1	6.4		6.4	4.3	0.44		4.74	11.14	95.3	12.3	3+3+CN	3+3	2+2	1+1	1+1	1+1			0
SGH	Surgery	Ward 19 HOBS	6		4											0				0	0						2+0	2+0	2+0			0
SGH	Surgery	ICU	8		8		41.83	1.68	43.51	89/11	100/0	100/0		NA	2.4		NA				0	71.3	31	8+1	8+0	8+0	8+1	8+1	8+0			0
DPoW	Family Services	Laurel	0		4	3	16.24	10.61	26.85	66/33	66/33	66/33		NA			NA				0			2+1	2+1	2+1	2+1	2+1	2+0			0
DPoW	Family Services	Laurel Assess	0		6											0				0	0											0
DPoW	Family Services	Rainforest	10+ 2 HDU		12	4	21.01	7.75	28.76	50/50	50/50	66/33	13	15.5		15.5	10.3	0.3		10.6	26.1	100	7.3	2+2	2+2	2+1	2+2	2+2	2+1	23.21	8.21	31.42
DPoW	Family Services	PAU	8		8					100/0	100/0	100/0				0				0	0			2+0	2+0	2+0	2+0	2+0	2+0			0
DPoW	Family Services	NICU (Level 1)	8		8		20.91	10.33	31.24	67/33	67/33	67/33		NA			NA				0	85.3	12	4+2	4+2	4+2	5+2	5+2	5+2	29.38	10.94	40.32
DPoW	Family Services	NICU (Level 2)	4		4											0				0	0											0
DPoW	Family Services	NICU (Trans Care)	4		4											0				0	0											0
SGH	Family Services	Gynae Ward (CCU)	0		4	3	15.34	6.01	21.35	66/33	66/33	66/33		NA			NA				0			2+1	2+1	2+0	2+1	2+1	2+0			0
SGH	Family Services	Gynae Ward Assess	0		6											0				0	0											0
SGH	Family Services	Disney	10+ 2 close obs	4	12	4	22.76	9.43	32.19	50/50	50/50	66/33	11.4	13.4		13.4	8.9	0.2		9.1	22.5	66.9	10.8	2+2	2+2	2+1	3+2	3+2	3+1	24.22	9.99	34.21
SGH	Family Services	Disney PAU	8		8					100/0	100/0	100/0				0				0	0			2+0	2+0	2+0	2+0	2+0	2+0			0
SGH	Family Services	NICU (Level 1)	6		6		15.77	10.33	26.1	60/40	60/40	60/40		NA			NA				0	53.7	17.9	3+2	3+2	3+2	3+2	3+2	3+2	17.48	10.94	28.42
SGH	Family Services	NICU (Level 2)	4		4											0				0	0											0
SGH	Family Services	NICU (Trans Care)	4		4											0				0	0											0
GDH	Medicine	Ward 3	15		15		12.6	9.43	22.03	50/50	50/50	66/33	6.8	6.1		6.1	4.1	0.66		4.76	10.86	88.5	10	3+3	2+2	2+1	3+3	2+2	2+1			0
GDH	Surgery	Ward 6			15	16	19.78	4.32	24.1	66/33	66/33	66/33	13.2	9		9	6	0		6	15	42.1	13.4	2+1	2+1	2+1	2+1	2+1	2+1			0
GDH	Surgery	Ward 6 Enh care			3											0				0	0						1+1	1+1	1+1			0
GDH	C&TS	NRC	14		14		11.78	10.67	22.45	40/60	40/60	40/60	12.3	12		12	8	0.2		8.2	20.2	82.8	9.2	2+3	2+3	2+1	2+4	2+4	2+2			0

Appendix 5 Establishment Reviews June 2021							
Medicine							
Ward	**Bed nos.**	**Ops plan bed nos.**	**2019 staffing levels**	**Recommended staffing levels**	**Comments**	**CN establishment review cost**	**Remodelling/ escalation/Covid/winter cost**
C5	24	24	4+3+CN 3+2+TL 2+2	4+4+CN 4+4 3+3	Using 4+4+CN, 3+4+TL, 2+3 Immediate risk – to mitigate, increase to extra RN on a night shift. Change RN TL to N - 0.92wte Increase RN on L - 1.60wte Increase 1 HCA E, 2 HCA L, 1 HCA N - 7.72wte	Total B5 RN = 2.52 Total B2 HCA = 7.43	
C2	27	27	4+4+CN 3+3+TL 2+3	4+4+CN 4+4 3+3	3rd HCA on N currently unfunded (should have been funded from 2019) - 2.63wte Immediate risk on N – to mitigate move TL to full N Change RN TL to N - 0.92wte Increase 1 RN on late - 1.6wte Increase 1 HCA on late - 1.6wte	Total B5 RN = 2.52 Total B2 HCA = 4.23 (2.74wte should have been funded from last review)	
C3 Short Stay	30	30+9esc	5+1+3+CN 5+1+3 4+1+3	6+1+4 6+1+4 5+1+4	Increase 1 HCA 24/7 - 5.26wte Increase 1 RN shift coordinator 24/7 - 5..26wte Above recommend for 39 beds - gives flexibility for 1:1 supportive care across sites		AAU model escalation bed cost - Total B5 RN = 5.26 Total B2 HCA = 5.26
B2 AAU (A)	24	24+8esc	5+4+CN 5+4 5+4	5+4+CN 5+4 5+4			AAU model escalation bed cost. For 32 assessment beds need: 6+4+CN, 6+4, 6+4 8 escalation beds not in recommended establishment
C1	26	26	5+3+CN 5+3 4+2	5+3+CN 5+3 4+2			
C6	22	22	4+4+CN 3+4+TL 2+3	4+4+CN 3+4+TL 2+3			
Stroke Unit	25	25	4+4+CN 3+4+TL 2+3	4+4+CN 3+4+TL 2+3			
Amethyst	23	23	4+3+CN 4+2+ TL	4+3+CN 4+3	Note establishment covers day unit. Interim plan – convert RN TL to HCA N plus 3rd HCA on days		

			2+2	3+2	from 7am-6pm to 7am to 8pm M-F. Then: Move RN TL to N - 0.92wte Increase HCA by 2 hours/day from 7-6 to 7-8pm - 0.46wte	Total B5 RN = 0.92 Total B2 HCA = 0.46	
A1 (AAU B)	18	18	4+3+CN 4+3 3+3	4+4+CN 4+4 4+4	Immediate risk - to mitigate increase x1 HCA Night shift. Increase 1 RN N - 2.63wte Increase 1 HCA LD - 2.63wte Increase 1 HCA N - 2.63wte	Total B5 RN = 2.63 Total HCA = 5.26	
ECC DPOW			11+5 11+5+TL 9+3	12+6 12+6 10+4	Additional B6 24/7 - 5.26wte B6 Additional B5 12.00-24.00 7 days - 2.63wte Establish ENPs to 12 hours (increase of 1 hour per shift) to match SGH - 0.48wte B7 WSW B2 7.5 hours per day for 7 days - 1.71wte Fund B7 CE post substantively - 1wte B7 Increase B2 24/7 - 5.26wte **Phase 2:** Consider 10% increase in establishment to support winter & increased resus & dept. activity	Total B7 CE = 1 Total B7 ECP = 0.48 Total B6 RN = 5.26 Total B5 RN = 2.63 Total HCA = 6.97	
16	23	23	3+4+CN 3+4+TL 2+2	4+4+CN 4+4 3+3	Increase 1 RN LD - 2.63wte TL RN to N - 0.92wte Increase 1 HCA N - 2.63wte	Total B5 RN = 3.55 Total HCA = 2.63	
17	19	19	3+4+CN 3+4 3+2	3+4+CN 3+4 3+2	5th RN on N not funded but used (CQC recommendation) Fund 5th RN on N - 2.63wte	Total B5 RN = 2.63	
RHOBS	4	4 RHOBS	2+0 2+0 2+0	2+0 2+0 2+0			
18	14	0		3+2 2+2 2+0	CLOSED – staff moved to ward 25		
22	27	27	3+4+CN 3+4+TL 2+3	4+4+CN 4+4 3+3	Established for 23 beds. 3rd HCA on N never funded - 2.63wte Increase 1 RN LD - 2.63wte, TL RN to N - 0.92wte	Total B5 RN = 3.55 Total HCSW = 2.63(3rd HCA on N for additional 4 beds never funded)	
23 Short Stay	26	26+2esc	6+3+CN 6+3 5+3	6+3+CN 6+3 5+1+3	4 monitored beds (can't increase to 24+4 until central monitoring). Increase 1 NA or RN on N - 2.63wte B5	Total B5 RN = 2.63	
24 AAU (A)	24	23		5+5+CN 5+5			6 escalation beds opened since gynae

				5+3			moved off ward – ops plan does not include escalation beds therefore not in recommended establishment
Ward 25	28	14+14esc	3+2 2+2 2+1	For 14 beds 3+2 2+2 2+2	For 14 beds increase 1 HCA N - 2.63wte	Total B2 = 2.63	For 28 beds need 4+5+CN, 4+5, 3+3 Recommend establish to 28 with escalation beds as an interim measure until ward 25 refurbished
IAAU (B)	21	9+12esc	2+2+CN 2+2 2+2	5+3 5+3 4+3	Budgeted for 9 beds, has escalation beds open therefore using 5+3, 5+3, 4+2. Increase 1 HCA on N – fund from CN post – 2.74wte 3 RN LD – 7.89wte 1 HCA LD - 2.63wte 2 RN Night - 5.26wte This money already being spent as beds open?	No change for 9 beds	AAU modelling escalation beds cost - 12 beds open
Stroke Unit	15	15	4+2 2+2 2+1	4+2 2+2 2+1	Immediate risk - to mitigate increase stroke responder service to include a HCA between the hours of 8-8 - 2.63wte Uplift B5 to B6 Clinical Sr. - cost? Have stroke responder 24/7	Total uplift B5 to B6 RN x 1 Total B2 HCA = 2.63	
HASU	6	6	2+1 2+1 2+1	2+1 2+1 2+1			
ECC SGH			11+5 11+5+TL 9+3	12+5+ RN 10-10 12+5+TL 10+4	Currently using: 12+5 12+5+T/L 10+4 Increase B5 RN 10-10 - 2.63wte Increase B6 24/7 - 5.26wte Increase HCA on N (used since 2018) - 2.63wte Fund B7 CE substantively - 1wte B7 Phase 2: Consider 10% increase in establishment to support winter &	Total B7 CE = 1 Total B6 RN = 5.26 Total B5 RN = 2.63 Total HCA = 2.63	

					increased resus & dept. activity		
Surgery							
Ward	**Bed nos.**	**Ops plan bed nos.**	**2019 staffing levels**	**Recommended staffing levels**	**Comments**	**CN establishment review cost**	**Remodelling/ escalation/Covid/winter cost**
B4		0					
B4 Surgical Day unit	~~12 IP beds (6+6 HOBS)~~	0	~~3+2~~ ~~3+2~~ ~~3+2~~	~~3+2~~ ~~3+2~~ ~~3+2~~	Temp establishment has ended. Remove B4 from IP beds base as now DSU		
B3	20	26	3+3+CN 3+3 2+2+TL	3+3+CN 3+3 3+2	Change RN TL to N - 0.95wte2	Total B5 RN = 0.92	
HOBS	6		2+0 2+0 2+0	2+1 2+1 2+0	Increase 1 HCA LD - 2.63wte	Total HCA = 2.63	
B6	22	22	3+3+CN 3+3+TL 2+2	4+3+CN 4+3 3+3	Increase RN LD - 2.63wte Change TL RN to N - 0.92wte Increase 1 HCA on N - 2.63wte	Total B5 RN = 3.55 Total HCA = 2.63	
B7	22 18+4 HOBS	14 + 4 HOBS +4esc	3+3+CN 3+3 2+2+TL	4+3+CN 4+3 3+2 (HOBS 2+1, 2+1, 2+0 Ward 2+2+CN, 2+2, 2+2)	Immediate risk - to mitigate this swap the TL to a night shift RN - 0.92wte and add a RN LD - 2.63wte. Plus increase 1 HCA 24/7 – no longer required as ring fenced surgery	Total B5 RN = 3.55	Using additional 4th RN on N to manage HOBS – funded through Covid - 2.63wte For 22 beds: Ward 3+32+CN, 3+32, 3+2 HOBS 2+1, 2+1, 2+0)
ICU DPOW	6	6	7+1 7+1 7+0	7+2 7+2 7+1	Increase HCA 24/7 whilst managing Covid - 5.26wte		Total B2 HCA = 5.26
HDU	7	7	4+1 4+1 4+0	5+1 5+1 4+1	Increase 1 RN LD - 2.63wte Increase 1 HCA N - 2.63wte	Total B5 RN = 2.63 Total HCA = 2.63	
29	25	25	4+3+CN 4+3 3+2	4+4+CN 4+4 3+3	Increase HCA 24/7 - 5.26wte	Total HCA = 5.26	

28	24	24+4HOBS	5+4+CN 5+4 5+2	4+3 +CN 4+3 3+2	Increase 1 RN LD - 2.63wte Remove 1 HCA LD – 2.63wte	Total B5 RN = 2.63 Total HCA = -2.63 (remove)	
			Inc HOBS				
HOBS	4	4		2+0 2+0 2+0			
ICU	8	8	8+1 8+0 8+0	8+1 8+1 8+0	Increase HCA from E to LD 7/7 - assuming 7.5 hour shift increasing to 11.5 hours – 0.92wte	Total HCA = 0.92	
19	6	4+4esc	3+3+CN 3+3 2+2	1+1 1+1 1+1			
HOBS	6	4		2+0 2+0 2+0			
Family Services							
Ward	**Bed nos.**	**Ops plan bed nos.**	**2019 staffing levels**	**Recommended staffing levels**	**Comments**	**CN establishment review cost**	**Remodelling/ escalation/Covid/winter cost**
Laurel	0	4+3 esc 6 chairs	2+1 2+0	2+1 2+0			
Rainforest	10+2 HDU	12+4	2+2 2+2 2+1	2+2 2+2 2+1	No space for 4 escalation beds as assessment area. To review winter with increased RSV once regional plan finalised. Establishment based on 3+1 on nights, use 4+1 (10-6 shift changed to a night)		– –
PAU		8	2+0 2+0 2+0	2+0 2+0 2+0			
NICU DPOW	8+ 4 HDU/ICU + 4 TC	12	4+2 4+2 4+2	5+2 5+2 5+2	Immediate risk - to mitigate establishments to 5 RNs 24/7 - 5.26wte Ward manager time to lead 5 days supernumerary – 0.96wte B5 Phase 2: Supernumerary shift lead B6 24/7 B6 CE post	Total B5 RN = 6.22	
Gynae (CCU)		4+3 esc 6 chairs	2+1 2+0	2+1 2+0			

Disney	10+2 close obs (+ 4 esc	12+4	2+2 2+2 2+1	3+2 3+2 3+1	12 beds include 2 close observation beds. Recommend 5 RSCNs over winter - 5.26wte		Recommend 5 B5 RSCNs over winter - 5.26wte
	beds)						
PAU		8	2+0 2+0 2+0	2+0 2+0 2+0			
NICU SGH	2 ICU 2 HDU 6 spec 4 TC	10	3+2 3+2 3+2	3+2 3+2 3+2	Ward manager time to lead 5 days supernumerary – 0.96wte B5 Phase 2: Recommend supernumerary shift lead B6 24/7	Total B5 RN = 0.96wte	
Goole							
Ward	**Bed nos.**	**Ops plan bed nos.**	**2019 staffing levels**	**Recommended staffing levels**			
NRC	14	14	2+3 2+3 2+1	2+4 2+4 2+2	Increase 1HCA 24/7 - 5.26wte Consider B4 complex care/discharge coordinator role. Review psychology input Therapist input well below recommendations.	Total B2 HCA = 5.26	
Ward 3	15	15	3+3 2+2 2+1	3+3 2+2 2+1	For 8 beds – 2+2, 2+2, 2+1		
Ward 6		15+16esc	2+1 2+1 2+1	2+1 2+1 2+1			16 escalation beds are not in establishment
Ward 6 Enhanced Peri-Operative care area		3 beds Included in the bed base of ward 6		1+1 1+1 1+1	Enhanced Peri-Operative care area		

Appendix 6 IP wards – Establishment, SNCT & Recommended Establishment

	Establishment			SNCT Calculation Before Triangulation			Proposed establishment		
Ward	RN	HCA	RN & HCA	RN	HCA	RN & HCA	RN	HCA	RN & HCA
16	15.63	17.03	32.66	21.6	15.28	36.88			0
17 (ward 22 staff)	20.05	17.37	37.42	21.85	15.54	37.39			0
22 (ward 17 staff)	15.41	17.37	32.78	25	17.42	42.42			0
24 AAU (A)	26.87	22.31	49.18	20.7	15.38	36.08			0
A1 (AAU B) (B4 staff)	18.89	17.14	36.03	17.88	12.68	30.56			0
Amethyst	25.92	20.57	46.49	16.8	11.58	28.38			0
B2 IAAU (A)	26.87	23.88	50.75	22.1	22.75	44.85			0
B3	25.7	14.73	40.43	17.8	12.1	29.9			0
B3 HOBS				0	0	0			0
B6	15.41	14.43	29.84	18.6	12.87	31.47			0
B7	15.41	14.43	29.84	18.9	13.2	32.1			0
B7 HOBS				0	0	0			0
C1 (Glover)	23.72	14.35	38.07	17	11.67	28.67			0
C2	16.53	15.8	32.33	22.5	15.4	37.9			0
C3 Short Stay	28.77	16.81	45.58	22.9	15.57	38.47			0
C5	16.17	15.57	31.74	24.98	17.26	42.24			0
C6	16.53	19.84	36.37	18.8	12.97	31.77			0
Disney	22.76	9.43	32.19	13.4	9.1	22.5	24.22	9.99	34.21
Disney PAU				0	0	0			0
HASU				0	0	0			0
IAAU (B)	15.41	17.37	32.78	21.7	15.17	36.87			0
NRC	11.78	10.67	22.45	12	8.2	20.2			0
PAU				0	0	0			0
Rainforest	21.01	7.75	28.76	15.5	10.6	26.1	23.21	8.21	31.42
RHOBS				0	0	0			0
Stroke Unit	45.74	34.77	80.51	40.7	28.22	68.92			0
Ward 19	14.62	16.06	30.68	6.4	4.74	11.14			0
Ward 19 HOBS				0	0	0			0
Ward 23 SS	29.22	17.14	46.36	22.1	15.42	37.52	Awaiting Data from finance		0
Ward 25 (ward 18 staff)	12.15	7.36	19.51	25.6	17.47	43.07			0
Ward 28	19.66	17.6	37.26	21.4	14.61	36.01			0
Ward 28 HOBS				0	0	0			0
Ward 29	18.89	15.12	34.01	20.7	15.13	35.83			0
Ward 3	12.6	9.43	22.03	6.1	4.76	10.86			0
Ward 6	19.78	4.32	24.1	9	6	15			0
Ward 6 Enh care				0	0	0			0
Grand Total	**551.5**	**428.65**	**980.15**	**522.01**	**371.09**	**893.1**	**47.43**	**18.2**	**65.63**

Appendix x IP wards – Establishment & Recommended Establishment

Division	(All)			Wards excluded from SNCT assessment		
Row Labels	Sum of RN (Est)	Sum of HCA (Est)	Sum of RN & HCA Total (Est)	Sum of RN (Prop)	Sum of HCA (Prop)	Sum of Total (Prop)
DPoW	**94.41**	**26.44**	**120.85**	**29.38**	**10.94**	**40.32**
HDU	20.86	2.92	23.78	Awaiting data from finance		0
ICU	36.4	2.58	38.98			0
Laurel	16.24	10.61	26.85			0
Laurel Assess						0
NICU (Level 1)	20.91	10.33	31.24	29.38	10.94	40.32
NICU (Level 2)						0
NICU (Trans Care)						0
SGH	**72.94**	**18.02**	**90.96**	**17.48**	**10.94**	**28.42**
Gynae Ward (CCU	15.34	6.01	21.35			0
Gynae Ward Assess						0
ICU	41.83	1.68	43.51			0
NICU (Level 1)	15.77	10.33	26.1	17.48	10.94	28.42
NICU (Level 2)						0
NICU (Trans Care)						0
Grand Total	**167.35**	**44.46**	**211.81**	**46.86**	**21.88**	**68.74**

Appendix 7 Staffing Incidents - Inpatient wards

Indicator	Staffing Incidents		Red Flags	
Site - Ward	Value	Change	Value	Change
DPOW - Rainforest	20	▼ -7	4	▲ 2
SGH - CDS	20	▼ -4	1	▲ 1
DPOW - Maternity	18	▲ 8	0	▼ -1
DPOW - C2	0	▼ -1	16	▲ 14
SGH - Ward 26	16	▼ -3	0	0
SGH - Ward 23 Short Stay	2	0	9	▲ 1
SGH - Ward 28	6	▲ 2	5	▲ 1
DPOW - C3 Short Stay	0	▼ -2	9	▲ 3
DPOW - HDU	0	▼ -1	9	▲ 4
DPOW - ITU	0	▼ -1	7	▲ 7
DPOW - Stroke DPW	0	▼ -2	6	▼ -10
SGH - Ward 17	2	▼ -3	4	▼ -7
SGH - Ward 24 Assessment Unit	0	0	6	▲ 2
SGH - Ward 22	3	▼ -2	2	▼ -4
DPOW - B3	2	▲ 2	2	▲ 2
SGH - CDU	2	▲ 2	2	▲ 2
SGH - Stroke SGH	2	▲ 2	2	▲ 2
SGH - Ward 16	1	▲ 1	3	▲ 1
SGH - ICU	0	0	3	▼ -4
SGH - Ward 25	1	0	2	▼ -2
DPOW - B6	0	0	2	▲ 2
DPOW - NICU DPW	2	▲ 2	0	▼ -6
GDH - Ward 3	1	▲ 1	1	▲ 1
GDH - Ward 6	0	0	2	▲ 2
SGH - Disney	2	0	0	0
SGH - Ward 29	0	▼ -1	2	▲ 1
DPOW - A1	0	▼ -4	1	▼ -6

Appendix 8

Midwifery Establishment Review (Safer Staffing)

March 2021

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Deputy Chief Nurse/Head of Midwifery

May 2021

1.0 Introduction

NHS providers are responsible for delivering the right staff, with the right skills, in the right place at the right time in line with the requirements of the updated National Quality Board Safe Sustainable and Productive Staffing Guidance (July 2016), the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014 and Developing Workforce Safeguards (2018). The Board are required to receive an annual review of nurse staffing and approve any changes to nursing establishments.

Trusts must ensure the three components are used in their safe staffing processes:

- evidence-based tools (where they exist)
- professional judgement
- outcomes

In addition, within Safety Action 5 of the Clinical Negligence Scheme for Trusts (Maternity incentive scheme, NHS Resolution 2021) there is a requirement for Trusts to conduct a systematic, evidence-based process to calculate midwifery staffing establishments and submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year.

A full establishment review using BirthRate+ data was conducted in November 2019 following concerns being raised about a gap between establishments and BirthRate+ calculations. Staffing shortfalls were identified and the recommendations fully funded. A further review using BirthRate+ has been procured however will be commenced in June 2021 due to awaiting availability of the team, therefore a review of workforce, activity and patient safety data was undertaken by the Chief Nurse in March 2021 for the maternity wards, delivery suites and community services.

This paper will provide the Board with the safe staffing review of maternity staffing in line with the above guidance and requirements.

2.0 Context

The Trust has a duty to ensure that Midwifery staffing levels are adequate and that women are cared for safely by appropriately qualified and experienced staff. This is incorporated within the NHS Constitution (2013) and the Health and Social Care Act (2012). NICE (2015) states of the Trust Board that it should ensure that the budget for maternity services covers the required midwifery staffing establishment for all settings**.**

The evidence suggests that appropriate staffing levels and skill mix influences patient outcomes, for example:

- Reducing mortality & morbidity
- Reducing 30 day readmissions for both mothers and babies
- Reducing adverse incidents, particularly related to medication errors
- Improving the patient experience – continuity of carer throughout the pregnancy

Safe midwifery staffing for maternity settings (NICE 2015) has recommended the use of red flags. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will determine whether midwifery staffing is the cause, and the action that is needed. Red flags are reported monthly as part of the midwifery dashboard.

It is essential that the Trust can demonstrate an effective system of midwifery workforce planning to the required standard. It should be underpinned by a systematic workforce strategy and use of a recognised workforce planning tool for determining the total number of Midwifery and Midwifery Support Worker (MSW) staff required per maternity service. Staffing levels and skill mix within maternity services have been the focus of much debate in recent years. Maternity services nationally are constantly under pressure to utilise their manpower resources effectively and efficiently. A number of other factors have emerged, which include population demographics, national reports and guidelines along with an increase in public awareness and expectations especially in light of Morecambe Bay and, more recently, the Ockenden Review. In addition, diversity and complexity of patient needs continue to increase and range from promoting health and well-being through the wider public health agenda, to the high dependency care of sick women and babies. National data published in July 2018 by the ONS stated that the rate of women having babies in their 40s is higher than that of under 20s for the first time since 1949. This increase in age profile comes with a recognised increase in complexities. The additional work associated with increased antenatal screening and the national Saving Babies Lives Care Bundle v2, which includes the GAP/GROW programme of assessing foetal growth, has been an additional pressure to the service.

Safe midwifery staffing for maternity settings (NICE 2015) also recommends that when calculating the midwifery staffing levels, the number of whole-time equivalents should be based on registered midwives and should not include the following in the calculations:

- Registered midwives with supernumerary status (this may include newly qualified midwives, or midwives returning to practice)
- Student midwives
- The proportion of time specialist and consultant midwives who are part of the establishment spend delivering contracted specialist work (for example, specialist midwives in bereavement roles)
- The proportion of time midwives who are part of the establishment spend coordinating a service, for example the labour ward.

The Clinical Negligence Scheme for Trusts (CNST) has introduced an incentive scheme for Trusts and maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend. Trusts that improve their maternity safety will be saving the NHS money, allowing more money to be made available for frontline care. One of the ten required standards for the Trust is:

"*Can you demonstrate an effective system of midwifery workforce planning to the required standard*"

Required standard and evidential requirement for this standard is:

- Completion of a systematic, evidence-based process to calculate midwifery staffing establishment.
- The midwifery coordinator in charge of the labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service.
- All women in active labour receive one-to-one midwifery care.
- A midwifery staffing oversight report that covers staffing/safety issues is submitted to the Board at least once a year during the maternity incentive scheme three year reporting period.

Minimum evidence for the Trust Board is a clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. BirthRate+ data helps to inform decisions about staffing numbers, staff deployment, models of care and skill mix.

The Trust publishes its midwifery staffing hours both Registered and Unregistered - planned versus actual, in line with the National Quality Board (NQB) guidance. This is published externally on NHS Choices with a link to the Trust's own website.

3.0 Background

Maternity care is delivered across the three hospital sites, with an obstetric unit at Grimsby and Scunthorpe and a Home from Home midwifery led facility at Goole. Community midwifery, which includes antenatal, intrapartum (home delivery) and postnatal care, covers a wider area in Lincolnshire including Louth, Mablethorpe and Alford.

The number of births have continued to reduce over recent years, although have increased in complexity with more interventions required.

Year	SGH		DPOW
	Total births	MW: Birth ratio/WTE midwives	MW: Birth ratio/WTE midwives
2016-17	4468	1:32/ 60.23 wte	1:32 / 73.59 wte
2017-18	4322	1:22/ 58.91 wte	1:27/ 75.53 wte
2018-19	4033	1:22 / 58.61 wte	1:27/ 74.4 wte
2019-20	4041	1:24/68.22 wte	1:28/87.34wte
2020-2021	3751	1:22 / 73.62 wte	1:26 / 94.45 wte

With the full implementation of Better Births, Maternity 5 year Forward View (2016), the maternity service must be providing a Continuity of Carer pathway. The current target which has altered since the recent pandemic is for 'all eligible women' to be cared for in a Continuity of Care team by March 2023. Continuity of Carer was reinforced within the NHS Long Term Plan (2019) and a change in NHS Contract. At the present time there are 5 Continuity of Carer teams, with 3 in Scunthorpe and a further 2 in Grimsby, and 36.% of women receiving care from midwives in a Continuity of Carer team. Teams are mixed risk, geographical models with an emphasis on women living in areas of deprivation and / or BAME women. Current 'in receipt of' care, i.e. women who have been cared for by a Continuity team during their pregnancy, intrapartum and postnatal periods stands at 16.2% which will increase over the forthcoming months.

The maternity service staffing establishments are required to be reviewed at yearly intervals as per CNST/NICE/Better Births. The recommended methodology by the Royal College of Midwives/CNST and CQC is BirthRate+ (which focuses on acuity), although NICE also have published an alternative methodology (NG4 2015).

A full establishment review using BirthRate+ data was conducted in November 2019 following concerns being raised about a gap between establishments BirthRate+ calculations, in particular in the community. Continuity of Carer teams were not included

within this establishment review. Staffing shortfalls were identified and the following recommendations were made and have all been fully funded:

Ward 26 SGH	• To increase RM x 1 long day 7 days per week • To increase HCA x 1 twilight shift (4pm-12 midnight) x 7 days per week • To increase supervisory time of ward manager to 15 hours per week except for the months of December, January, February and August.
Delivery Suite SGH	• To increase supervisory time of Labour ward manager to 15 hours per week except for the months of December, January, February and August.
Pregnancy Assessment Centre (SGH)	• To increase HCA x 1 weekend (8am-4pm) 8 hours for Saturday and Sunday • To increase HCA x 1 until 8pm (4pm-8pm) Monday to Friday • To increase supervisory time of manager to 15 hours per week except for the months of December, January, February and August.
Maternity DPOW	• To increase RM x 1 across the floor night shift (12 hours) seven days per week • To increase band 3 Maternity support worker x 1 across the floor early shift (7.5 hours) for transitional care babies seven days per week 8am-4pm • To increase supervisory time of ward manager to 15 hours per week except for the months of December, January, February and August.
Antenatal Unit (DPOW)	• To increase service with additional x 1 RM and x 1 HCA cover 8:30am- 8pm seven days per week • To increase supervisory time of unit manager to 15 hours per week except for the months of December, January, February and August.
Community Midwifery DPOW & Louth	• To increase RM x 1 9am- 5pm seven days per week
Community Midwifery SGH & Goole	• To increase RM x 1 9am- 5pm seven days per week
Total	• MW - 11.76wte • Support worker - 3.75wte

Due to the Covid-19 pandemic the planned 6 monthly establishment reviews were not undertaken in 2020 however the maternity dashboard and workforce data has been reviewed monthly by the Chief Nurse and Head of Midwifery and in the Nursing Metric Panel meeting, and reported monthly to the Quality and Safety Committee during this period.

4.0 Methodology for March 2021 establishment review

An establishment review using BirthRate+ has been procured however will not be undertaken until summer of 2021 due to availability of the team, therefore a review of workforce, activity and patient safety data was undertaken for the maternity wards, delivery suites and community services.

The review groups consisted of the ward/department/service manager, Chief Nurse, Deputy Chief Nurse, Head of Nurse Staffing, Head of Midwifery, Matron and Finance Business

Partner. It is essential to include the manager in the review process as they are the accountable leader and meetings were arranged to accommodate their attendance.

The review considered a triangulation of elements for each ward/department/service, which also included a financial review. It is an important factor to incorporate the professional judgment of the midwifery managers. Their views were then supported objectively by the use of the following information:

- Review of registered to unregistered midwives ratios
- Booking & delivery statistics
- Review of the maternity dashboard (Appendix 1)
- Clinical/ Professional judgement
- A review of ward budgets and establishments, with a clear breakdown of staffing budgets at each band and non-pay
- Agency and bank use
- Roster management
- HR benchmarks including vacancy and sickness
- NICE Guidance (2015) Safe midwifery staffing for maternity settings
- Review of staffing red flags and staffing incidents
- Mandatory Training, appraisals and professional development
- Recruitment and retention
- Temporary staffing and fill rates

The review included a celebration of what is going well on the ward areas, which highlighted good practice and exceptional leadership. A consistent theme from the managers included ability to cover rosters due to the impact of Covid-19 (increased sickness and staff shielding), impact of Continuity of Carer team still being realised, and the difference filling the vacant posts will make (recruitment is underway). Lone working was no longer an issue due to the increases in establishments last year. There had been a sustained increase in statutory and mandatory training and appraisal rates, with most areas advising that they are near completion.

At the end of each review a discussion and decision was made on what recommendations would be put forward so the entire panel was in agreement.

Identifying how many midwives and MSWs are needed will vary from service to service and will depend on a number of variables, such as models of care, configuration of services, case mix, length of stay in the acute setting and the competency levels of MSWs. Each of these will have implications for how staff are deployed.

5.0 Findings

Quality and Safety

There is a robust assurance process including Birthrate Plus Intrapartum Acuity Tool that is a live data collection tool as well as Midwifery Red Flag data collection via the Datix system. This clearly demonstrates that safety is maintained. This is achieved utilising a bank of midwives, agency midwives and re-deployment from the community setting including those that cover an on-call service for home deliveries and the management team currently work on an 80% clinical rota.

In order to gain assurance of safe staffing levels on a daily basis, there are 4 times a day sit rep reviews in the acute clinical areas (LDRP and CDS), highlighting those areas most acute to enable deployment of staff.

There is a robust Maternity Escalation Tool that is enacted when necessary as well as the BirthRate+ Intrapartum Tool that is undertaken 4 hourly.

Labour Co-ordinators maintain their role consistently without requiring to undertake care of a woman in labour and there is a 1:1 provision of care in labour to 100% of labouring women.

Staffing is discussed as part of the shift leader hand over. This meeting takes place twice a day and ward dependency, women on protocol (high risk needing midwifery high dependency 1:1 care) and overall staffing ratios/ gaps are discussed. The following actions are agreed to support a reduction of risk:

- Moving from outpatient areas
- Moving staff from one ward to another
- Moving from or to Community midwifery
- Sanctioning additional staff if required due to a patient safety risk
- Closing the Maternity Unit

To support the management of any identifiable risks, the midwives in charge of wards/departments are engaged with staff at a safety brief. A Trust Midwifery Staffing Policy is in place to support the decision making process. The risks discussed, for example, are high acuity women and babies requiring additional monitoring to that of a low risk new born. Staff also receive feedback regarding complaints or leaning from incidents that have taken place in or that affect the Trust.

Midwife: Birth ratio

The midwife: birth ratio for the Trust has been below 1:28 and in line with national guidance since January 2020. On one occasion in March 2020 the ratio was 1:30 at DPOW. This calculation is derived from the Birthrate Plus tool and is based upon an understanding of the total midwifery time required to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour.

Midwifery Unit closure

There have been no incidents of unit closure in the last year. There have been occasions when one unit has diverted to the other and whereby the Maternity Escalation Tool has been enacted, likewise the maternity unit has accepted women from other units when they have been closed due to acuity.

Challenges & Risks

The age profile of the Midwifery staff and the limitations of staff recruited to the midwifery bank resulting in below minimum staffing on occasions remain a potential risk to the organisation. However, we have not experienced a problem with recruitment into any Midwifery vacancies to date and continue to explore recruitment to the Midwifery bank and staff work additional hours to cover gaps in off duty where possible.

Changes in acuity in workload due to an increase of complexities women present with is not reflected at present in current staffing levels. There are plans in place to implement Safecare Live on 14 June 2021 which will support deployment of staff to maintain patient safety.

The Ockenden Review was in respect of 250 cases from Shrewsbury & Telford NHS Trust Maternity Services. The Terms of Reference set out an independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm following efforts made by parents whose babies died in 2009 and 2016 respectively. A total of 1862 cases are being reviewed and a further report is anticipated next year. The report highlighted a number of themes which were identified and shared with all Maternity Services urgently following the publication of the report on 10th December 2020. There are seven Immediate and Essential Actions including:

- Enhanced Safety
- Listening to Women and Families
- Staff training and working together
- Managing complex pregnancy
- Risk assessment throughout pregnancy
- Monitoring Foetal Wellbeing
- Informed Consent

The Trust has identified a programme of improvements however there are risks associated with maintaining compliance with standards linked to ongoing challenges of working differently due to Covid-19, potential periods of transition and transformation and financial costs of achieving recommendations in the report. There are opportunities for financial support to meet the requirements from the Ockenden review in respect of midwifery and medical staffing and multi-disciplinary training and at the time of writing the outcome of this is awaited.

Covid-19 pandemic

The Covid-19 pandemic had some impact on staffing levels. There were a number of midwives that had to shield as per government guidelines although the majority were able to continue providing support to the service in some way. A weekly national maternity sit-rep was completed which requested detail of midwifery staffing and if there was an impact on service provision. The Trust was able to continue with all services including home birth, labour and anaesthetic care etc.

Preparation for sudden staff shortages was monitored daily with a review of e-roster, co-ordinator daily tool, intrapartum acuity tool and daily operations meetings.

6.0 Conclusion

The review identified that recruitment is underway to fill the vacancies and staff in most areas felt that staffing levels would be appropriate when vacancies were filled. A shortfall in midwifery staffing was identified in two areas where it was found that staffing reduced at weekends however this was not reflected in reduced activity, and for increased diabetic specialist midwife capacity to support high numbers of diabetic pregnant women.

7.0 Recommendations

Antenatal SGH

- To increase 1 WTE band 7 diabetic specialist midwife – cross-site post

Cost £51.1k (requested via Ockenden funding)

Central Delivery Suite SGH

No change

Ward 26

No change

Community Midwifery SGH

- To increase MSW x 1 at a weekend 09.00-17.00 hours – 0.48 WTE

Cost £13.2k

Antenatal DPOW

No change

(See above re 1 wte Band 7 Diabetic Specialist Midwife – cross-site post)

Blueberry/Holly DPOW

To increase RM x 1 weekend Saturday and Sunday – 0.79 WTE
Cost 41.1k (requested via Ockenden funding)

Jasmine/Honeysuckle

No change

Community Midwifery DPOW

No change

Total:

Midwives – 0.79 WTE
Specialist Midwife – 1 WTE
MSW – 0.48 WTE

Appendix 1

Maternity Dashboard

DPOW	2020	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Midwife:Birth Ratio	< 1:28	1:28	1:28	1:30	1:26	1:26	1:26	1:26	1:26	1:26	1:26	1:25	1:25
Red Flags -		0	1	4	1	6	1	8	7	3	10	2	5
Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours).		0	0	0	1	5	1	2	2	0	2	2	0
Missed or delayed care (washing, suturing)		0	0	2	0	0	0	0	0	0	0	0	0
Missed medication during an admission to hospital		0	0	1	0	1	0	0	0	0	0	0	0
Delay of more than 30 minutes in providing pain relief.		0	0	0	0	0	0	0	0	0	0	0	0
Delay of 30 minutes or more between presentation onto the ward and being seen.		0	0	0	0	0	0	0	0	0	0	0	0
Full clinical examination not carried out when presenting in labour.		0	0	0	0	0	0	1	0	0	0	0	0
Delay of 2 hours or more between admission for induction and beginning of process.		0	1	1	0	0	0	3	0	0	3	0	0
Delayed recognition of and action on abnormal vital signs (eg, sepsis or urine output).		0	0	0	0	0	0	0	1	0	0	0	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.		0	0	0	0	0	0	0	0	0	0	0	0
Community staff have been called into work on the unit		0	0	0	0	0	0	2	4	3	5	0	1
Continuity of Carer													
Divert / Unit closures		0	0	1 (D)	0	0	0	1	0	0	0	0	0
Actual v planned staffing	100%	93%	99%		108%	106%	104%	104%	102%	102%	99%	102%	95%
Labour Co-ordinator supernumery status	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
1:1 care in labour	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%		
Sickness absence													

SGH	2020	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Midwife:Birth Ratio	< 1:28	1:24	1:24	1:25	1:22	1:22	1:21	1:22	1:21	1:22	1:22	1:23	1:21
Red Flags -		2	6	4	2	7	6	5	4	9	11	8	4
Delayed or cancelled time critical activity (delay in inpatient IOL >24 hours, Emer or El LSCS, delay in ARM >24 hours, delay in augmentation of SROM >30 hours).		0	4	1	2	5	3	0	1	0	6	2	3
Missed or delayed care (washing, suturing)		0	0	0	0	0	0	0	0	0	0	0	0
Missed medication during an admission to hospital (.		0	0	1	0	0	0	0	0	0	0	1	0
Delay of more than 30 minutes in providing pain relief.		0	0	0	0	0	0	0	0	0	0	0	0
Delay of 30 minutes or more between presentation onto the ward and being seen.		0	0	0	0	0	0	0	0	0	0	0	0
Full clinical examination not carried out when presenting in labour.		0	0	0	0	0	0	1	0	0	0	0	0
Delay of 2 hours or more between admission for induction and beginning of process.		0	0	0	0	0	3	2	0	3	3	4	0
Delayed recognition of and action on abnormal vital signs (eg, sepsis or urine output).		1	0	0	0	1	0	0	0	1	0	0	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.		0	0	0	0	0	0	2	0	0	0	0	0
Community staff have been called into work on the unit		1	2	2	0	1	0	0	3	5	2	1	1
Continuity of Carer													
Divert / Unit closures		0	0	0	0	0	0	0	0	0	0	0	0
Actual v planned staffing	100%	93%	89%		108%	105%	107%	104%	104%	105%	106%	110%	100%
Labour Co-ordinator Supernumery status	100%		98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
1:1 care in labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Sickness absence													

DPOW / SGH	2020	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Midwife:Birth Ratio	< 1:28	1:26	1:26	1:28	1:24	1:24	1:24	1:24	1:23	1:24	1:24	1:23	1:23
Red Flags -		2	7	8	3	13	7	14	11	12	21	10	5
Delayed or cancelled time critical activity (delay in inpatient IOL >24 hours, Emer or El LSCS, delay in ARM >24 hours, delay in augmentation of SROM >30 hours).		0	4	1	3	10	4	2	3	0	8	4	3
Missed or delayed care (washing, suturing)		0	0	2	0	0	0	0	0	0	0	0	0
Missed medication during an admission to hospital (.		0	0	2	0	1	0	0	0	0	0	1	0
Delay of more than 30 minutes in providing pain relief.		0	0	0	0	0	0	0	0	0	0	0	0
Delay of 30 minutes or more between presentation onto the ward and being seen.		0	0	0	0	0	0	0	0	0	0	0	0
Full clinical examination not carried out when presenting in labour.		0	0	0	0	0	0	2	0	0	0	0	0
Delay of 2 hours or more between admission for induction and beginning of process.		0	1	1	0	0	3	5	0	3	6	4	0
Delayed recognition of and action on abnormal vital signs (eg, sepsis or urine output).		1	0	0	0	1	0	0	1	1	0	0	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.		0	0	0	0	0	0	2	0	0	0	0	0
Community staff have been called into work on the unit		1	2	2	0	1	0	2	7	8	7	1	2
Continuity of Carer **> 35% - March 2020** **> 51% - March 2021**	> 35%	46.5%	54.9%	57.7%	46%	40.7%	44.7%	39.7%	42.3 %	48.4%	43.1%	40.8%	34.2%
Divert / Unit closures		0	0	1	0	0	0	1	0	0	0	0	0
Actual v planned staffing													
Sickness absence (Division)	4.1%	6.02%	6.85%	4.49%	5.1%	6.1%	5.9	4.36	4.45	4.68	4.68	5.36	6.52
PALS new in month (Division)			9	11	11	8	2	7	9	26	14	15	15
Complaints new in month (Division)			2	7	2	9*	0	4	4	12	7	5	4

DPOW	2021	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Midwife:Birth Ratio	< 1:28	1:23	1:26	1:26									
Red Flags -		0	3	3									
Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours).		0	2	1									
Missed or delayed care (washing, suturing)		0	0	0									
Missed medication during an admission to hospital		0	0	2									
Delay of more than 30 minutes in providing pain relief.		0	0	0									
Delay of 30 minutes or more between presentation onto the ward and being seen.		0	0	0									
Full clinical examination not carried out when presenting in labour.		0	0	0									
Delay of 2 hours or more between admission for induction and beginning of process.		0	0	0									
Delayed recognition of and action on abnormal vital signs (eg, sepsis or urine output).		0	0	0									
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.		0	0	0									
Community staff have been called into work on the unit		0	1	0									
Continuity of Carer													
Divert / Unit closures		0	0	0									
Actual v planned staffing	100%	102%	102%	102%									
Labour Co-ordinator supernumery status	100%	100%	100%	100%									
1:1 care in labour	100%	100%	100%	100%									
Sickness absence													

SGH	2021	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Midwife:Birth Ratio	< 1:28	1:21	1:25	1:25									
Red Flags -		2	16	18									
Delayed or cancelled time critical activity (delay in inpatient IOL >24 hours, Emer or El LSCS, delay in ARM >24 hours, delay in augmentation of SROM >30 hours).		1	10	12									
Missed or delayed care (washing, suturing)		0	0	1									
Missed medication during an admission to hospital (.		1	1	0									
Delay of more than 30 minutes in providing pain relief.		0	0	0									
Delay of 30 minutes or more between presentation onto the ward and being seen.		0	0	0									
Full clinical examination not carried out when presenting in labour.		0	0	0									
Delay of 2 hours or more between admission for induction and beginning of process.		0	0	0									
Delayed recognition of and action on abnormal vital signs (eg, sepsis or urine output).		0	0	0									
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.		0	0	0									
Community staff have been called into work on the unit		0	5	5									
Continuity of Carer													
Divert / Unit closures		0	1	0									
Actual v planned staffing	100%	102%	107%	97%									
Labour Co-ordinator Supernumery status	100%	100%	100%	100%									
1:1 care in labour	100%	100%	100%	100%									
Sickness absence													

DPOW / SGH	2021	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Midwife:Birth Ratio	< 1:28	1:22	1:25	1:25									
Red Flags -		2	19	20									
Delayed or cancelled time critical activity (delay in inpatient IOL >24 hours, Emer or El LSCS, delay in ARM >24 hours, delay in augmentation of SROM >30 hours).		1	12	13									
Missed or delayed care (washing, suturing)		0	0	1									
Missed medication during an admission to hospital (.		1	1	2									
Delay of more than 30 minutes in providing pain relief.		0	0	0									
Delay of 30 minutes or more between presentation onto the ward and being seen.		0	0	0									
Full clinical examination not carried out when presenting in labour.		0	0	0									
Delay of 2 hours or more between admission for induction and beginning of process.		0	0	0									
Delayed recognition of and action on abnormal vital signs (eg, sepsis or urine output).		0	0	0									
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.		0	0	0									
Community staff have been called into work on the unit		0	6	5									
Continuity of Carer **> 35% - March 2020** **> 51% - March 2021**	> 35%	40.8%	42.9%	36.2%									
Divert / Unit closures		0	1	0									
Actual v planned staffing													
Sickness absence (Division)	4.1%	6.09%	5.95%	5.74%									
PALS new in month (Division)		13	9	21									
Complaints new in month (Division)		5	7	4									

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NLG(21)256

DATE OF MEETING	7th December 2021
REPORT FOR	Trust Board (Public)
REPORT FROM	Shaun Stacey, Chief Operating Officer
CONTACT OFFICER	Richard Peasgood, Executive Assistant
SUBJECT	Executive Report - Performance
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
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)	SO 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				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Urgent and Emergency Care

Highlights	Lowlights
• The Urgent Care Service (UCS) went live at SGH on 18th October and is showing the following benefits: ➢ First week of November has average UCS performance at 97.7% against the 4hr target ➢ The waiting room is less crowded ➢ Patients are being seen quicker ➢ Reduction in number of investigations carried out ➢ Positive feedback from patients ➢ Positive feedback from clinicians ➢ Increase in SDEC activity	• UCS at SGH unable to operate 24/7 yet due to lack of primary care workforce overnight and shortage of ENPs • October performance against the 4hr target was 52.9% (DPOWH 45.8%, SGH 55.1%) • 115x 12hr DTA breaches during October (78 at DPOWH and 37 at SGH) due to ongoing challenged patient flow (ED exit block)
• Work is underway to implement the UCS model at DPOWH, linking in with NELCCG urgent GP hub appointments pilot to promote redirection of non-ED patients from streaming	• ED attendances continue to be higher than last year with covid-19 implications and social distancing restricting the physical capacity • Increase in walk-in attendances with non-ED patients due to lack of alternative service availability/accessibility
• ED middle grade rota consultation to commence 1st-30th November with expected implementation in January 2022. New posts already started to be appointed to • New clinical leadership structure introduced for ED and UCS	• Workforce sickness, covid-19 isolation, vacancies, low morale and impacts on staff wellbeing continue to challenge rota fill with reduction of bank/agency pick up • High reliance on agency doctors and nurses to support safe staffing numbers but adds challenge of less experience
• The new ED builds are progressing well with DPOWH expected completion in April 2022 and SGH late 2022. Procurement of clinical equipment and digital strategy being finalised	• Delays in diagnostic imaging at times and in specialty in-reach not meeting the less than 30min attendance to review Emergency Care Standards

Risks

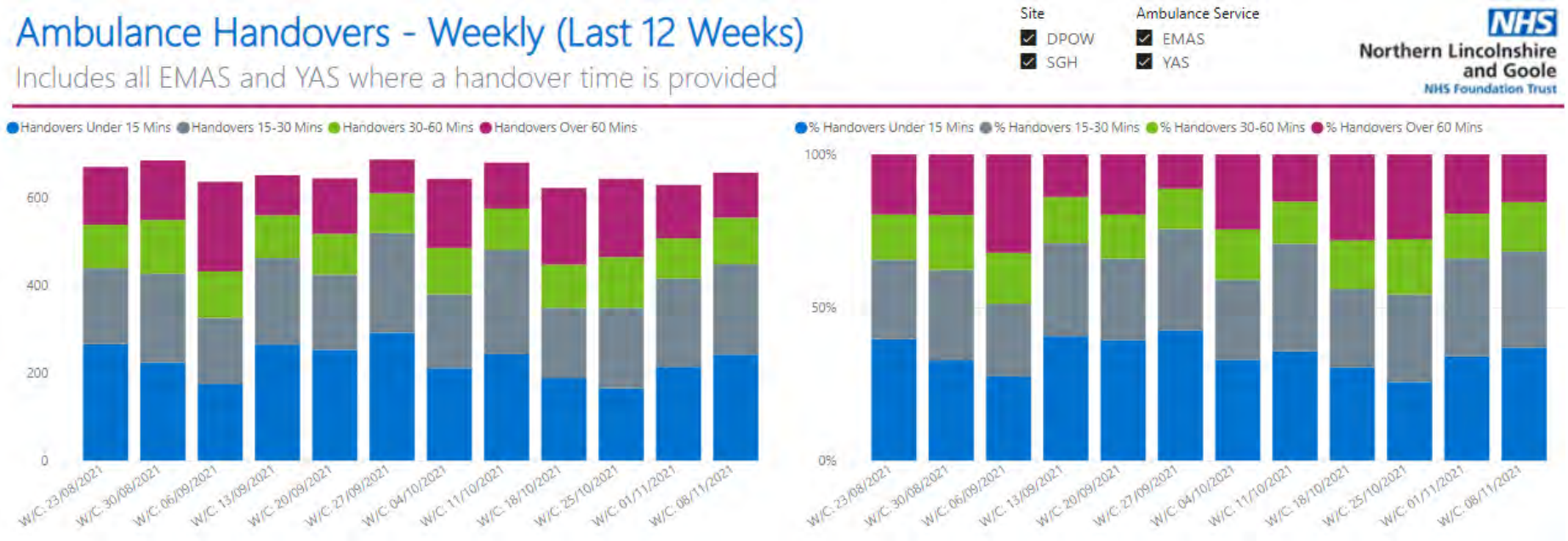
- Shortage in available workforce to meet service needs (skill mix and experience) – Reliance on agency doctors and nurses
- Risk of delays in booking in walk-in patients due to no capacity within ED waiting area to bring more patients into the ED
- Inappropriate attendances and conveyances to ED
- Covid-19 impacting physical capacity within the current ED footprint
- High acuity levels and patients remaining in resus for significant periods of time rather than being stabilised and transferred to a suitable service (ITU/HDU)

Ambulance Handovers

Highlights	Lowlights
• HCV wide ambulance improvement plan in development • Relaunch of 'direct to SDEC' ambulance pathway bypassing ED showing small increase in success referrals • Patient self-handover protocol is compatible with UCS model for patients who meet UCS criteria	• October saw 32% of ambulance handovers completed in under 15mins and 22% taking 60mins+ (DPOWH 294, SGH 345) • Northern Lincolnshire is experiencing highest levels of acuity for EMAS conveyances impacting on resus capacity • Frailty Pathway DPOWH - The SPA service is reporting that this is not being utilised by the ambulance crews. EMAS working on internal promotion of pathway

Risks

- Lack of patient flow through the system is resulting in exit block in ED for patients requiring admission delays in offloading patients from incoming ambulances



Integrated Acute Assessment Unit / SDEC

Highlights	Lowlights
• Newly revised IAAU/SDEC SOP launched during October 2021 to support improved patient flow from ED and the new UCS pathway	• High levels of vacancies exist within the Acute Medicine team while recruitment continues and we are awaiting appointed medical staff to start
• The pathway to access SDEC has changed from a 'refer and accept' model to a 'notify and send' model	• Work is still in progress on developing an IT systems integration solution for SDEC services and community (NHS111/GP/SPA)
• Increased physical capacity within SDEC at both sites from introducing a SDEC additional seating area	
• Patient Flow Improvement Group continues to oversee actions to improve SDEC accessibility and specialty input	• Specialty SDEC capacity and access not sufficient to meet patient demand – Focus on this is part of newly established Patient Flow Improvement Group
• Introduced an additional junior doctor for SDEC at SGH to support the increased activity going into the evening	• Reduced winter funding received for SDEC extended hours compared to amount submitted in bid as required. Review taking place on allocation of received funding between SDEC and UCS requests to identify most beneficial spend to support improved patient flow and patient safety
• FBC for new IAAU refurbishment and implementation of phase 3 of the IAAU workforce plan was submitted to NHSE/I and construction work will commence once the new ED build becomes operational at each site	• Work is still in progress on developing an IT systems integration solution for SDEC services and community (NHS111/GP/SPA)

Risks

- Reliance on sufficient daily discharges to enable flow out of IAAU is required to prevent bottleneck between ED and IAAU
- A lack of sufficient specialty SDEC capacity impacts on the ED workforce, patient waits and crowding in ED
- High vacancy levels in the medical workforce with a risk of burnout for Consultant ACPs working a high number of hours every week

Discharge to Assess (D2A)

Highlights	Lowlights
• The trust still remains at one of the best performing trusts in the north for length of stay. • Long length of Stay reviews now taking place twice a week to support wards and staff. • All wards now have senior consultant presence at board rounds before 10am, work to now focus on the effectiveness of board rounds and ensuring every patient has a plan with an EDD. • 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 • Improvement work taking place with system partners looking at the discharge process as a whole and what elements require further improvement. • Empowered care navigators who feel okay to ask the questions why not home, why not today.	• The Trust's performance for 21 day + currently reported at 10% remains under the national ambition of 12% • Medical and Nurse staffing numbers remain a challenge and this impacts on the overall flow on all sites and the continuation of effective board rounds. • A vast amount of work now needs to take place to improve the effectiveness of board rounds to ensure every patient has a plan, work taking place to ensure board rounds are effective through QI methodology and a PDSA approach • Significant pressures on partner organisations for home care, this has resulted in some discharge delays and more placements to temporary care homes.

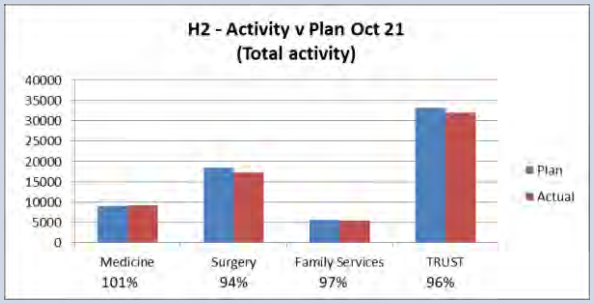
Risks

- 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 by our IT systems
- Significant system capacity issues across northern Lincolnshire resulting in delayed discharges for patients on a discharge to assess pathway

Electives and Cancer

Highlights

- Volume of patients waiting longer than 104 days in Cancer is improving since July 2020.
- The number of RTT 52 week plus waiters has increased to 464 with this number including the mutual aid patients transferred from Hull
- The Trust have now entered into delivery of the H2 plans and performance against plan for month 7 (October) is detailed below:



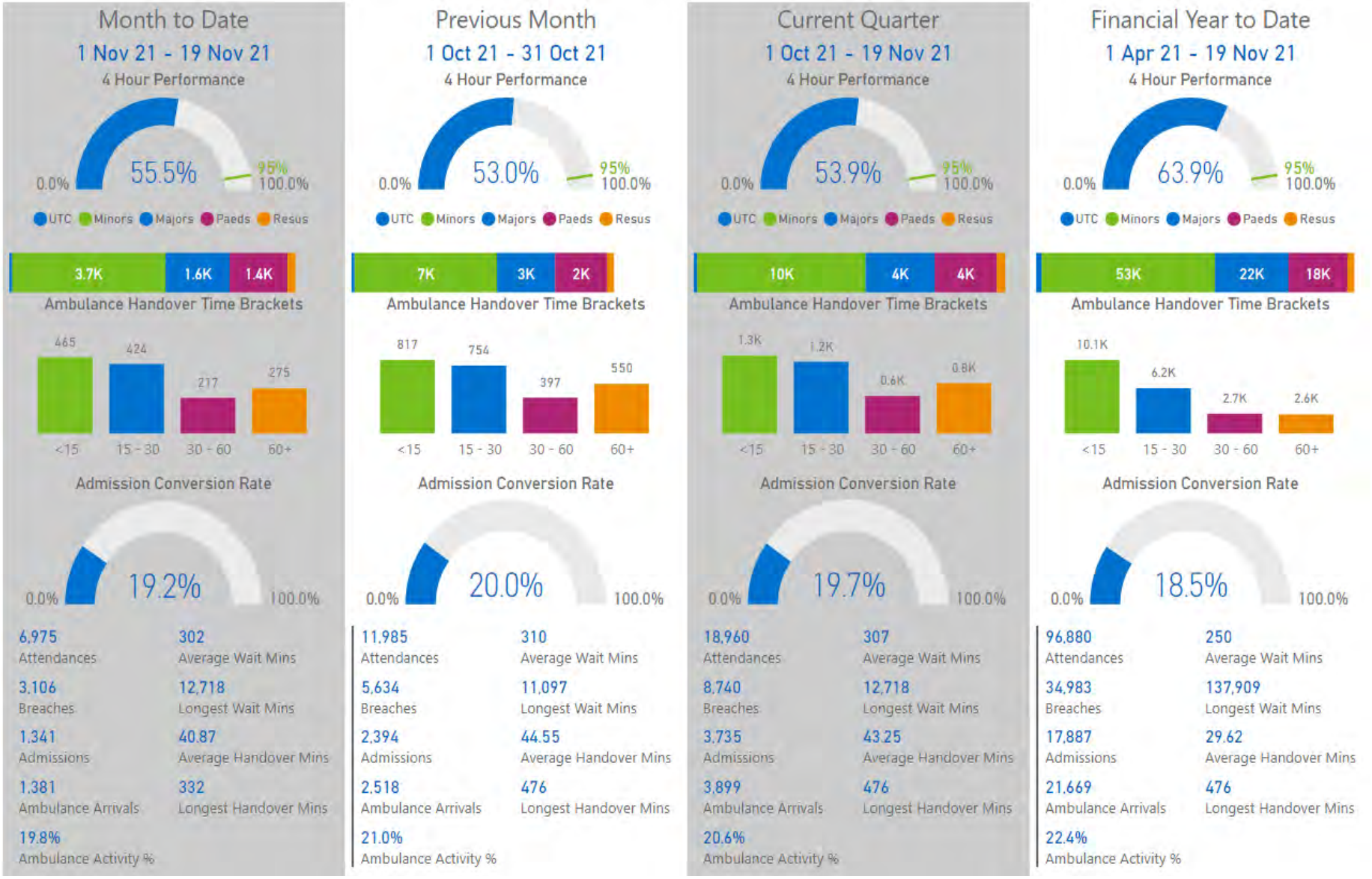
- Independent Sector usage continues to support with agreed H2 plans. In place for St Hughs, Medefer, Medinet and Trent Cliffs.
- Inpatients Live Risk Stratification at 100%

Lowlights

- 15 patients waiting longer than 104 days in Cancer (trust wide – all tumour sites except Breast & Gynaecology (18th November 2021))
- Each specialty is working up plans to deliver their share of the maximum 9,000 Outpatient FU Overdue waiters as at the end of March 2022
- The Trust has not met the target for both new and review out-patients in October.

- Workforce risk around significant vacancy gap
- Workforce risk around carried over annual leave
- Potential future waves of COVID-19
- Capacity to deliver risk stratification for Outpatients
- Challenges to delivery of the elective recovery plan with a current risk to theatre staffing

ED Performance



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DATE OF MEETING	7 December 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Gill Ponder, Chair of Finance & Performance Committee
CONTACT OFFICERS	N/A
SUBJECT	Performance and Estates and Facilities Highlight Report from Committee Meetings on 27 October and 24 November 2021
BACKGROUND DOCUMENT (if any)	Minutes of meeting
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	• A&E 4-hour performance and ambulance delays over 60 minutes had deteriorated. The UCS model was a success. • RTT performance had deteriorated. A requirement to level up across the system would impact on continued recovery. • The Trust continued to be unable to meet the 62-day cancer standard, due mainly to referrals outside the Trust. • NHSE had confirmed Trust EPRR self-assessment assurance rating as 'substantial'. • Assurance on management of LV and HV electrical supply. • Estates infrastructure deep dive confirmed risk score of 20 and need for a plan to mitigate resulting operational risks.

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	SO1 1.2 SO1 1.3 (now realigned to Strategic Development Committee) SO1 1.4 SO1 1.5 SO1 1.6 SO3 3.1 SO3 3.2 SO4 (now realigned to Strategic Development Committee)				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	✓

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	7 December 2021
Report From:	Finance & Performance Committee on 27 October & 24 November 2021

Highlight Report:

- A&E performance and ambulance delays over 60 minutes had deteriorated due to high levels of attendance, workforce issues and difficulty discharging some patients. Ambulance services could stream patients directly to SDEC and 111 were able to book patients into appointment slots in ED's. The frailty pilot at DPOW had been extended as 93% of elderly patients attending SDEC were discharged home that day. A successful UTS at Scunthorpe started on 18-10-21. Experienced clinicians were assessing the needs of 111 referred and walk-in patients and 98% of arrivals were triaged, streamed and treated in less than 4 hours. Plans were in place to extend this service to Grimsby.
- RTT performance had deteriorated due to prioritising long waiting patients. The Trust remained on track to clear 52 week waiters by 31-3-22, but a requirement to level up the system would impact on continued recovery.
- The use of theatres for IPC posed a risk to elective recovery.
- H2 recovery plans had been submitted and feedback was awaited.
- Diagnostics performance had not improved as much as hoped due to prioritising cancer over routine diagnostics.
- 62 day Cancer performance remained a challenge where there was a need for diagnostics or treatment outside the Trust.
- A deep dive report provided assurance on the management of the HV and LV electrical systems. The ED/AAU had included a number of LV upgrades and demolitions of buildings, both of which had reduced the BLM figure. A red rated risk remained as the previous Contractor had failed to keep records of testing completed. A new Contractor had been appointed.
- A deep dive into Estates Infrastructure risk had confirmed the score of 20 and the need for a plan to mitigate the resulting operational risk to services.
- Substantial assurance EPRR self-assessment had been confirmed by NHSE.

Confirm or Challenge of the Board Assurance Framework:

The scheduled Deep Dive into the BAF Strategic Risk– SO1 – 1.3 (The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy) did not take place due to the realignment to the new Strategic Development Committee.

Action Required by the Trust Board:

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)259

DATE OF MEETING	07 December 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)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The report provides an update on highlights and lowlights within the People Directorate and a progress update on key projects. The risks identified are aligned to the People Risk Register and are consistently triangulated. Progress against People Directorate plans are reported to the Workforce Committee.

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)	Links to: Strategic Objective 2 – To be a Good Employer, and Strategic Objective 5 – To Provide Good Leadership				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	

People Directorate November 2021

Highlights	Lowlights	Risks
Workforce Committee A deep dive into Trust wide sickness has been produced and tabled at the committee which outlines an overview of the current and previous sickness levels and trends experienced by the Trust, including risks and mitigation. The committee also received the standard agenda items in line with the programme of work such as the People Strategy Q2 report and the Freedom to Speak Up Q2 report. **People Directorate Restructure** The People Directorate has now concluded across all areas and is now in the implementation phases. **NHS People Plan** A framework has been developed with performance reported through the workforce committee. This is supported by the people related metrics contained within the IPR. **WORKFORCE:** **1st April - Mandatory vaccinations – detailed below** **11th November – Mandatory vaccination in Care Homes** A review of staff required to work in the community linked to Care homes is on-going following the 11th November legislation. 93% are vaccinated or are medically exempt. This equates to 41 staff members out of a group 544 outstanding that the Trust are now entering into formal processes with such as redeployment, where this is possible.		

Trust wide Vacancies As reported through the IPR, trust wide vacancies have reduced in month by 8.57 WTE, with an overall vacancy of 9.41% which remains within control limits. Registered Nurse vacancies decreased by 19 WTE in comparison to the previous period. Medical and Dental vacancies remained stable. Recruitment activity continued across various work streams including recruitment for international nursing, HCAs and AHP's seeing a successful dietetics campaign. Targeted medical campaigns continue in A&E and other high-risk areas.	**Vacancies** Covid continues to make international recruitment difficult due to the closure of borders. Travel guidance has relaxed, however given identification of new covid strains it is likely that travel restrictions will now again increase. Sourcing accommodation remains a concern, particularly family accommodation. Recruitment and accommodation teams continue to work together to explore options however rental accommodation is currently in short supply. **Turnover** Turnover has gradually deteriorated over time since the start of the pandemic in April 2020 to present**.** The latest turnover data point is 9.84% 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%.	**Recruitment -** Failure to recruit to clinical hard to fill posts will result in an increased vacancy rate with increased agency cost and compromised service delivery.
Omicron The Trust are continuing to update staff guidance in line with known national guidance in relation to Covid**.** Currently further advice in relation to travel is being developed but will be comparable with previously issued advice in relation to travel following previous restrictions. **Risk Assessments** – Work continues with risk assessments and is part of the on-boarding process for new starters and is managed by recruitment. Work continues to finalise those outstanding. To date 620 outstanding. There are 620 outstanding 50% of these are for bank staff. HR Business partners are working with divisional and bank management teams to complete outstanding risk assessments.		

AFC Panel Process The new AFC evaluation process is now in place with agreement from our Trade Union partners. The Trust has identified a wider cohort of panel members that will enable greater availability however this will not take place until Feb 22 with the national team. There is still a backlog of jobs requiring matching and consistency checking but this is now reducing following the introduction of the new process. To mitigate any risk in terms of delays, the Trust is also now working with Doncaster, Lincoln and Humber Trusts.		**AFC –** High levels of outstanding job matching workload although now reducing with the new processes in place. 53 jobs pending matching, 41 matched, awaiting consistency checking
Sickness Absence - Over the last 3 months the sickness rates have slowly increased to 6.4% as of September 2021 from 5.74% in July 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 forward. Short term sickness is being driven by gastrointestinal problems and influenza (covid inclusive). Daily monitoring has recommenced with ICC and Infection Control lead to monitor specifically covid absences. A sickness absence deep dive was presented to the workforce committee.		**Sickness –** Levels of sickness have increased and are likely to continue do so in the winter months causing workforce pressures
Trade Union Partnership The Trust is currently focused on reviewing facility time with TU's and a temporary interim proposal has been submitted to them to increase RCN facilities time. This involves a review of current agreed time against demand. The Trust has an ambitious workforce plan that is been driven by the people strategy, much of this activity will require TU engagement.		
COVID Booster/FLU Campaign / Mandatory Vaccination – The Covid booster campaign has been running throughout October and November seeing hub closures at the end of November due to low uptake following a period of high engagement. The project is currently under evaluation in line with the proposed mandatory vaccination legislation that is potentially coming into place as		**Mandatory Vaccination –** The potential introduction of the April 1st legislation requiring a 1st & 2nd Covid

of the 1st April 2022. Staff are currently being directed towards community provision for 1st, 2nd, and the booster vaccination. The flu vaccination programme is continuing to be delivered via the peer vaccinator networks across the Trust. **% staff vaccinated (where we are aware):** Flu: 54.57% Covid 1&2nd: 68.7% Covid booster of those already vaccinated: 50.01% **CULTURE** **Equality Diversity and Inclusion** Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Data – These two reports have been approved at Trust Management Board and Trust Board. As contractually required the findings have been shared with NHS England and the reports have been published on our external website. A new Trust Diversity Calendar has been published to showcase and promote key events. The October version promoted Black History Month and we held a number of drop-in sessions / engagement events during October to celebrate the benefits diversity brings to our Trust. Additionally, we shared the nationally recognised 'History Teacher' children's diversity book with our staff, which was kindly commissioned and donated by the Trade Union Unison. The November and December calendar has been published and this is promoting Disability History Month and some further events are being planned. As part of the Trust Board development day on the 2 November an Equality, Diversity, and Inclusion (EDI) presentation was delivered to update the Trust Board on their EDI responsibilities and to gain their support going forward with this growing agenda. The session was well received. **Long Service Awards** the OD team is planning for spring/summer 2022 LSA and Stars Award events; held over due to the pandemic.	**Staffing** Recruitment to address resource constraints in Leadership, Culture & OD continues. Appointment of ODBP-Leadership confirmed; Interim Head of ETD appointed; ODBP-Engagement back following extended absence **Culture** – We are considering conducting focus groups post-NSS survey to further support what might be a low NSS Response Rate this year, to further understand the primary engagement factors affecting staff engagement levels; current business planning review of resources required to deliver Culture & Leadership initiatives	vaccination for staff undertaking regulated activity to disrupt service delivery should staff not receive the vaccination in time

Culture & Engagement Transformation Programme Further socialisation of the programme was shared at a 2nd Nov Board Development session, and well received. The next steps are to confirm Terms of Reference, memberships, and reporting data for this to be approved through TMB. The People Pulse Survey is next scheduled for Dec 2021. The National Staff Survey has now closed, and our response rate is approx. 36% similar to 2020. We will await the final outcomes and information from the staff survey will feed into the Culture Transformation Board. **Health & Wellbeing** – , Health & Wellbeing Business Partner in post, and has completed **a** First Look audit of all HWB initiatives and developed an initial skeleton plan to identify immediate priorities to address staff HWB during winter pressures; and secondary and tertiary priorities to be addressed medium to longer term. NHSE/I Trailblazer Pilot has begun and running until March 2022, a project plan with seven distinct workstreams has been developed to support the pilot's delivery and has been socialised at the HWB Working Group. LCOD staff members are also engaging with the NHSE/I's Regional COP to share learning and best practice and receive support on any challenges. On site counselling soon to be available one day a week at Grimsby and one day a week at Scunthorpe, with additional counselling provision across 3 sites to be secured through repurposing NHSEI monies. A new approach is being trialled with Remploy to support staff who are experiencing stress or mental health issues which are impacting upon their work, with a virtual clinic taking place on 1st December, after which success will be measured and a schedule of bi-monthly clinics planned if staff are keen to engage. HWB Steering Group is currently being refreshed and additional membership included to lead on HWB strategy and support the delivery of the Trailblazer Pilot. Revised TOR's have been presented as an initial draft to the group and are currently being finalised.		**Health and Wellbeing –** ICS monies would potentially need to be returned if they cannot be spent by the end of the financial year**.**

LEADERSHIP **Mandatory training and appraisal –**Core mandatory training is currently 92% for the Trust, role specific 80% and PADR 80%, there has been a slight drop in compliance due to the August intake of Medical Staff being included in the reports for the first time. 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. **Apprenticeships** – The total number of apprenticeships ongoing in the Trust is currently 295 learners and 9 new starts between August – October 2021. Focussed work is ongoing with apprenticeship providers to enhance the understanding of apprenticeships to attract larger cohorts and working with departments to support current workforce initiatives. **Leadership development** - A Leadership Development Programme for all leaders, refreshing the Trust Values and supporting the Culture and Engagement Transformation Programme is in draft form and will be part of a wider Culture and Leadership strategy and business planning proposal for resourcing and agreement of timeframes for delivery of an integrated leadership and core people skills development programme. **Executive Development** - A series of executive development sessions will be mapped to support the Culture & Engagement Transformation Programme.	**Annual Appraisal** – not compliant with Trust target- currently 80% against a target of 85%. **Mandatory Training** –. Currently achieving 92% against a target of 90% for core mandatory training and 80% against a target of 85%for role specific mandatory training- remains on People risk register until consistently achieving. The Trust does not currently meet its public sector requirements of 2.3% of the organisation headcount for new apprenticeship starts.	**Mandatory Training and Appraisal** – Due to the current capacity issues in staffing, staff are not being released for training some training has been stood down due to low demand, resulting in training compliance will not progress. The ability to fully utilise the apprenticeship levy without increased activity to recruit to vacancies.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)260

DATE OF MEETING	07 December 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	There were no matters escalated from the November 30th Committee meeting, and no recommended changes to the BAF for the Board to consider. The Committee received a positive update from the Medical Director on the actions being undertaken to improve the working experience of training doctors in the Trust. The Committee were assured by the direction and progress being made on Leadership development within the Trust, although noting the long-term nature of this work. There was a focussed item on CQC performance indicators with the CQC lead and the workforce performance team and new report. The Committee was encouraged by the available data now being shared with the divisions and the targeted support to improve important workforce indicators. The Committee welcomed the deep dive into sickness absence data and how it was increasingly being used to target prevention, support and self-help initiatives. The Committee had an initial discussion on the proposed compulsory vaccination of staff against Covid and noted the project arrangements that were being put in place.

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 for 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:	07 December 2021
Report From:	Michael Whitworth, NED & Chair of Workforce Committee
Highlight Report: Workforce Committee – 30 November 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 a positive update from the Medical Director on the actions being undertaken to improve the working experience of training doctors in the Trust following the annual report being discussed at the September Committee.

2.2 The Committee were assured by the direction and progress being made on Leadership development within the Trust. Although the long-term nature of this work was noted, the practical steps being taken now around core skills, and coaching and mentoring were very assuring. A deep dive will be undertaken in the new year to monitor progress following further discussion and agreement at Executive level and Trust Management Board.

2.3 There was a focussed item on CQC performance indicators with the CQC lead and the new workforce performance report. Progress will continue to be closely monitored, particularity in areas such as levels of PADR undertaken when there has been an history of under-achievement. The Committee was encouraged by the available data now being shared with the divisions and the targeted support to improve workforce standards indicators.

2.4 The Committee had an initial discussion on the proposed compulsory vaccination of staff against Covid and noted the project arrangements and resources that were being put in place.

3 Items for Committee Ratification and Assurance

3.1 There were no specific matters for ratification presented to the November Committee meeting.

3.2 The Committee welcomed the deep dive into sickness absence data and how it was increasingly being used to target prevention, support and self-help initiatives, and was assured by the progress made.

Confirm or Challenge of the Board Assurance Framework:
No changes to the Board Assurance Framework were recommended.
Action Required by the Trust Board:
The Board is asked to receive and note the content of this highlight report.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)261

DATE OF MEETING	07 December 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 Q2 (July-September 2021)
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Workforce Committee on 30 November 2021
EXECUTIVE SUMMARY	The FTSU Guardian Q2 2021 Report gives an update from the last Trust Board report, an overview of the number of concerns raised, national and regional updates and the proactive work undertaken by the Trust's FTSU Guardian.

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)	Strategic Objective 2 - To be a good employer				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
				✓	

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Q2– July – September 2021

Liz Houchin
8th November 2021

Contents

1. Executive Summary

1.1 This paper provides an update regarding NLaG activity for Q2 2021-22 (which covers the period July –September 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 Q2 2021-22 the number of concerns received was 40. 1 concern was raised anonymously in Q2

4.2 The Q2 figure of 40 is the same as Q2 2020-21.

4.3 The main themes raised were around behaviours, process and worker safety. The high number of concerns relating to behaviours may still be an indication of the impact of the pandemic, staff being exhausted and burnt out. It may also be as a result of Trust Communications highlighting that behaviours that do not live our Trust values are unacceptable.

Model Hospital data indicates that in Q1 2021-22 the number of patient safety cases recorded for the Trust was 7, which is higher than the national average of 2. These concerns related to staffing levels and concern that these were impacting on patient safety. The number of concerns where Bullying & Harassment was indicated during Q1 was 8, the national average for this period was 4.

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

4.5 FTSU Guardian continues to produce quarterly reports for all divisions to ensure that the FTSU information is used to triangulate with other data ie HR information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified and interventions put in place where needed.

Q1. 2021-2022 (April-June 2021)			**Q2. 2021-2022 (July-September 2021)**
Concerns	**33**		**40**
Themes	Behaviour / relationships	21	22
	Bullying & Harassment	9	3
	Culture	2	1
	Leadership	0	0
	Patient Safety	7	9
	Process/Systems	10	14
	Personal Grievance	1	1
	Worker Safety	10	16
	Staff Safety	4	2
How Raised	Openly	12	19
	Confidentially	21	20
	Anonymously	0	1
Perceived detriment		1	0

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

Report Breakdown by Division and Role.

Q1. 2021-2022(April-June 2021)			Q2. 2021-2022 (July-September 2021)		
Role	**Division**	**Number**	**Role**	**Division**	**Number**
Doctor	2 x Medicine 1 x S&CC 1 x Med Director	4	Doctor	1 x Medicine 1 x S&CC	2
Nurse	6 x Medicine 2 x S&CC 4 x W&C 2 x Chief Nurse 1 x CSS	15	Nurse	2 x POE 3 x Chief Nurse 2 x S&CC 3 x Medicine 1 x C&T	11
HCA	2 x Medicine 1 x S&CC 1 x C&T	4	HCA	1 x POE 4 x Medicine 1 x S&CC	6
Midwife	W&C	1	Midwife	2 x W & C	2
Admin	2 x Medicine 1 x Medical Director 2 x CSS 1 x Corporate	6	Admin	2 x POE 1 x Chief Nurse 1 x Medicine 2 x S&CC 1 x Digital Services	10

				1 x Trust Secretary 1 x Finance 1 x Medical Director	
AHP		0	AHP	1 x C&T 1 x Medicine 1 x S&CC	3
Other	CSS x 2 C&T x 1	3	Other	3 x E&F 1 x C&T 1 x CSS 1 x Medical Director	6

4.6 FTSUG Feedback /Evaluations received:

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback has been provided by staff that have spoken up and has been predominantly positive. In Q2 all staff who completed the feedback said that they would speak up again.

Quarter 2021-22	Feedback received	Would you speak up again? Yes
Q1	9	8
Q2	15	15
Q3		
Q4		

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

Liz was incredibly supportive and kept me informed and advised on the process that needed taking, she also chased matters tactfully when we had heard nothing etc. She has generally been absolutely amazing, and I felt safe

having her support. Thank you Liz, I think I would have struggled to see this through without your support and bad behaviours might then have been allowed to continue affecting others. It is so good to have you in role to support us in our moments of need.

Was handled exceptionally well and felt thoroughly supported throughout the process.

I am confident that this approach to addressing issues is appropriate and maintains confidentiality when required. It is not an easy option to speak up but I would encourage others to do so if they felt that they had exhausted all options. Everything has been professionally addressed and thank you Liz for your compassionate and sensitive approach

4.7 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

FTSUG was contacted by a Trainee Doctor citing Bullying & Harassment behaviours by the Trainer. FTSUG contacted the GP Lead trainer to inform them of the allegations. The Training School completed an investigation; the investigation concluded there was a significant mismatch in the expectations and communication between the trainer and trainee which led to a breakdown in the relationship. Issues with the practice timetable were also highlighted and learning points shared with all parties. The FTSUG supported the trainee throughout the process. The trainee wanted to ensure that future trainees had a more positive experience at the practice and felt this outcome had been achieved by the end of the process.

5. Regional and National Information and Data

5.1.1 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. Q1 Data for 2021-22 has not been released yet.

.

The National Guardian Freedom To Speak Up policy is being reviewed, Guardians have been asked for comments to be submitted regionally by 31st October 2021

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. There may be some delay to publication due to recruitment of new National Guardian.

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.

The NHS Staff survey has undergone significant changes in line with the NHS People Plan. As a result, some of the questions which comprised the FTSU Index have been dropped and therefore the NGO will no longer be publishing the FTSU Index.

Q2 data for 2021-22 has been submitted to the NGO by the Guardian.

The National Guardian Annual survey has been released, FTSUG has completed this. It is an anonymous survey, information collected will be used by the NGO to guide future development of the Guardian role and how the NGO supports Guardians.

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. Recent meetings have included a presentation by the GMC regional Liaison Officer about confidentiality and documentation. There have also been discussions about the Civility & Respect Toolkit and if organisations are using this, and how effective it is.

6. Proactive work of the FTSUG during Q2

- Monthly 1 to 1’s with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly ‘buddy’ calls
- Attendance at Network Meetings
- Attendance at Doctor’s Induction and Overseas Nurse Inductions
- Board Development Session completed
- Attendance at Regional Guardian meeting
- Walk round with Trust Chair at DPOW
- Attendance at Chaplaincy Team meeting
- Meeting with SID
- Attendance at Culture Task & Finish Group
- Publication of NLaG Case study by the NGO as part of the 100 Voices Campaign
- Trust shortlisted for HSJ ‘Speaking Up’ Organisation of the year for the BAME Covid-19 Response

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 – Comms plan developed for October national 'Speak Up' month
- 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 Trust Board is asked to:

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

Compiled By: Liz Houchin,
Date: 8th November 2021

NLG(21)262

DATE OF MEETING	07 December 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Christine Brereton – Director of People
CONTACT OFFICER	Christine Brereton – Director of People
SUBJECT	Overview on NHSE/I future of HR and OD Development
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The attached report and presentation were produced and released on Monday 22nd November by the national People Directorate and Chief People Officer, Prerana Issar. The report sets out and clearly articulates the NHSI/E People Directorates shared vision for the first time and sets out how our people ambitions can be realised. NHS Trusts are asked to share the contents of the report with Board and leaders across the Trust to establish how the actions whether locally, through ICS, regions and other collaborations can be achieved. The national report has been co-created with leaders nationally to tackle real issues and opportunities to enhance patient care and staff experience. The aim of the report is to create a baseline for people services across the NHS and understand what people professionals must do to maximise their collective contribution and fully implement the People Plan and People Promise. Underpinning the report is three things: • Increase the focus of people services on organisational development and workforce transformation • Improve transactional HR and OD services by simplifying, digitising, and working at scale • Enhance the development of the People profession The vision is structured around eight clear themes, each with a set of recommendations designed to enable delivery and provide a clear call to action for national, system and provider people teams across the NHS. This will lead to a more resilient,

	flexible, and sustainable service, attracting people who want to join, remain, and develop with the NHS, and facilitating high quality care for our patients and communities. The report is shared with the Board for information at this stage given it has only just been released. Work will now be undertaken by the People Director and team to align actions in the report to ongoing work to deliver the Trust's People Strategy • understand how the actions can be delivered either locally, through collaboration with neighbouring Trusts and where specifically identified through working with the newly developing ICS (and the ICS People Strategy to be launched on 9th December) • develop any key metrics to identify and demonstrate how the actions can be achieved. • How we can share the expected actions with our leaders and staff Once the report and its recommendations have been fully digested a further report will be submitted through the Workforce Committee and Trust Board on the proposed actions and outcomes.

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			

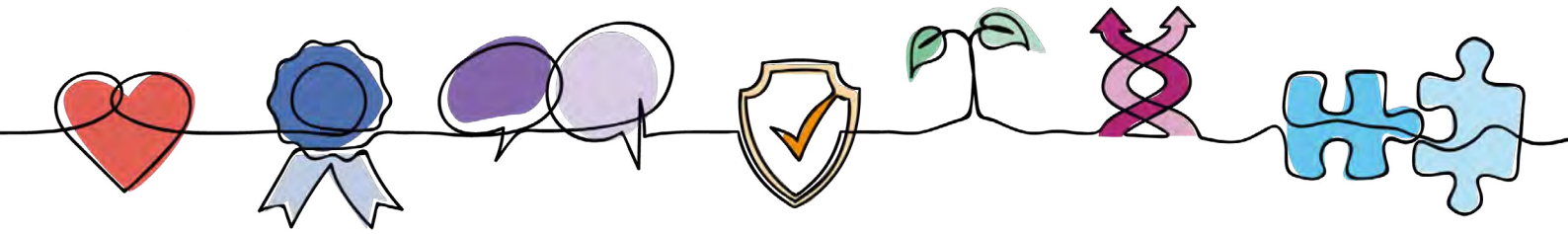
BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Links to: Strategic Objective 2 – To be a Good Employer, and				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Classification: Official
Publications approval reference: PAR659

The future of NHS human resources and organisational development

Prerana Issar, Chief People Officer

22 November 2021



Acknowledgments

We would like to thank the members of the people profession and our stakeholders who brought their knowledge, skills and experience to the conversation. Their voices were essential in developing a vision that is grounded in their aspirations to address the key issues and opportunities facing the profession.

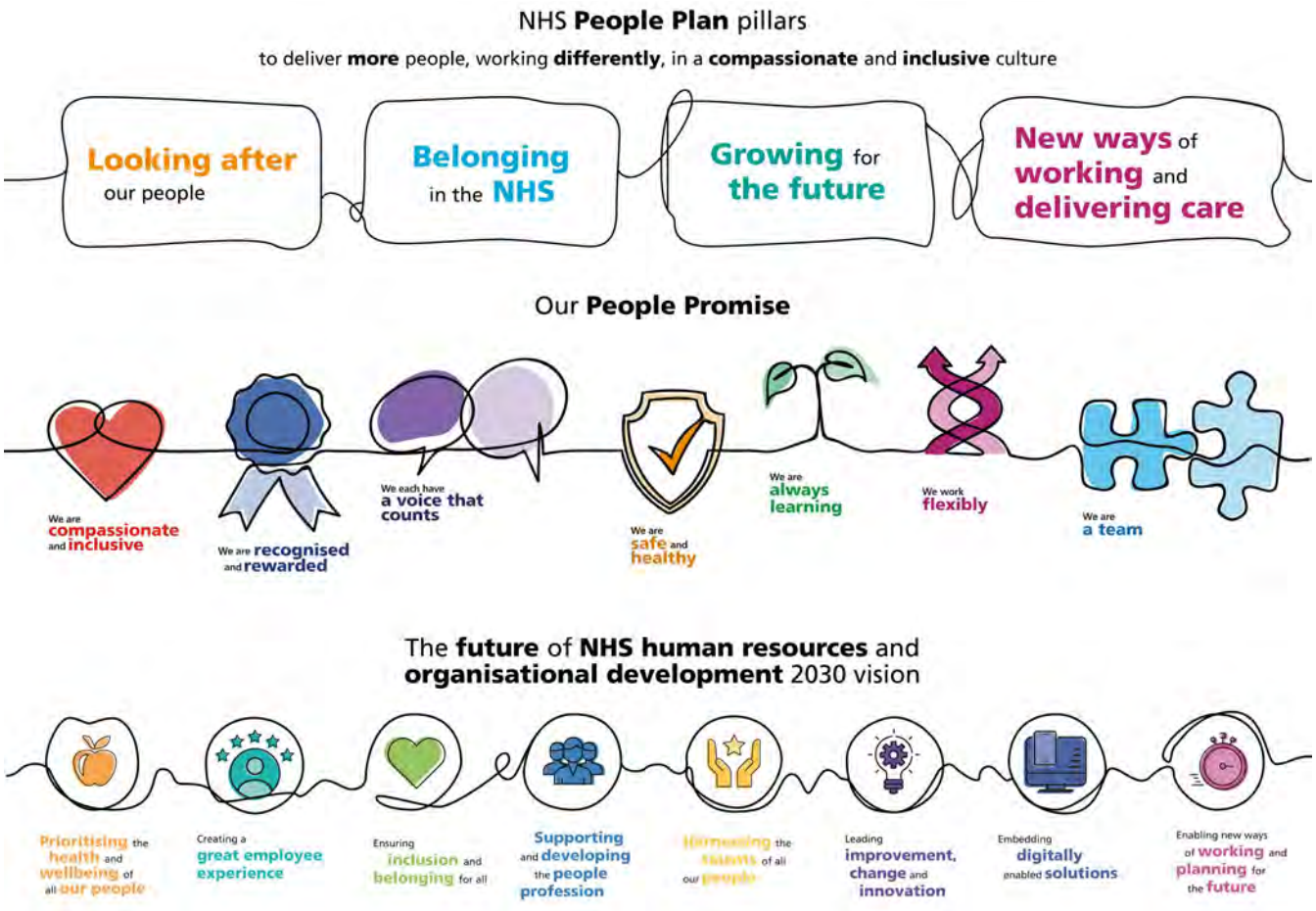
Thanks are also due to the partners that supported this work: Lancaster University Management School, the Chartered Institute of Personnel and Development (CIPD), EY and Clever Together.

We are grateful to members of our three advisory groups: chief executives, heads of profession, and directors of human resources or chief people officers. We also thank the Department of Health and Social Care (DHSC), Health Education England (HEE), NHSX, Social Partnership Forum (SPF), NHS Employers, Healthcare People Management Association (HPMA) and the CIPD for their input via the programme's steering committee.

The People Plan, the People Promise and the future of NHS human resources and organisational development

The future of NHS human resources and organisational development report outlines a vision and actions that support the delivery of the four pillars of We are NHS: People Plan for 2020/2021 – action for us all and embeds the seven elements of our People Promise.

The future of NHS human resources and organisational development vision for 2030 has eight themes which are referenced throughout the report. Chapter 3 provides detail on these eight vision statements.



Contents

Foreword

The NHS touches all of our lives at times of basic human need when care and compassion are what matter most. At the very heart of this compassion is our fantastic workforce. Made up of a rich community of professions, experiences and backgrounds, our people truly are our most precious asset.

People professionals – those who lead on all aspects of the people agenda – play a huge part in making the NHS the vibrant, resourceful organisation it is today, and will continue to influence how it will develop in the future.

This report was co-created by those most impacted by our work: NHS staff and their representatives, leaders and members of the people profession itself. It sets out the vision for how the people profession will continue to maximise our collective contribution to the NHS and meet the needs of staff, patients and local communities over the coming decade and beyond – building a brighter future for all.

Underpinning this vision is a shared commitment to enhance capabilities across the profession, to increase our level of intentional collaboration, beyond traditional teams or organisational boundaries and to use our collective resources to make significant progress on the key issues of our day and those we can predict for the future.

At its heart are the ambitions of the NHS People Plan and People Promise, to help support the delivery of the NHS Long Term Plan.

All of this will add up to a more resilient, flexible and sustainable service, attracting people who want to join the NHS, supporting people to remain and develop in the NHS, and facilitating high quality care for our communities.

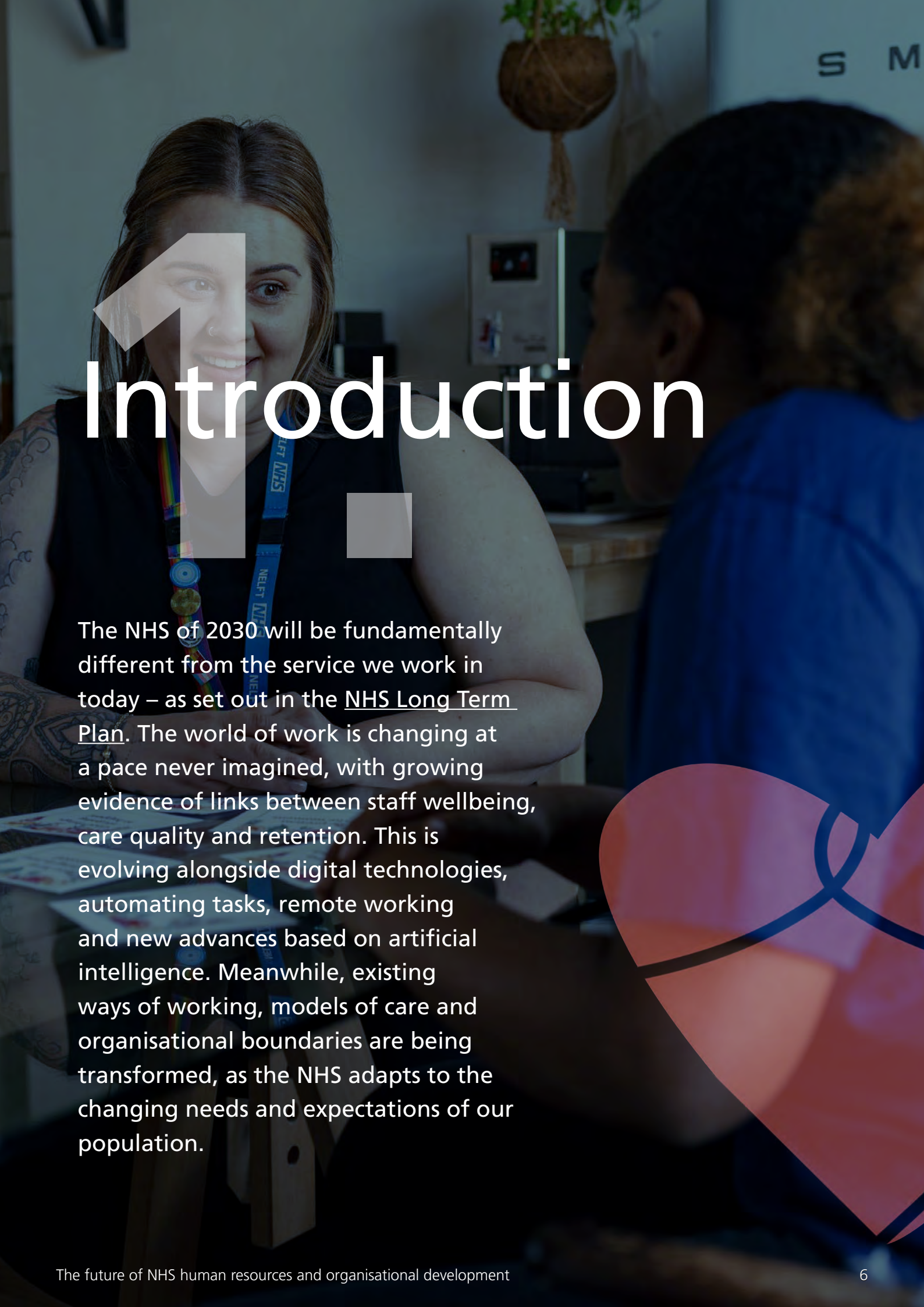
The pandemic has placed demands on everyone in our NHS, and these are still being felt. But it has also highlighted our many strengths, including an astonishing flexibility in responding to changing needs and expectations. All 16,000 members of our people profession have much to be proud of – they have demonstrated a commitment that has never been stronger and a value to the NHS that has never been clearer.

I have every confidence that the people profession will rise to the challenge set out in this plan and will use its expertise to help the NHS thrive in the years to come. I would greatly appreciate the ongoing efforts of all our people professionals and leaders to get behind our collective vision – and the actions set out in this report – to make it our reality, in service of people professionals, our wider workforce and, of course, patients and local communities.

Best wishes,

Prerana Issar

NHS Chief People Officer



1. Introduction

The NHS of 2030 will be fundamentally different from the service we work in today – as set out in the NHS Long Term Plan. The world of work is changing at a pace never imagined, with growing evidence of links between staff wellbeing, care quality and retention. This is evolving alongside digital technologies, automating tasks, remote working and new advances based on artificial intelligence. Meanwhile, existing ways of working, models of care and organisational boundaries are being transformed, as the NHS adapts to the changing needs and expectations of our population.

If the NHS is to meet the challenges ahead, the people profession, which comprises human resources and organisational development practitioners, has a key role to play in shaping the future. This includes steering organisations towards the vision set out within the People Plan: more people, working differently, in a compassionate and inclusive culture.

The Government recently announced that additional funding will be invested in the NHS over the next three years, funded by a new Health and Social Care Levy and a rise in dividend tax. The people profession – working alongside other decision-makers in the NHS – will have a key role in optimising available resources and maximising the value of taxpayer investment, to support recovery of routine services, to tackle waiting lists, and to deliver the care that NHS patients need.

This report sets out a vision for how the people profession will develop and work differently over the coming decade. It draws on the diversity of voices from across the profession and beyond. It also sets out a roadmap for action.

A position of strength

The profession is starting from a position of strength. Especially in the past year, the value of NHS people professionals, and their skills, have shone through. The current approach is effective for today's ways of working. But the NHS of 2030 will need something new. This will mean changing the way people professionals and managers, throughout the service support our people.

Meeting the challenges and opportunities of work and healthcare in 2030 will involve working beyond existing organisational boundaries, overcoming barriers and transforming roles. This will mean spreading innovative practice and ensuring widespread adoption, to create a consistently compassionate, inclusive, values-driven culture. This will be fundamental to the NHS that we all want to see, and be part of, in 2030. The people profession must be at the forefront of this change, leading and supporting this transition. To do this, the profession itself needs far-reaching transformation too.

This transformation involves building on what the profession does best today, through managing and developing people, while building new systems and processes to deliver desired health outcomes – all the while, ensuring our people feel valued and supported. Meeting these future challenges places an increasing importance on the people profession to help leaders move forward, ensuring the very best health outcomes for all.

What is the people profession?

This report uses the term **the people profession** to refer to people at every level across the NHS, including human resources (HR), organisational development (OD) and workforce departments, who alongside managers and trade unions contribute to and improve our NHS people's working experiences.

The vision refers to the people who work in the profession as **people professionals** and refers to the services that they deliver as **people services**.

The report also uses the term **customers** to refer to all our people who interact with, and benefit from, people services – whether directly or indirectly. This includes leaders, line managers and people more broadly who are supported by people professionals.

2 Evolving to meet a changing world

The need for change is set against a backdrop of rapid and widespread change transition across health and care services, and in working lives more generally – especially in three key areas:

- **Integrated care**: The introduction of integrated care systems (ICSs) heralds not just new structures but a new emphasis of openness to working alongside others, ensuring collaboration rather than competition. There will also be increased opportunities to scale up what works, sharing learning and resources. This will include extending people-service support to areas of the health service that have had little access in the past, such as primary care.
- **The nature of healthcare**: The way healthcare is accessed and provided is changing, with new technologies advancing communication and interventions. Our people need to be supported to adapt to these new ways of working.
- **The nature of work**: Ways of working are changing beyond healthcare, too, with major transformation in the nature of work and what people expect from their employment. People want flexible arrangements that enable them to balance their job with other parts of their life. The pandemic accelerated the move towards novel approaches to care and remote working and many of these changes are here to stay.

Trends in healthcare and work

The trends affecting the nature of healthcare form an important context for how people services need to evolve in the coming years. The people profession will need to support the health and care service as it evolves, to meet a number of challenges. For example:

- There is a rising demand for health services due to an ageing population with increasingly complex healthcare needs. People are living longer and, as they age, their healthcare needs change. The number of people living with long-term conditions is set to increase, with more individuals managing multiple conditions.
- Workforce supply challenges are expected to continue as demand rises. For the past decade, workforce growth has not kept up with the increasing demands on the NHS.
- Significant inequalities in life expectancy are likely to persist. These are linked to deep-rooted inequalities in how care is accessed, further perpetuating unequal outcomes for our patients. The COVID-19 pandemic has caused life expectancy to fall, and has further increased inequalities in mortality and the number of years lived in good health across the population.
- Health and care will need to be more joined up and co-ordinated, to provide an integrated approach that supports the whole person. To support the growing number of people with long-term conditions, the NHS will need to focus on breaking down traditional barriers between care organisations, teams and funding streams, rather than viewing each encounter with the health service as a single, unconnected episode of care.
- The role of the patient is likely to change, with more wanting support for self-care and prevention, and greater personalisation, so that their care focuses on the things that really matter to them. Individual preferences on type and location of care differ quite widely. With the right support, people of all ages can – and want to – take more control of how they manage their physical and mental wellbeing.
- Continued technological and scientific innovation is likely to change the nature of care and how it is delivered – including enabling care to be more personalised. This includes several key areas:
  - Technology is helping health and care professionals communicate better and enable people to access the care they need quickly and easily when it suits them. For example, devices and apps can support remote monitoring for patients.

- The increasing use of remote phone and video consultations is likely to continue, offering new and flexible ways for clinicians and patients to manage care and treatment together.
- The ability of artificial intelligence (AI) to analyse large quantities of complex information has the potential to make a significant difference in health and care settings, including speeding up the detection of diseases.
- Continued scientific innovation, including through increased understanding and use of genomics, will enable faster and more accurate diagnoses for inherited and acquired diseases, which can lead to personalised and effective treatments and interventions.

- **There is a continuing need to take a proactive and preventative approach to health.** This includes using population health management as a way of targeting prevention activity, to better support people to stay healthy and reduce health inequalities across entire populations.

Alongside this, the NHS and the people profession need to respond to the changing nature of work, including people's expectations from their employment. Key trends, identified by external partners based on academic research and international trends, include:

- **Demographics within the workforce are changing.** Working lives are lengthening as the UK population ages. As the UK state pension age rises, more older people will be in employment. By 2030, the number of economically active people aged 65 and over is projected to increase by one third. The UK is also now seeing emergence of a four-generational workforce (baby boomers, generation X, millennials and the first of generation Z).
- **There is more competition for the workforce.** The UK faces a labour shortage, linked to the ageing population, which results in more people leaving the jobs market than entering it. Alongside this, demand for health and care services is growing, also due to the ageing population, so a larger workforce will be needed. For example, Skills for Care has calculated that if the adult social care workforce grows proportionally to the projected number of people aged 65 and over in the population, the number of adult social care jobs will need to increase by 29% (480,000 jobs) – to around 2.16 million jobs by 2035.

There is likely to be increased global demand, too, with expectations that the expansion of global economic activity will increase the demand for educated labour. For example, the World Health Organization has stated that six million more nurses will be needed by 2030 to deliver the higher standards of healthcare needed once the COVID-19 pandemic has passed. Most will be needed in middle- and low-income nations, but it notes that some developed nations will require more, as those currently working in the profession grow older.

- **People's expectations of work are changing.** What people value in a job is changing. People increasingly want 'good work' (a term used in the Taylor review referring to meaningful work where people have autonomy, feel their work makes a contribution and feel listened to). They also want to be able to balance their work more easily with other areas of their lives. These factors may become as important to individuals as levels of pay, reward and potential for career progression.
- **There is an increase in non-linear careers rather than 'careers for life'.** People are continuing to work later in life. This shift is likely to lead to people having more stages in their career and perhaps making changes to new sectors or having 'portfolio careers', where they work in more than one area simultaneously. This, in turn, may lead to higher expectations of employers to make it easier for people to move in and out of roles, to create more opportunities for non-linear progression, and to show that it is still possible to work in health and care in the longer term while still enjoying a career that encompasses different roles and areas.
- **Technological change is likely to reshape job and skills demands.** As technology moves forwards, jobs are more likely to need technology skills. Advances in technology are likely to take over routine, repetitive tasks, allowing workers to reallocate their time to higher-productivity tasks that machines cannot do. This means that many roles will be reconfigured, rather than eliminated, and most occupations will need to reshape job roles. Technology can also free up opportunities for individuals, including providing greater flexibility in where and how they work.
- **A continuous and agile approach to development and training is needed to keep pace with innovation and changing expectations.** This may include the need for a more flexible training offer (such as modular training, apprenticeships or 'earn while you learn' approaches), as well as increasing training in new areas, such as digital.
- **More is expected of employers on issues of inequalities and social justice.** Organisations, particularly public sector organisations, will be expected to lead the way in tackling injustice and inequalities and demonstrably provide equal opportunities for all. Citizens also expect greater efforts to address climate change, with employers expected to play their part as well government and individuals.

By changing the way we work, the NHS and care partners have a chance to genuinely improve the lives of local populations. We can reach into our communities and reduce inequality, acting as 'anchor institutions' or 'anchor networks'. Read more about how the NHS can use these strategies to build a healthy, sustainable post-COVID-19 recovery.

- **These changes will affect not only the way the people profession needs to lead and act, but how the whole health and care system will deliver.** Managers across the sector and at every level will need to play their part, to respond to these changes and use them as an opportunity to transform the experience that our people have at work.

3 The vision for the future of the people profession

This report sets out a vision of where the profession wants to get to by 2030 so it can play its unique part in supporting the health and care system to provide what our patients and citizens will need.

This vision has been co-created through crowdsourcing and networking by the people who are most impacted by people services: staff, leaders and members of the people profession itself.

Photo captured at Do OD Conference 2020

The vision begins with themes that focus on how the profession itself will evolve over time. It then sets out wider, strategic themes where the people profession needs to focus to support the rest of the system.

The vision is aimed at people professionals, wider leaders and champions of people issues at all levels across the NHS, but especially the senior leaders of organisations, systems and regional and national bodies.

Prioritising the **health** and **wellbeing** of all **our people**

We take a positive and proactive approach in supporting the health, safety and wellbeing of our NHS people, ensuring that work has a positive impact. We address health inequalities at work and in our communities.

Creating a **great employee experience**

We understand the diverse needs, expectations and experiences of our NHS people, and use that insight to tailor our people services. We attract and retain people in health and care, creating a positive impact on our communities.

Ensuring **inclusion** and **belonging** for all

We use our expertise and influence to create an inclusive culture, which values and celebrates our diversity. We listen to our people and take action to ensure there is equity for everyone.

Supporting and **developing** the **people profession**

We support everyone working in the people profession to be their very best and reach their full potential. Together we provide outstanding people practices.

Harnessing the **talents** of all our **people**

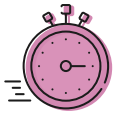
We help all our people to fulfil their ambition and potential. We build strong leadership and management capability at all levels.

Leading **improvement, change** and **innovation**

The people profession is productive, efficient and responsive. Our operating model delivers transformation and embeds innovation across organisations and systems.

Embedding **digitally** enabled **solutions**

We make best use of technology and digital solutions to deliver great people services. We develop our digital capability to equip ourselves for the future.



Enabling new ways of **working** and **planning** for the **future**

We enable our people to work differently, to support new models of care. We anticipate the needs of the health and care system, and play our part in creating a sustainable supply of workforce which meets the needs our patients now and for the future.

4 Turning the vision into action

This chapter sets out the actions planned to achieve the 2030 vision for the NHS people profession. These actions were co-designed by working groups made up of national leaders, subject-matter experts and directors of human resources. They were refined further through crowdsourced discussion with the people profession and their customers.

The chapter addresses each of the themes of the vision in turn. Many actions are best carried out locally, in organisations and systems, while others will be better carried out nationally or regionally – but always in collaboration and partnership. The actions also reflect growing opportunities to work at scale across health and care, helping standardise approaches, reduce duplication and increase impact.

The delivery of the priorities in this report and the People Plan require senior people professional leadership. The majority of NHS organisations have a director of human resources or chief people officer (CPO) as a member of their board. The minority of trusts that have not established this role yet are strongly encouraged to do so as soon as possible.

This journey will take time, and different organisations and systems will be at different starting points. Each section outlines actions for the national team, organisation and ICS chief people officers, or boards.

Where actions are for the national team, timescales are set out. Where they are for organisations and systems, timescales are not provided: it will be for them to develop their plans to respond to this report, based on their local priorities and current position.

More detail on this process – and how we can work together to make it happen – is set out in chapter 5.

Supporting and developing the people profession

We support everyone working in the people profession to be their very best and reach their full potential. Together we provide outstanding people practices.

There will be an essential change in the way people professionals develop through their careers, with a strong emphasis on building the capabilities and expertise that support service transformation and cultural change within organisations.

Action 1

The national team will work alongside the profession, CIPD, HPMA and other experts to develop dynamic **professional standards** for the people profession that meet the needs of our NHS people and support the delivery of high-quality patient care. The national team will:

- introduce NHS people profession standards, to create a curriculum of development tailored to the needs of the health and care sector (by 2023)
- develop the infrastructure to support implementation, including a national people profession development board and strong links to the regional people boards (by 2023)
- deliver development programmes and tools to increase organisational development skills, capability and capacity – building on the 'Do OD' community resources (by 2023)
- ensure that systems, with support from the national team, adopt standard benchmarking tools, to help teams and organisations understand capability, and ensure tailored development (by 2025)
- ensure that employing organisations demonstrate they are meeting the professional standards set nationally

Action 2

CPOs, or equivalent, need to ensure all people professionals have **professional development plans** aligned to the delivery priorities. Organisation and ICS CPOs should enable all people professionals to:

- undertake continuous professional development and appraisal processes that align to professional standards and incorporate customer feedback, to support development and continuous improvement
- have opportunities to enhance their skills, knowledge and experience through experiential and formal learning, to reach their full potential throughout their career journey
- access a high-quality development support that covers the emerging skills and capabilities needed, such as workforce planning organisation development, digital, equality, diversity and inclusion, transformational change, culture change and design and system thinking
- access apprenticeship programmes to enable CIPD accreditation at all stages of the career journey
- access professional support, such as coaching, mentoring, role modelling and senior sponsorship

Action 3

The **people profession must be representative of the communities they serve and need to lead by example**. Organisations and systems need to develop a representative talent pipeline, using their position in anchor networks. Organisation and ICS CPOs should:

- provide clear and inspiring pathways to address the under-representation of our NHS people with protected characteristics, through improving development support, talent management, recruitment and promotion
- assess proactively the equality, diversity and inclusion (EDI) development gaps in knowledge and upskill people professionals to be the catalysts for change and to positively disrupt the norms
- collaborate with local communities – through multiple agencies, non-profit organisations and academic establishments – to improve the talent supply pipeline for the people profession
- advance the NHS people profession to be representative of the communities that our NHS people serve. Introduce new and comprehensive routes into and within the profession, including through apprenticeships
- create a vibrant and active succession planning framework within the people profession to ensure inclusive talent acquisition and management across systems and organisations
- recognise and sponsor all high-potential individuals from under-represented backgrounds to enable them to fulfil potential and ambition. Use data and robust monitoring to understand the experience and outcomes of people professionals from under-represented backgrounds, and take action where needed
- commit to professional accreditation, including apprenticeships, experience assessments and professional developmental pathways for all people professionals

Leading **improvement, change** and **innovation**

The people profession is productive, efficient and responsive. Our operating model delivers transformation and embeds innovation across organisations and systems.

As the NHS innovates and changes, the people profession should innovate and change too, to ensure that it continues to provide high quality support that enables the delivery of high-quality care to our patients, both now and in the future.

Action 4

National bodies and organisations will work together to develop **leading-edge practice for people services, based on robust research** and evidence. The national team will:

- develop frameworks to enable people services to assess alignment of resources with the delivery of the NHS Long Term Plan, People Plan, People Promise and local priorities (by 2023)
- develop a range of new people function service models to support our vision for 2030 (by 2023)
- establish a central repository of best practice to support profession-wide collaboration, knowledge sharing, horizon scanning, collaboration and celebration of successes (by 2023)
- create a clear view on the expectations of line managers in the service in relation to people practice and the implications for provision of people services (by 2023)
- conduct research with academic partners to build the evidence base on core topics, such as health and wellbeing interventions (by 2025).
- ensure the NHS is part of CIPD policy and strategy discussion (by 2025)
- embed research and evidence-based practice in the work and learning activities of the people profession (by 2025)

Action 5

The national team, working with trade unions, systems and organisations, will simplify and standardise **core NHS people policies and processes**, to drive innovation, bring more consistency, support quality improvements, and ensure alignment to the People Plan and Promise. The national team will:

- develop national standards and key performance indicators for people services to support improvement (from 2022)
- develop national toolkits and training that support the people profession to embed these standards for local adaptation (from 2022)
- develop and implement a national framework for collecting customer feedback (by 2025)
- develop in partnership a standard set of simplified national people policies (by 2025)
- create a national guide for scaling transactional services, to enable successful implementation (by 2023)

Action 6

People professionals should deliver services at the level where they benefit most from scale and where they can have the most impact. The people profession needs to take the opportunity of working at scale across systems – particularly on core transactional services – to create a more streamlined, standardised offer. Organisational and ICS CPOs should:

- create system-level consolidated and simplified transactional people services, with a focus on customer service, reducing duplication and the increasing the benefits of digital systems (see 'Embedding digitally enabled solutions', below)
- review the allocation and distribution of people function resources to ensure alignment with the People Plan, NHS Long Term Plan and local system priorities
- build strong organisational development capability across people services, to support cultural change in our organisations and systems
- agree the provision of people services across the full scope of the ICS 'one workforce'– including, in the future, primary care and social care
- use regular customer feedback to help shape the development and improvement of services

Embedding **digitally** enabled **solutions**

We make best use of technology and digital solutions to deliver great people services. We develop our digital capability to equip ourselves for the future.

The people profession will transform the way people access people services – using digital tools and platforms to create a more timely, standardised and intuitive service. This approach will also release more time for people professionals to focus on priorities that improve the working lives of our NHS people, which in turn supports delivery of high-quality care for patients. In making these changes it is essential that they deliver improvements for all and address digital exclusion risks.

Action 7

Improve accountability and clarity on roles, responsibilities and decision making for digital workforce and people programmes at a national level. National organisations will:

- establish a strategic board that effectively prioritises, co-ordinates and agrees the digital people strategic initiatives, aligning them to the NHS Long Term Plan, People Plan and People Promise (by 2022)
- prioritise and actively manage interdependencies between digital workforce programmes and the People Plan (by 2023)
- build digital workforce and business intelligence capability at national, ICS and provider level to support delivery of the People Plan and People Digital Strategy towards enabling improved efficiency and workforce planning (by 2025)
- provide support and tools for providers to undertake reviews of systems and processes, to establish effective routes for automation (by 2025)
- co-design and support the implementation of the new national People Digital Solution (successor to current electronic staff record [ESR]) (from 2024)

Action 8

Organisations and systems should create a **local plan for optimising use of existing digital solutions**. Organisation and ICS CPOs should:

- create a local plan which is aligned to ICS digital architecture, to optimise adoption of current digital solutions (eg ESR, e-rostering) to improve our NHS people, leader and line-management experience, normalising self-service across the NHS
- align and harmonise digital strategies and solutions, across providers wherever possible, to enable more joined-up working (eg harmonised e-rostering systems improve the ability to plan and deploy staff across systems)
- refine and improve digitally-enabled services based on real-time customer feedback
- co-design new people digital systems that optimise how our NHS people interact with people services (such as 'digital in your hand', push notifications, removal of duplicated data entry, and mobility across systems)
- design digital systems to be predictive, intelligent and interoperable to support strategic and operational decision making – for example, enabling data sets to be triangulated to provide new insights; supporting real-time pulse surveys; and analysing EDI trends

Action 9

Collaborate at national, ICS and organisation level to optimise the procurement and the introduction of digital services, creating **more efficient and aligned digital services through using economies of scale** to provide richer, more timely insights to support decision-making. Organisation and ICS CPOs, within a national framework, should:

- ensure that digital services are procured in compliance with national technology standards and commercial digital frameworks (by 2023)
- leverage the use of procurement frameworks to adopt digitally enabled and intuitive transactional processes at all levels, including the opportunities for efficiency through robotics, which will provide high-quality and responsive services that minimise time spent on administration in areas such as pay and recruitment

Action 10

Organisations and systems should have **high quality reporting of people data and insights**, enabled through the use of digital services to support effective, informed decision making. To support this the national team will:

- establish data standards across multiple people digital systems to enable interoperability and informed decision making (by 2023)
- define a benchmarked set of key performance indicators for people services, with a consistent reporting framework (by 2023)
- create opportunities for organisations to share best practice and support learning and development (by 2025)

Action 11

Organisations, supported by the national team and arms-length bodies (eg HEE), need to **build digital capability, skills and leadership** at all levels of the people profession to enable and support the shift from transactional to transformational people services. Organisation and ICS CPOs should:

- use competencies, training and agreed standards to help build digital capability within the people profession, creating a supportive environment so that staff feel supported and skilled to embed the change to digitally-led services

Prioritising the health and wellbeing of all our people

We take a positive and proactive approach in supporting the health, safety and wellbeing of our NHS people, ensuring that work has a positive impact. We address health inequalities at work and in our communities.

For the NHS to deliver great patient care, our people need to be safe and healthy. The people profession should lead the development of an organisational culture that prioritises the health and wellbeing of our people.

The people profession should ensure that leaders and managers have the support they need to prioritise their own health and wellbeing so that they, in turn, can prioritise the health and wellbeing of their people.

People professionals need to ensure they understand where there are inequalities in staff health and wellbeing in their systems and organisations and take action to address them.

Action 12

The national team will develop a **standard set of skills, competencies and behaviours for leaders on health and wellbeing**, creating a core curriculum to be embedded locally. It will:

- continue to set out national direction on health and wellbeing, such as through operational planning guidance (by 2023)
- work with the profession to define metrics to be used locally and nationally, to measure and track the health and wellbeing of our people (by 2023)
- define minimum standards for the physical work environment that supports good health and wellbeing, such as access to rest spaces (by 2023)
- formalise an approach to ensure rapid access to core health and care services when our people need it, to enable people to feel well and supported to get back to work quickly, wherever possible (by 2025)

Action 13

Systems and organisations must formalise **governance arrangements** for overseeing the health and wellbeing of its people, which is a core responsibility. Organisation and ICS boards should:

- appoint the CPO, or equivalent, as the accountable lead – working with the board-level guardian for staff health and wellbeing
- consider staff health and wellbeing metrics with the same scrutiny as operational and financial performance
- support the development and sharing of evidence and best practice, alongside ICS and regional people boards

Action 14

Organisations and systems health and wellbeing plans reflect national plans and local priorities. Organisation and ICS CPOs should:

- embed best practice from the NHS Health and Wellbeing Framework for the whole NHS workforce
- embed a standard set of skills, competencies and behaviours for leaders on health and wellbeing – with shared responsibility between line managers and their people professional team
- ensure that estates and facilities teams are key partners in how the physical work environment is improved for our people, to support their health and wellbeing

Action 15

Prevention is always better than cure. The people profession needs to help design job roles, to provide our people with good work.

- review and baseline their current offer, including identifying which areas to enhance or evolve
- personalise the health and wellbeing offer to reflect the diverse needs of our NHS people, taking into account population health information
- make sure the people profession and line managers have the capability and support to provide the health and wellbeing offer – through regular one-to-one health and wellbeing conversations
- make sure occupational health professionals are engaged as a strategic partner in developing and delivering prevention-focused health and wellbeing services

Ensuring **inclusion** and **belonging** for all

We use our expertise and influence to create an inclusive culture, which values and celebrates our diversity. We listen to our people and take action to ensure there is equity for everyone.

Our NHS people do their best work in strong teams where they feel that they are valued and that they can make a difference to others. Our People Promise is that all NHS teams, organisations and systems must have a compassionate, inclusive and equitable culture – where everyone feels that they belong.

The people profession will develop leaders and teams to have the capability, skills and understanding to create working environments where all our NHS people prosper, thrive and fulfil their potential – without discrimination – and where there is equity of outcomes for all staff.

Action 16

National bodies will align the **approach to national equality, diversity and inclusion policy and set clear standards and competencies**. The national team will:

- engage with regulators (such as the Care Quality Commission [CQC] and the Health and Safety Executive) to provide influence and ensure greater emphasis is placed on EDI and employee experience measures when assessing organisational performance (by 2023)
- Identify EDI standards and expertise as core competencies within the people profession, to be tested during recruitment, promotion and appraisal with support provided for development (by 2023)
- work in partnership with the CIPD to develop and accredit standards, competencies and skills in EDI (by 2023)
- support the implementation of the NHS Director Leadership Competency Framework in relation to EDI (by 2023)
- develop resources for leaders and line managers, through co-creation, to help them deliver compassionate and inclusive people practices (by 2023)

Action 17

All organisations must have a **talent management strategy and recruitment and careers pathways that address under-representation** and lack of diversity. Organisation and ICS CPOs should:

- overhaul recruitment processes to take account of EDI considerations and be responsive to personal circumstances
- provide appropriate developmental support and pathways, including coaching, mentoring and role modelling for staff in under-represented groups
- ensure that all job appointment processes, including promotions, include evidence of the candidate's personal positive impact on equality, diversity and inclusion in the workplace
- ensure that high-potential individuals from under-represented backgrounds have a clear development plan, to help them reach their potential

Action 18

Every team, organisation and ICS must **champion policies and practices that achieve tangible, measurable improvements** to the culture within the NHS – particularly on equality, diversity and inclusion. Organisation and ICS boards should:

- ensure that all individuals, teams and organisations have measurable objectives on EDI, including all board members
- ensure equality impact assessment tools are used to inform decision-making at all levels and periodically reviewed to assess progress
- take account of and explicitly address issues of equality, diversity and inclusion in culture change programmes
- monitor key indicators of impact – to include as a minimum the Workforce Race Equality Standard, Workforce Disability Equality Standard, gender pay gap assessment, and NHS staff survey data to pick up other protected characteristics

Action 19

Every team, organisation and ICS must have a **systematic way of capturing and understanding our people's lived experience** of, and concerns in relation to, equality, diversity and inclusion – and take responsibility for addressing them. Organisation and ICS CPOs should:

- build on existing interventions and develop new mechanisms to support our NHS people to speak up and feel heard, without fear of reprisal – including staff networks, freedom to speak up channels and trade unions
- create an open, productive and learning environment that educates and addresses privilege and everyday bias
- create a continuous improvement process, through seeking regular feedback
- develop skills and capability across the people profession to equip them to connect with staff and communities affected by discrimination and bias, so that they can better effect change

Action 20

The people profession must help develop and embed a 'restorative just culture' across organisations and systems that helps to eliminate cultures that propagate blame or fear. Organisation and ICS CPOs should:

- embed the principles of a restorative just culture into all people practices, for example employee relations, leadership and talent frameworks
- implement healing, compassionate interventions and programmes for staff who have experienced hurt due to people practices, incivility, bullying/harassment and/or discrimination
- develop leaders and line managers at all levels to create psychological safety within teams to enact and sustain consistency of restorative just cultures

Creating a **great employee experience**

We understand the diverse needs, expectations and experiences of our NHS people, and use that insight to tailor our people services. We attract and retain people in health and care, creating a positive impact on our communities.

The people profession will focus on creating a great employee experience, making sure jobs are designed to provide good work, so that people can thrive at work – delivering and supporting high quality patient care and services.

Action 21

The national team will provide support and guidance for systems and organisations to enable them to **improve the experience of current and future staff**. It will:

- establish a range of ways to measure employee experience that complement the staff survey, to be included in performance dashboards across NHS organisations and systems and to be used to benchmark, learn and improve (by 2023)
- provide advice, guidance and support on how to promote the full range of careers in the NHS, including sharing good practice (by 2023)

Action 22

Organisations and systems need to understand the experience of their people to enable them to create great places to work, to enable individuals and teams to thrive, and to deliver great patient care. Organisations and systems need to establish their approach to **board-level accountability for staff experience**, including the People Promise. Organisation and ICS boards should:

- formalise governance and reporting arrangements for overseeing employee experience, by appointing the CPO (or equivalent) as the accountable board-level lead
- build employee experience metrics into performance dashboards so they have the same weight as other forms of performance data

Action 23

Organisations and systems must embed the **People Promise — by building on the strong NHS brand, values and proposition to attract and retain** our NHS people. Organisation and ICS CPOs should:

- review regularly what staff in all parts of the organisation, at all stages of their careers, are saying about 'what it is like to work here'.
- develop clear plans to improve employee experience, based on evidence and staff suggestions
- understand why people leave the NHS and take systemic action to address the causes, working with leaders and line managers to create a vibrant employment value proposition
- design job roles proactively to ensure they are fulfilling and meaningful and support good staff health and wellbeing

Action 24

Organisations and systems need to develop strategies to make health and care **the first choice for local employment** using our position in anchor networks. Organisation and ICS CPOs should:

- develop plans to capitalise on the strong NHS brand, values and proposition to attract people to a career in health and care.
- communicate the core NHS employment offer with creativity and pride, reaching a wide range of audiences
- develop greater insight, supported by data, into what is attracting people to health and care careers, to enable more tailoring and targeting
- use innovative ways to bring to life the breadth of roles and career opportunities in health and care and diverse routes into employment, including through volunteering, work experience and apprenticeships

Action 25

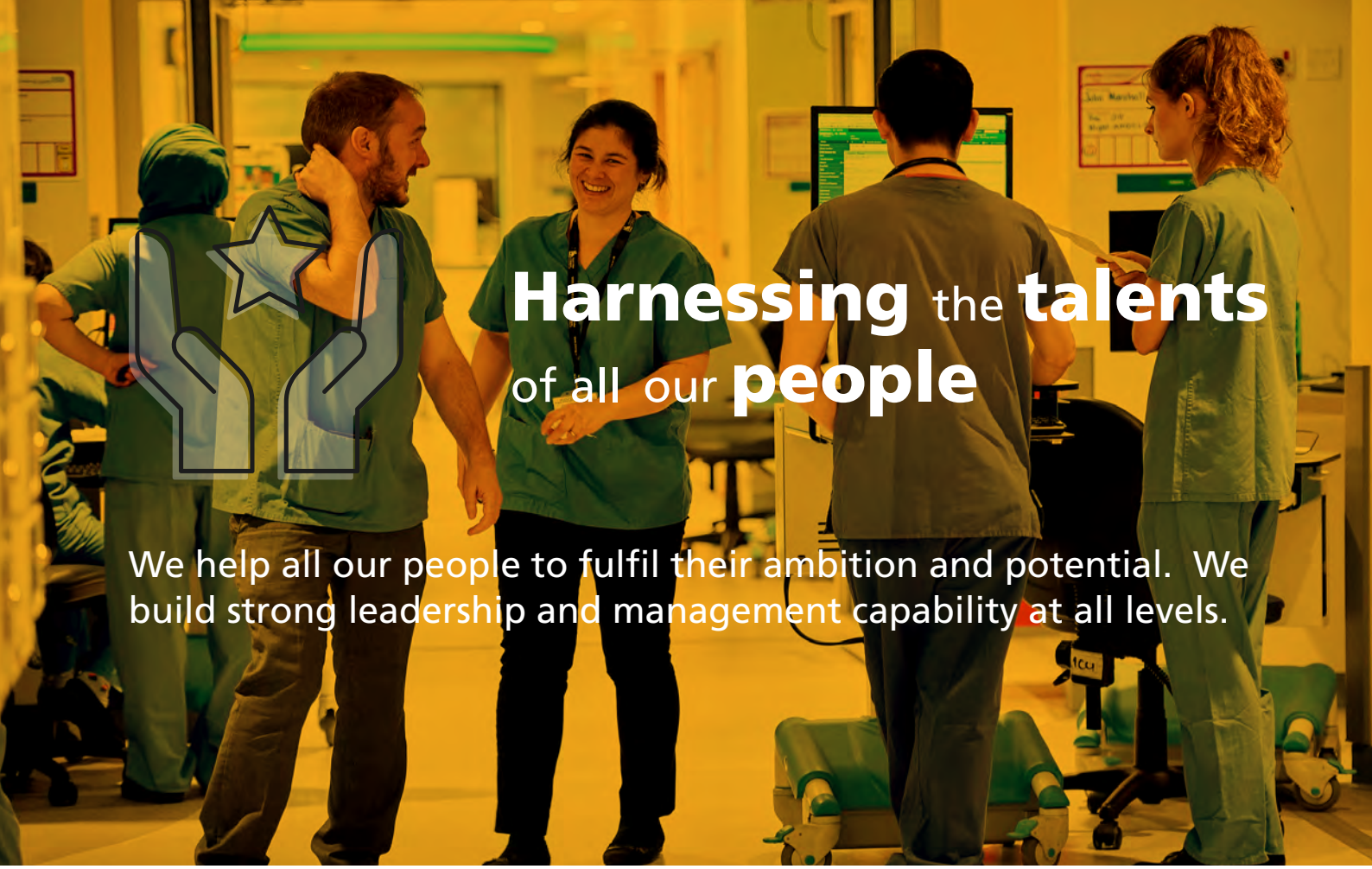
Organisations and systems should use **fair, inclusive and modern recruitment methods** and simple processes to provide a high-quality candidate experience. Organisation and ICS CPOs should:

- design recruitment processes to focus on skills and competencies, enabling potential candidates to demonstrate how their skills could best fit with roles
- use technology to create a 'frictionless' recruitment pathway that improves the candidate experience
- use the opportunity to recruit at scale across a system, to create a more open and efficient process

Action 26

Organisations and systems should create **strong onboarding processes** that reflect the People Plan and People Promise. Organisation and ICS CPOs should:

- ensure that welcoming and onboarding new joiners is recognised as a crucial driver of retention and that it is a personal priority for leaders
- remove unnecessary bureaucracy and duplication, such as repeated statutory and mandatory training



Harnessing the talents of all our people

We help all our people to fulfil their ambition and potential. We build strong leadership and management capability at all levels.

Everyone should be able to have a fulfilling career and be able to access the right development opportunities for them.

The people profession should lead action to make sure this happens across organisations and systems, supporting line managers and leaders to build their skills at talent management and development. Attracting, developing and retaining talented people from all backgrounds, is a key commitment in our People Promise.

Action 27

The national team will develop a framework for talent management, to set out core elements that should be adopted across all systems, with flexibility for local adaption. The national team will:

- develop clear standards and responsibilities, and practical support for organisations and systems for talent management (by 2023)
- use digital talent-management tools and platforms to enable a single view of talent across the NHS, including skills, experience, progression readiness, talent assessment and mobility preferences (by 2025)

Action 28

Organisations and systems must have **formal governance in place to enable senior involvement and oversight** in talent management, succession planning and development. Organisation and ICS boards should:

- enable CPOs, or equivalent, to chair people boards that adopt and adapt the national framework locally and oversee the approach to apprenticeships, talent development and mobility
- ensure the CPO, or equivalent, is involved in all senior appointments and performance management discussions about senior staff
- engage all professions within talent and leadership strategic planning in designing a common framework and driving the agenda
- ensure that chairs, chairs of the remuneration committee, chief executives and CPOs or equivalent collaborate on talent development
- build non-executive director capability and ensure that a defined board subcommittee owns the talent and leadership agenda

Action 29

Organisations and systems need to **proactively set the direction for talent management**, working collaboratively with all partners across systems to a common framework. Organisation and ICS CPOs should:

- lead the long-term talent strategy – building capabilities for all people leaders with an explicit focus on addressing issues of equality, diversity and inclusion
- set expectations that normalise talent mobility, alongside support programmes that encourage movement
- prepare aspiring leaders through proactive development and stretch opportunities well in advance of being appointed into a leadership or line-management role
- design the approach for consistent succession-planning processes, tools and approaches for key leadership roles across the system
- use data and insights to provide a holistic view of local talent pipeline for talent managers and leaders
- develop a system-level skills recognition and certification programme that facilitates talent mobility
- make sure line managers are developed and supported to achieve their talent management responsibilities
- develop an alumni programme to create an additional, flexible talent supply

Action 30

Organisations need to support leaders and line managers **to understand the needs, expectations and aspirations of their teams**. People professionals will play a leading role in intentionally building capability and space for leaders and line managers to prioritise and effectively lead for talent, enabling them to spot, develop and nurture talent at all levels. Organisation and ICS CPOs should:

- ensure that all professions and staff groups in the NHS are developing talent
- provide support for development that focuses on sideways moves and broad development – not just 'upwards' progression
- create a careers-advice approach within the NHS, using interactive tools and support mechanisms to help our NHS people and potential new joiners understand how to navigate careers in the NHS and what opportunities could be available to them

Enabling new ways of **working** and **planning** for the **future**

We enable our people to work differently, to support new models of care. We anticipate the needs of the health and care system, and play our part in creating a sustainable supply of workforce which meets the needs our patients now and for the future.

Workforce planning needs to be rooted in understanding of the future health and care needs of the population at local, system and national level. This understanding can be used to drive workforce, service and financial planning.

The people profession has a leading role to play in workforce planning, both in the short and longer term, including in designing roles that provide good work and supporting its implementation.

Action 31

Systems need to lead **comprehensive 'planning for the future'**: developing workforce plans, based on service planning, to meet population health needs – with clear actions for meeting the plans through new ways of working and growing the workforce. System and organisation CPOs should:

- develop governance and infrastructure that enables workforce plans to align with local service and financial planning, HEE plans and the responsibilities set out in guidance on the ICS people function
- take account of the needs of the whole health and care sector and its workforce in planning for the future, taking a 'one workforce' approach across the NHS (primary and secondary care), social care and the independent and charity sectors
- use workforce plans to help shape the local and national education and training needs, recruitment and retention and workforce transformation
- continue to evolve the approach to workforce planning, to take account of new ways of working and workforce transformation
- support the embedding of new roles into multidisciplinary teams, to make the most of the available skill mix

Action 32

DHSC, HEE and NHS England and NHS Improvement national and regional teams will work together to support further **development of workforce planning capacity and capability**. The people profession should be supported and developed to carry out planning directly, and through convening and facilitating other key partners (including clinical leaders, finance and service planners). National and regional teams will work together to:

- help develop and promote tools that support clinical, people professionals and other specialist leaders, to plan for workforce needs (by 2023)
- consolidate training materials and a programme of development to support the people profession grow and evolve its skills and capacity in workforce planning (by 2023)

Action 33

Organisations and systems need to ensure that planning for the future, including workforce planning, is **digitally enabled** and draws on **more robust and timely data**. Organisation and ICS CPOs should:

- ensure that digital planning tools (such as e-rostering and e-job planning) are fully implemented, to support the day-to-day deployment of staff across the ICS
- ensure better use of digital planning tools, to improve data quality – making it more accurate and timely, supporting more accurate medium-term and long-term planning
- work with systems to understand their planning needs, then develop common data standards to allow data to be shared. This will enable them to build workforce planning platforms that use improved existing data and integrate across existing tools

Action 34

Organisations and systems need to **support our people to work differently and more flexibly** to support action to deliver care to patients in new and different ways. This will mean actively designing teams around the full range of experience and capabilities of their clinical and non-clinical staff, including those in partner organisations and volunteers. Organisation and ICS CPOs should:

- lead planning on the opportunities of new ways of working and new roles to transform service delivery and achieve sustainable workforce supply
- enable our people to access wider opportunities across the system, supporting their development and helping them gain wider experience
- consider different employment models, to enable more flexibility in the movement of staff across the system to work in different teams
- implement digital staff passports, to enable seamless moves between teams and organisations
- use the benefit of scale to develop shared bank and temporary staffing arrangements
- ensure the benefits from remote and virtual working are carefully considered and benefits realised for the long term

Action 35

Organisations and systems should continue to lead action to **address local supply issues, using the benefit of scale** wherever possible and innovative approaches that broaden access to roles for the local community. Organisation and ICS CPOs should:

- support the introduction and embedding of new roles and new ways of working into the service – such as advanced clinical practitioners
- build strong relationships with local communities to share the opportunities working in the NHS and wider health and care service can bring, encouraging social mobility
- implement approaches that use the benefit of scale, such as running larger-scale recruitment rounds that cover multiple providers
- adopt a wide range of supply approaches, including those that may only provide benefit in the longer term, including traineeships, work experience and volunteers
- embed the use of apprenticeships across different settings (clinical and non-clinical), such as locally commissioned apprenticeships
- establish, or become part of, volunteer services that make sure volunteers receive appropriate support and training and are made to feel a true part of the team support schemes such as the NHS cadets and NHS reservists, to support people from under-represented groups to embark on health and care careers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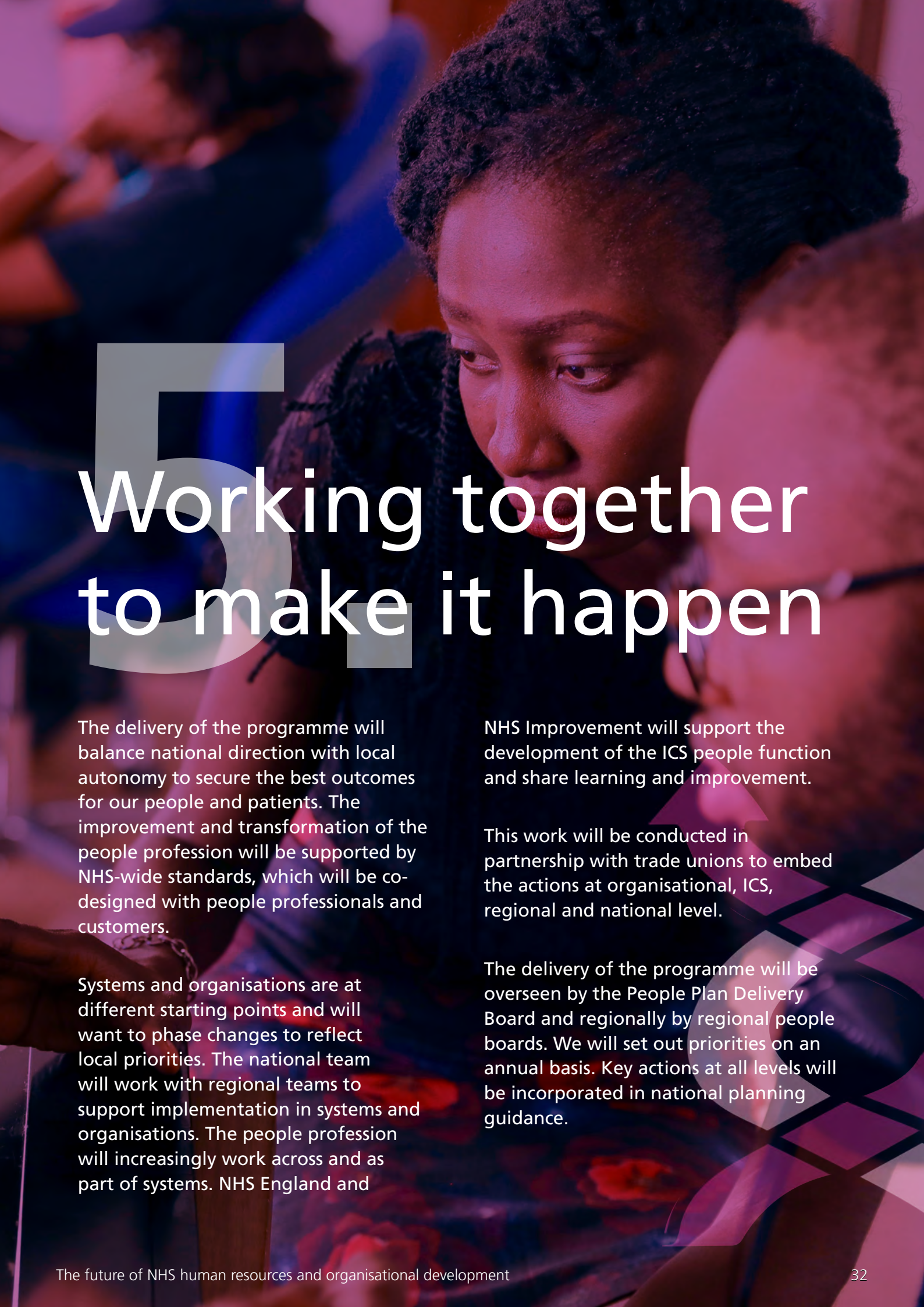


5 Working together to make it happen

The delivery of the programme will balance national direction with local autonomy to secure the best outcomes for our people and patients. The improvement and transformation of the people profession will be supported by NHS-wide standards, which will be co-designed with people professionals and customers.

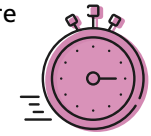
Systems and organisations are at different starting points and will want to phase changes to reflect local priorities. The national team will work with regional teams to support implementation in systems and organisations. The people profession will increasingly work across and as part of systems. NHS England and NHS Improvement will support the development of the ICS people function and share learning and improvement.

This work will be conducted in partnership with trade unions to embed the actions at organisational, ICS, regional and national level.

The delivery of the programme will be overseen by the People Plan Delivery Board and regionally by regional people boards. We will set out priorities on an annual basis. Key actions at all levels will be incorporated in national planning guidance.

The full implementation of the recommendations in this report will support the delivery of the People Plan and embed the People Promise for all staff.

Alongside the above priorities for the national team, organisations and ICSs will wish to develop their response to this report. The immediate priorities for organisations and systems are set out below.

Action	ICS and organisation priorities to March 2023
• All trusts to ensure that they have appointed a director of human resources/chief people officer as a member of their board.	
Supporting and developing the people profession Actions 2 and 3 	• Develop professional development plans for their teams, optimising use of apprenticeship levy
Leading improvement, change and innovation Action 6 	• Review allocation and distribution of people function resources to ensure alignment with the People Plan, NHS Long Term Plan and local system priorities • Create plans for system-level consolidated and simplified transactional people services
Embedding digitally enabled solutions Action 8 	• Optimise the adoption of current people digital solutions • Create plans and commence action to align and harmonise digital strategies and solutions, across providers wherever possible, to enable more joined-up
Prioritising the health and wellbeing of all our people Actions 13 and 15 	• Build health and wellbeing metrics into performance dashboards and consider them with the same scrutiny as operational and financial performance • Review and baseline the current health and wellbeing offer, including identifying which areas to enhance or evolve
Ensuring inclusion and belonging for all Actions 17 and 18 	• Embed the overhauled recruitment processes to take account of EDI considerations • Ensure that all individuals, teams and organisations have measurable objectives on equality, diversity and inclusion, including all board members
Creating a great employee experience Actions 21 and 24 	• Build employee experience metrics into performance dashboards • Develop strategies to make health and care the first choice for local employment
Harnessing the talents of all our people Action 29 	• Proactively set the direction for talent management and start embedding the approach
Enabling new ways of working and planning for the future Actions 31 and 35 	• Develop system workforce plans that align with local service and financial planning, HEE plans and the responsibilities set out in the guidance on the ICS people function • Lead action to address local supply issues, using the benefit of scale wherever possible and innovative approaches that broaden access to roles for the local community

Annex A: Developing the report

Both the Interim NHS People Plan (June 2019) and We Are The NHS: People Plan for 2020/21 – action for us all (July 2020) committed to a review of NHS HR and OD. The programme to develop a future vision for HR and OD was commissioned by the NHS Chief People Officer in 2020, and the programme began in January 2021.

The programme had three aims:

- to produce a baseline of people services across the NHS and understand what the people profession needs to fully implement the People Plan and People Promise
- to determine a shared vision for the future
- to recommend how the vision can be realised by 2030

The work was developed in line with the following principles:

- engage the people profession, and the customers they serve, to co-design the vision and plan for realising it
- consider external perspectives, external benchmarks and wider contextual realities for the people profession
- explore the role of the people profession in improving health, and health care
- better understand and address challenges related to equality, diversity and inclusion for and within the people profession
- understand the development needs of the people profession required to meet health and care needs – both today and in the future
- collect and share examples of good practice from across the people profession

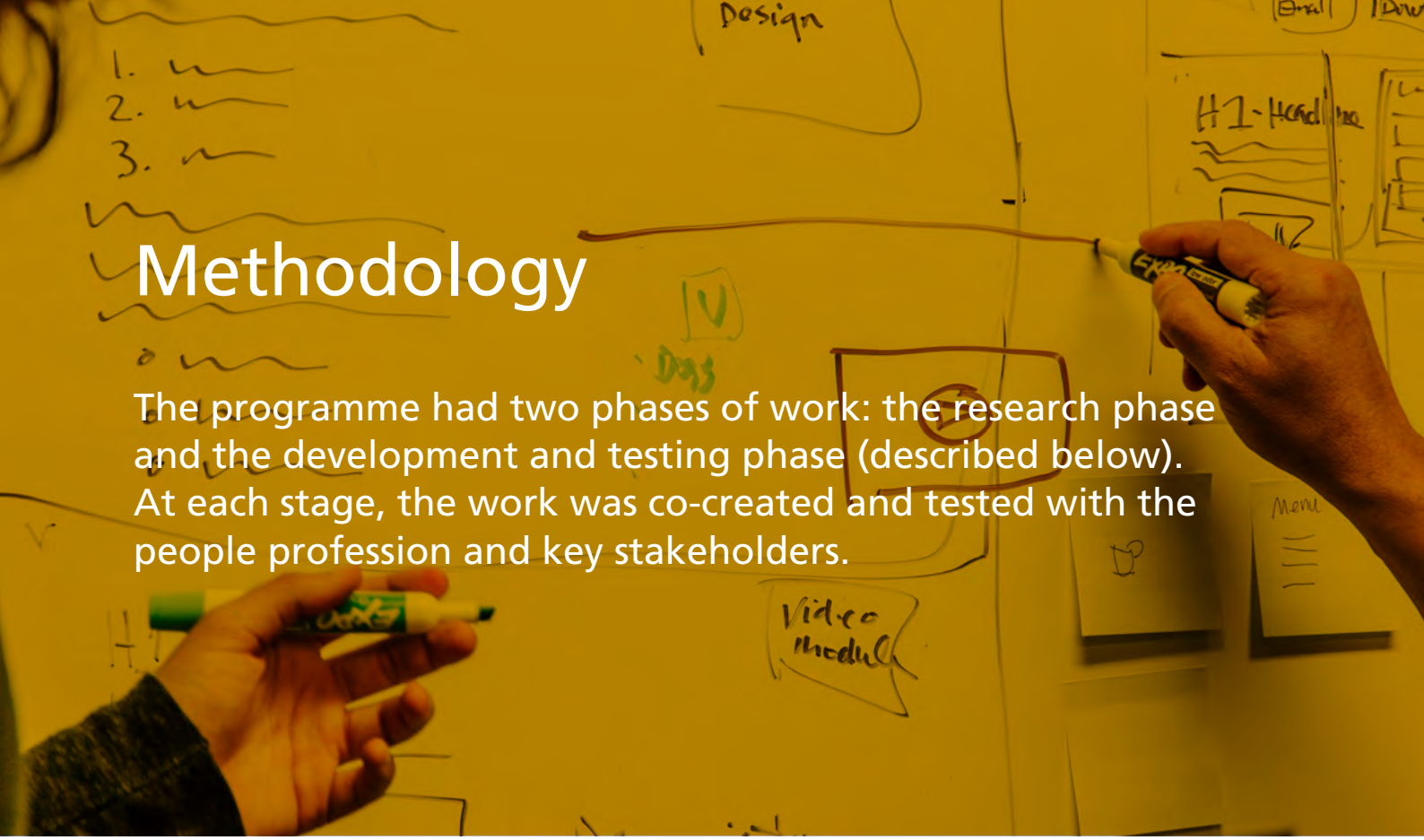
The senior responsible officer for the programme was Thomas Simons, Chief HR and OD Officer for NHS England and NHS Improvement, supported by a dedicated team in the People Directorate.

The programme had input from a steering committee comprising the NHS Chief People Officer and members of her senior team, DHSC, HEE, NHSX, NHS Employers, HPMA and the CIPD.

The programme was also actively supported by three advisory groups made up of chief executives, heads of profession and HR directors.

The HR Directors Advisory Group members, which met every two weeks, was critical to ensuring that the programme connected with the service regularly (through regional networks) and provided advice from senior people professionals and led the working groups in developing recommendations.

The team worked with three external partners: Lancaster University Management School, CIPD and EY. They provided global experience, best practice, academic rigor and evidence, as well as thought leadership in human resources, organisational development, digital technologies and talent management. They were also supported by Clever Together – specialists in facilitating digital crowd conversations and co-creative processes – who brought the voices of stakeholders from across the NHS to the fore in two 'Big Conversations'.



Methodology

The programme had two phases of work: the research phase and the development and testing phase (described below). At each stage, the work was co-created and tested with the people profession and key stakeholders.

Phase 1: Research

The research phase aimed to gain a qualitative and quantitative understanding of the key issues, challenges and ambitions of the people profession.

Extensive engagement was carried out with people professionals and their customers, along with organisations working with them across national, regional, system and local boundaries.

External partners, including CIPD, used several evidence-based diagnostic tools and surveys to build up a clear picture of the key issues. This was supported by desk-based research, using available data such as the NHS Model Health System, and working sessions.

Phase 2: Development and testing

This phase of the programme concentrated on developing recommendations to realise the vision for 2030. This was done by working groups comprising senior leaders from the NHS England and NHS Improvement People directorate, chief people officers and subject experts, through weekly meetings.

The vision and recommendations were tested back with members of the people profession and their customers through a second programme of engagement events, including another Big Conversation. The project steering group, CEO group and HR Advisory Group also provided feedback, along with further scrutiny and challenge.

Annex B: Summary of research findings

An independent review of the people profession[1] revealed that its capabilities are above average compared with other sectors, with strong functional maturity in individual provider functions. Meanwhile, in the research for this report,[2] colleagues across the NHS said they strongly valued the contribution of the people profession.

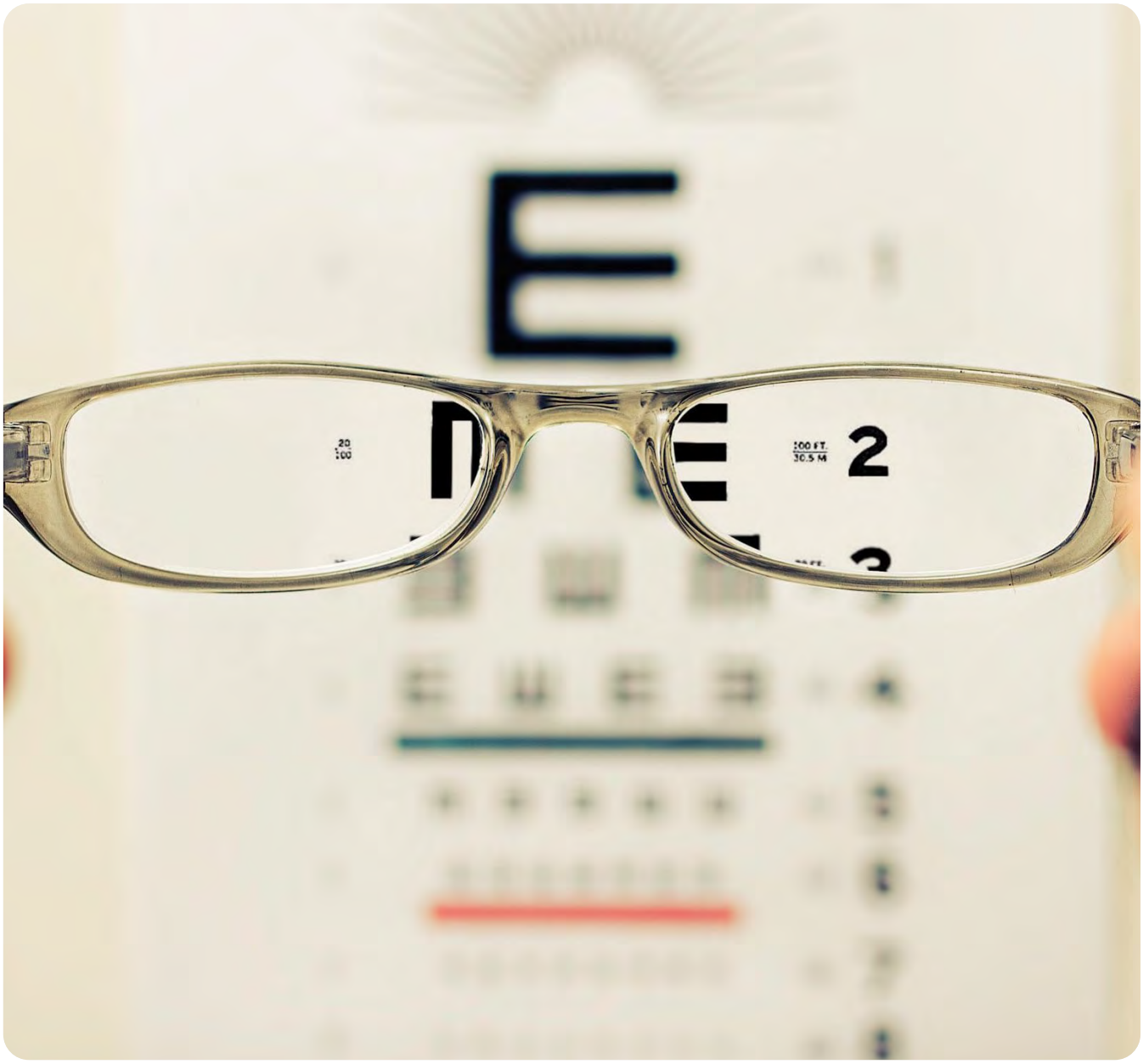
This annex sets out the research findings that underpin the vision.

[1] See research undertaken for the purposes of this report (CIPD Impact Tool).

[2] See outputs of the Big Conversation and research undertaken for the purposes of this report.

The research for this vision highlighted some areas of excellence in the NHS people profession:

- The first ever NHS People Plan provided clarity, focus and a common set of goals to align local strategies and national initiatives. This provided a more consistent focus on delivering what matters to our NHS people
- The pandemic provided significant opportunity for the people profession to play a strong role and demonstrate added value, by responding to the needs of our NHS people
- Respondents cited examples of strong collaboration and an excellent array of HR and OD networks and forums, such as regional networks and the Chief People Officer webinar, to share good practice
- Respondents highlighted a strong a co-ordinated response to national initiatives, such as mental health support and access to employee health and wellbeing apps



How people services are currently delivered within the NHS

A detailed review of people services for this report[3] found an above average capability of people functions. If work processes and practices were standardised and shared, we could build on these instances of high-quality and use our resources more effectively.

[3] See research undertaken for the purposes of this report (CIPD Impact Tool).

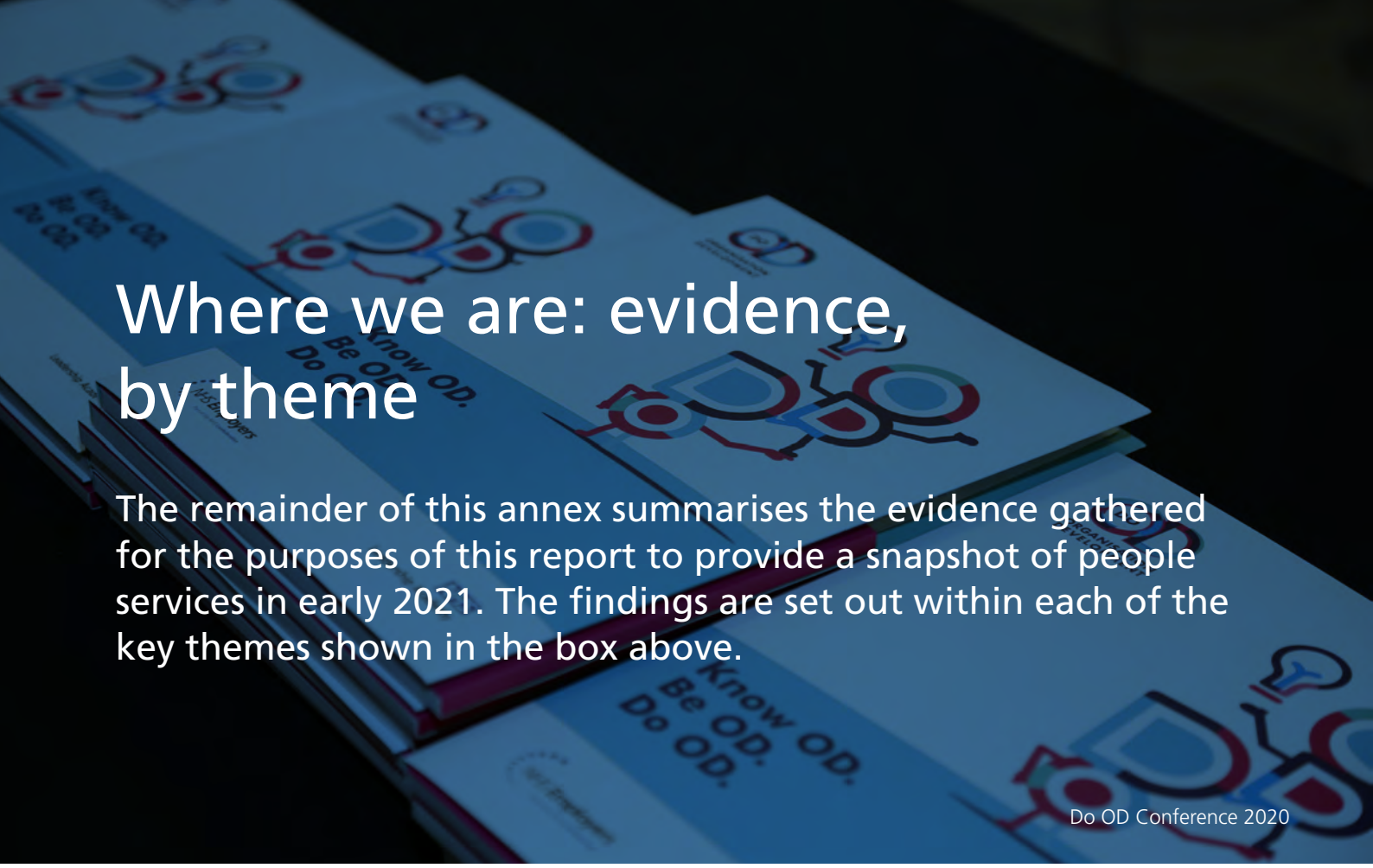
Most NHS organisations arrange and deliver their people services separately, with each employing its own people professionals and developing its own strategy, and the research identified significant variation in the way these are provided. Organisations employ many different work processes, using a wide array of software to deliver different functions. Some outsource parts of the service, while in primary care there is little access to these services at all. Most have a senior people professional within the executive team, or around the board table – but not all. Neither do all organisations make sure line managers take sufficient accountability for their people management responsibilities.

These differences mean that our NHS people have a range of experiences depending on which part of the health service they work in and the expectations and accountability of their leaders and line managers. It is not unusual for NHS organisations to compete for talent and resources.

Nevertheless, there is growing collaboration across organisational boundaries and some vertical and horizontal integration. So far, this has been locally led, with varying models across the country, but the development of integrated care systems will accelerate this collaboration across organisations and providers. The people profession will need to adapt and work differently to make sure people services are properly aligned across systems.

Key themes to address include:

- equality, diversity and inclusion
- culture and strategic positioning
- technology and data
- employee experience and wellbeing
- workforce planning
- professional development
- structure and process
- integrated care systems
- talent, leadership and line management
- organisational development



Do OD Conference 2020

Where we are: evidence, by theme

The remainder of this annex summarises the evidence gathered for the purposes of this report to provide a snapshot of people services in early 2021. The findings are set out within each of the key themes shown in the box above.

Equality, diversity and inclusion

- Strategic direction: While there are examples of good work data such as WRES, WDES and staff survey results show a lack of strategic impact.[4]
- Governance and quality standards: There is a lack of emphasis on EDI and other staff experience metrics in assessments of organisational performance by regulators such as the CQC.
- Accountability: Ownership of the EDI agenda by boards, senior NHS leaders and people functions is inconsistent, perpetuating inequality at all levels.
- Experience: The EDI indicators within the National NHS Staff Survey show wide gaps between the worst- and best-performing trusts. Our NHS people, leaders, and everyone we work with need to do more to treat BAME, disabled and LGBTQ+ colleagues in an equitable manner.[5]
- Access to learning: There is limited training on offer to enable people professionals to become role models for EDI, to guide and support leaders. As the training that is available has not been evaluated, the impact has not been measured.
- Belonging: People professionals identified creating a sense of belonging and an inclusive environment as a key priority and felt there was significant work needed to achieve it.
- Networks: There are excellent staff and professional networks, using lived experience to inform action. These represent opportunities to build on good practice, encourage collaboration as well as learn and share from each other.
- Impact: Data[6] and lived experience shows that the NHS and the people profession have much more to do to reduce bias and discrimination and improve experience in the workplace.

[4] WRES and WDES data – supported by consecutive NHS staff survey results.

[5] HPMA London Academy. Experience of HR and OD professionals from BAME communities in the NHS. 2020. [cited 2021 June 08]

[6] WRES, WDES and NHS Staff Survey results

Cultural and strategic positioning

- Increased profile: The people profession has risen to the challenge of COVID-19, demonstrating the value it adds to the service and the importance of the people agenda.
- Strategic positioning: Not all people professionals have a seat at the executive or board table and the people profession is still sometimes seen as a cost centre rather than a strategic partner to drive transformation and change.
- Impact: Much resource at provider level is spent on transactional activities rather than activities that improve patient care and outcomes. There is a need to measure the people profession on its impact on culture and behaviour as well as on transactional effectiveness.
- Reporting requirements: The multiple reporting requirements at national and system level are not joined up and limited reporting capabilities. As a result, this is often a time-consuming manual process.
- Leaders and managers: Capabilities of leaders and managers are highly variable, impacting on the experience of staff.

Technology and data

- Data systems: Out-of-date systems make it difficult to gain a snapshot of core people data across the NHS, impeding cross-organisational working.
- Procurement: The lack of a consistent framework for procuring people systems has led to a situation where multiple systems are being deployed by providers, duplicating efforts to secure funding. This results in lost opportunities to share purchasing power and learning.
- Interoperability: Limited interoperability between systems makes it difficult to analyse people data to measure and improve performance and increases the amount of manual work involved in reporting on key metrics.
- Self-service: Frequent challenges with managing self-service and people analytics through core HR information systems create a poor user experience and prevent systems being used to their full potential.
- Digital capability: Levels of digital capability across the workforce result in missed opportunities to optimise the experience of the NHS (as an employer and provider of health services) and to improve our responsiveness and efficiency.
- Integration: Better integrated systems analytics would save time and money and further support the people profession to deliver better services to our customers.

Employee experience and wellbeing

- Prioritising wellbeing: The COVID-19 pandemic has brought the importance of employee experience and wellbeing into sharp focus and the NHS has been responding to this need.
- People initiatives: There are excellent examples of people initiatives in EDI and wellbeing. However, because these are delivered inconsistently and line management is variable, the lived employee experience varies greatly across the NHS.
- Surveys: The NHS Staff Survey provides an excellent opportunity to benchmark employee experience, but employers need access to real-time data so they can be more responsive to need.
- Value proposition and brand: The NHS employee value proposition should be strengthened. There is a strong NHS brand, but it is not always used to best effect, to attract new talent into the NHS.

- Employee offerings: Competition between trusts has led to a divergence in the use of rewards and benefits and much is dependent on local organisations' reward strategy and available budgets.
- Partnership working: There is strong collaboration and working with trade unions. However, much time is spent reviewing, negotiating and updating policies.
- Just and restorative culture: Some trusts have reorientated their people policy and working practices towards a just and restorative culture, reducing systemic discrimination, but there is a need for all people functions to implement this approach.

Workforce planning

- Real-time data: The NHS needs a cross-organisational view of talent and a centralised capability database to enable people to move between organisations and systems. This will help the people profession plan and deploy the workforce, to meet patient needs.
- Systems-level planning: Incomplete data and a lack of interoperability – coupled with a lack of alignment between local, system and national workforce planning – make it difficult to plan services across different parts of the health and care infrastructure.
- Alignment: Nationally, there is a disconnect between long-term workforce supply predictions, education and commissioning and the workforce numbers needed to meet health and care demand.

Professional development

- Development: There is some excellent HR and OD development but no consistent approach. Delivery is often siloed and not offered universally. The profession does not have a clear view of the capabilities that must be developed to meet the future needs of the NHS.
- Standards: There is no consistent approach to applying a clear set of professional standards and competencies.
- Equity: There is an under-representation of people with protected characteristics in the people profession – especially in senior roles.
- Continuous learning: The people profession lacks the infrastructure required to build a culture of continuous learning across the NHS or for OD capability to systemically help form and develop high-performing teams.
- Investment: There is inconsistent commitment to the development of people professionals in different parts of the service. For example, some NHS organisations sponsor CIPD qualifications, while others do not.
- Professionalism: Connection to professional bodies and adoption of evidence and research from academia could be strengthened.
- The future generation: Currently, there is no coherent talent pipeline into, or within, the profession.

Structure and process

- **Process and delivery**: There is considerable variation in different organisations' process and delivery, leading to duplicated efforts and an inconsistent user experience.
- **People policies**: Each organisation has multiple, complex people policies that are cumbersome and labour intensive to interpret, implement, administer and update. Work is duplicated among different local employers.
- **Core processes**: Core processes are too complex. Our NHS people and their line managers waste time doing simple things that could be simplified and automated – particularly as they move across and within systems.
- **User experience**: People services do not consistently canvass the views of their customers to continuously build and improve the service. There is no regular customer feedback mechanism to track progress.
- **Initiatives and programmes**: Colleagues across the NHS have developed multiple people-related initiatives and programmes – for example, in wellbeing, EDI and workforce planning.

Integrated care systems

- ICS strategy: Integrated care systems are not yet statutory bodies, so in some areas the strategy for integrated, collaborative working is still in its infancy. The extensive benefits of system working for the people profession and the wider workforce are yet to be fully realised.
- System working: Often, competition between providers remains and there are missed opportunities to collaborate, leading to a lack of productivity.
- Silos: Primary and social care are often siloed within systems and excluded from key initiatives. Often, systems cannot access a view of the entire workforce. The provision of people services to primary and social care is variable and, in many cases, does not exist at all. This hampers work across the profession, including efforts to create workforce plans and talent pipelines.

Talent, leadership and line management

- Line managers: There is no universal expectation or standard for leaders and line managers at any level in the NHS. This means there is no agreed standard in the ability to create and sustain a compassionate and inclusive culture. Neither is there a mechanism for spotting or nurturing promising potential leaders.
- Capability: The NHS has invested in building strategic leadership capability, but the employee experience of leadership and line management depends on individual skills. Leaders who lack the skills to effectively manage the people issues for which they are responsible do not always get access to the development they need.
- Talent management framework: There is no agreed talent management framework used in the NHS and this makes it difficult to effectively mobilise talent within and across systems.
- Accountability: There are few consequences for line managers and leaders who do not fulfil their people responsibilities. This results in people professionals spending extended time focusing on tasks that affect the few, rather than those that affect the many.
- Team development: Although the evidence linking high-performing teams to patient safety is clear, there is no consistent approach in the NHS to developing teams and those who lead them. Some OD teams offer team development, but many do not. Where they do, the approach is seldom systematic.

Organisational development

- **Understanding**: There is a lack of shared understanding of what OD means, both within the profession and among stakeholders. 'People development' is often confused with 'organisational development'. Both are important and necessary.
- **Value and potential**: Limited value is placed upon OD compared to other aspects of the people profession. However, the potential of OD is increasingly apparent as the focus shifts towards addressing our organisational cultures and integrating services across organisations.
- **Capacity**: Although many members of the people profession contribute to developing our organisations, national benchmark data shows that only 6.2% of our resources are dedicated to OD. Increased capacity is needed to meet current and future demand.
- **A profession in itself**: The skills required to be an effective OD practitioner often mean that these staff have not come through the traditional HR route and are not fully integrated with the wider people profession. There is much to be gained from sharing and learning from each other.

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This publication can be made available in a number of other formats on request.

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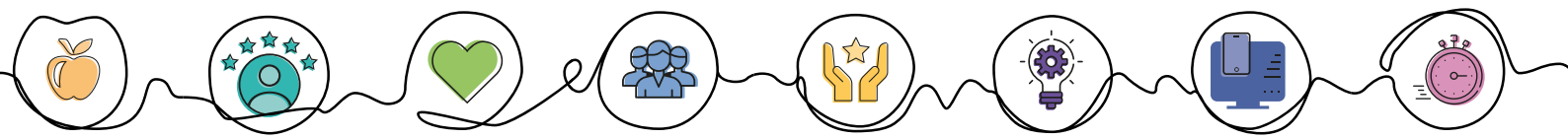
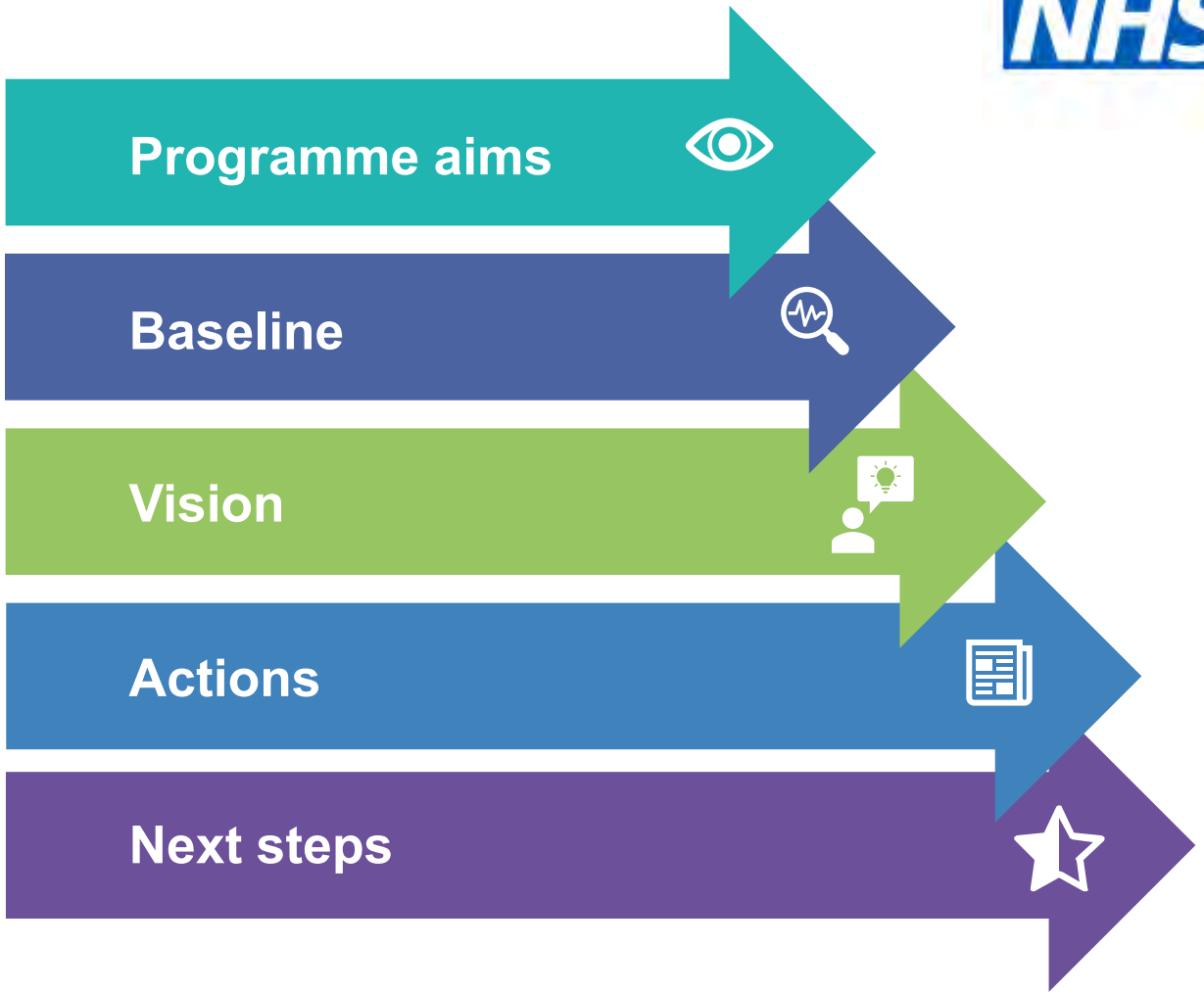


The future of NHS human resources and organisational development report

Briefing pack – trust boards slide deck

November 2021

Contents page



1: Programme aims: what were the aims of the future of NHS human resources (HR) and organisational development (OD) programme?

The programme had three aims:

1. to produce a baseline of people services across the NHS and understand what the people profession needs to do to fully implement the People Plan and People Promise.
2. to determine a shared vision for the future.
3. to recommend how the vision can be actioned by 2030.

How did we develop the report?

- **2** Patient and carers voice workshop
- **28** 4 x sprints with 7 regional HRD networks
- **24** HRD Advisory / CEO Advisory / Chiefs of Professions sessions
- **7** Regional People Board Discussions and SPFs
- **4** National NHS Chief People Officer webinar conversations
- **15** Dedicated sessions to discuss the ICS landscape
- **8** Working Groups developing recommendations
- **2,718** Opinions gathered on Menti to inform key outputs
- **8,000+** Individual contributions
- **30,000** Data/Information points (analysis by CIPD, EY)

BIG CONVERSATION #1

Feb – Mar 2021

- Seeking crowd views on current people services and vision for the future
- *1200* Individuals involved in the first Big Conversation

BIG CONVERSATION #2

May – June 2021

- Check and challenge on 46 recommendations across 8 themes
- 1000+ people contributed
- 8000+ contributions
- 67 new ideas

THE FUTURE OF NHS HR AND OD REPORT

- Future of health and work
- Baseline assessment
- Vision to 2030
- Actions

Department of Health & Social Care · NHS Health Education England · NHS Employers · hpma · social partnership forum · NHSX · CIPD · Lancaster University Management School · EY

2: Baseline: what did we find?

In this section:

- What we found about NHS HR and OD
- What the report says about the future of health
- What the report says about the future of work

What we found about NHS HR and OD

The people profession is key to creating an empowering and inclusive culture, supporting our people, and enabling workforce transformation.

The pandemic enabled the people profession to play a strong role, and demonstrate added value for organisations and our NHS people.

People service resources are heavily focused on transactional services – we can achieve more by simplifying, digitising and working at scale.

There are big opportunities to refocus people services on OD and workforce transformation.

Overall investment in NHS HR and OD is in the median range using global comparators – but investment in digital is below average.

There are strong networks which could be used to scale best practice across the service.

Our customers were more positive about people services than the people profession – this was unique amongst sectors that have used the CIPD diagnostic.

What the report says about the future of health

There is a rising demand for health services due to an ageing population with increasingly complex healthcare needs.

Significant inequalities in life expectancy persist. These are linked to deep-rooted inequalities in how care is accessed.

Workforce supply challenges to continue as demand rises.

Health and care need to provide an integrated approach that supports the whole person.

Need for a preventative approach to health.

Technological and scientific innovation to change the nature of care and its delivery – enabling care to be more personalised.

Changing role of patients, with more wanting greater personalisation, support for self-care and prevention, and their care focusing on what really matter to them.

What the report says about the future of work

Workforce demographics are changing.

More competition for the workforce.

People's expectations of work are changing.

Increase in non-linear careers rather than ‘careers for life’.

Technological change to reshape job and skills demands.

A continuous and agile approach to development and training is needed to keep pace with change.

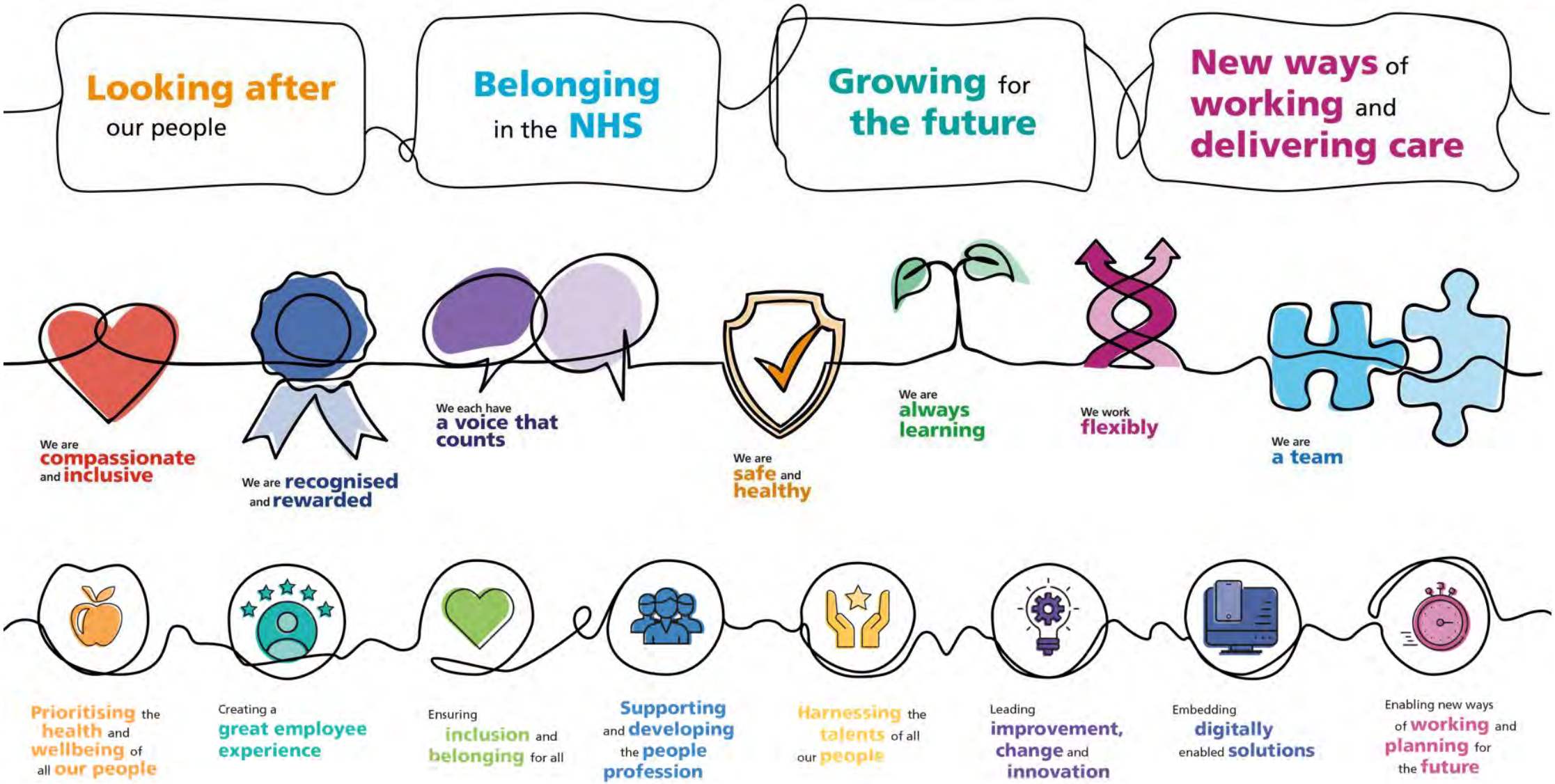
More is expected of employers on issues of inequality and social justice.

3: Vision: what is the 2030 vision for NHS HR and OD?

In this section:

- The vision to 2030 for HR and OD and how it relates to People Plan and People Promise

What is the 2030 vision for NHS HR and OD?



2030 Vision statements

 **Prioritising** the **health** and **wellbeing** of all **our people**	We take a positive and proactive approach in supporting the health, safety and wellbeing of our NHS people, ensuring that work has a positive impact. We address health inequalities at work and in our communities.
 Creating a **great employee experience**	We understand the diverse needs, expectations and experiences of our NHS people, and use that insight to tailor our people services. We attract and retain people in health and care, creating a positive impact on our communities
 Ensuring **inclusion** and **belonging** for all	We use our expertise and influence to create an inclusive culture, which values and celebrates our diversity. We listen to our people and take action to ensure there is equity for everyone.
 **Supporting** and **developing** the **people profession**	We support everyone working in the people profession to be their very best and reach their full potential. Together we provide outstanding people practices..
 **Harnessing** the **talents** of all our **people**	We help all our people to fulfil their ambition and potential. We build strong leadership and management capability at all levels.
 Leading **improvement, change** and **innovation**	The people profession is productive, efficient and responsive. Our operating model delivers transformation and embeds innovation across organisations and systems.
 Embedding **digitally** enabled **solutions**	We make best use of technology and digital solutions to deliver great people services. We develop our digital capability to equip ourselves for the future
 Enabling new ways of **working** and **planning** for the **future**	We enable our people to work differently, to support new models of care. We anticipate the needs of the health and care system, and play our part in creating a sustainable supply of workforce which meets the needs our patients now and for the future

4: Actions: what are the actions in the report?

- The report outlines actions under each of these themes – either at national/regional level or ICS/organisation level
- The national/regional actions have timescales from 2022 to 2025
- For ICS/organisation it will be for them to determine the priority and timescale for delivery of actions. The report recommends a number of areas for initial focus

In this section:

- Key actions at national/regional and ICS/organisation level
- Actions for organisations/systems to 2023

National/regional key actions

ICS/organisation key actions

- Develop a standard set of health and wellbeing skills, competencies and behaviours for all leaders
- Define minimum standards for physical work environments that supports good health and wellbeing, such as access to rest spaces
- Formalise an approach to ensure rapid access to core health and care services when our people need it

- Embed a standard set of health and wellbeing skills, competencies and behaviours for leaders
- Review and baseline their current offer, including identifying which areas to enhance or evolve
- Personalise the health and wellbeing offer to reflect the diverse needs of our NHS people
- Build health and wellbeing metrics into performance dashboards

- Establish regular ways to measure employee experience to complement the staff survey
- Provide advice, guidance and support on how to promote the full range of careers in the NHS, including sharing good practice (by 2023)

- Build employee experience metrics into performance dashboards and develop clear plans to improve
- Make health and care the first choice for local employment by using our positions as anchor organisations with a strong employment brand/offer.
- remove unnecessary bureaucracy and duplication, such as repeated mandatory and statutory training.

- Engage with regulators (such as the Care Quality Commission [CQC] and the Health and Safety Executive) to provide influence and ensure greater emphasis is placed on equality, diversity and inclusion (EDI) and employee experience measures when assessing organisational performance (by 2023)

- Overhaul of recruitment processes – no more tick boxes, frictionless
- Ensure everyone has measurable EDI objectives including Board members
- Embed the principles of a restorative just culture into all people practices, for example employee relations, leadership and talent frameworks

- Introduce NHS people profession standards tailored to the needs of the healthcare sector, now and in the future
- Develop a comprehensive apprenticeship offer to increase the capability levels and professional accreditation within the profession

- Develop professional development plans for their teams and individuals to build strong capabilities in key areas (e.g. workforce planning, redesign, digital, OD)
- Undertake CPD and appraisal processes that align to professional standards and incorporate customer feedback

National/regional key actions

ICS/organisation key actions

- Develop a clear approach for talent management for all staff, including defined standards and support for organisations and ICSs
- Use digital talent management tools and platforms to enable a single view of talent across the NHS

- Proactively set the direction for talent management, working with partners across the system to a common framework
- Establish formal governance to enable senior involvement and oversight of talent management, succession planning and development

- Develop frameworks to enable people services to assess strategic alignment of resources, and range of people services operating models.
- Develop expected people management standards for managers for adoption across the service
- Establish a central repository of people service good practice

- Review functional resources to ensure alignment with national and local priorities
- Create plans for system-level consolidated and simplified transactional people services at scale
- Appoint a chief people officer [CPO] (or equivalent) as the accountable board level lead for people

- Build digital workforce and business intelligence capability at national, ICS and provider level to support operational delivery and strategic decision making
- Co-design and support the implementation of the new national People Digital Solution with the service

- Create plans and commence actions to align digital systems to enable joined-up working and decision-making across systems
- Adopt digitally enabled and intuitive transactional processes at all levels, including the opportunities for efficiency through robotics

- Develop governance and infrastructure that enables workforce plans to align with local service and financial planning; HEE plans; and the responsibilities set out in the guidance on the ICS people function
- Take account of the needs of the whole healthcare sector and its workforce in planning for the future, taking a ‘one workforce’ approach

- Develop system workforce plans that align with local service and financial planning
- Organisations and systems need to support our people to work differently and more flexibly to support action to deliver care to patients in new and different ways
- Lead action to address local supply issues, using the benefit of scale e.g. increased use of volunteers, cadets and reservists

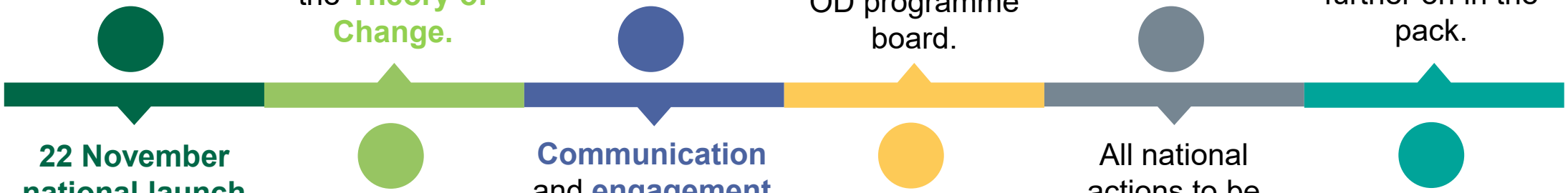
Action	ICS and organisation priorities to March 2023
 **Prioritising** the **health** and **wellbeing** of all **our people**	• Build health and wellbeing metrics into performance dashboards and consider them with the same scrutiny as operational and financial performance • Review and baseline the current health and wellbeing offer, including identifying which areas to enhance or evolve
 Creating a **great employee experience**	• Build employee experience metrics into performance dashboards • Develop strategies to make health and care the first choice for local employment
 Ensuring **inclusion** and **belonging** for all	• Embed the overhauled recruitment processes to take account of EDI considerations • Ensure that all individuals, teams and organisations have measurable objectives on EDI, including all board members
 **Supporting** and **developing** the **people profession**	• Develop professional development plans for their teams, optimising use of the apprenticeship levy
 **Harnessing** the **talents** of all our **people**	• Proactively set the direction for talent management and start embedding the approach
 Leading **improvement, change** and **innovation**	• Review allocation and distribution of people function resources to ensure alignment with the People Plan, NHS Long Term Plan and local system priorities • Create plans for system-level consolidated and simplified transactional people services
 Embedding **digitally** enabled **solutions**	• Optimise the adoption of current people digital solutions • Create plans and commence action to align and harmonise digital strategies and solutions, across providers wherever possible, to enable more joined-up
 Enabling new ways of **working** and **planning** for the **future**	• Develop system workforce plans that align with local service and financial planning; HEE plans; and the responsibilities set out in the guidance on the ICS people function • Lead action to address local supply issues, using the benefit of scale wherever possible and innovative approaches that broaden access to roles for the local community

5: Next steps: what happens next?

In this section:

- What happens next
- How the programme will be delivered: Theory of Change
- How we will engage with you
- How we will communicate with you
- Programme oversight – future of NHS HR and OD
- How the national team will support delivery
- Key opportunities for engagement in national actions
- Summary of next steps

What happens next



22 November national launch of the future of NHS HR and OD report, complemented by regional events.

The approach to delivery is summarised in the **Theory of Change.**

Communication and **engagement** with stakeholders will continue to be a core feature of the programme.

Programme oversight will be by the future of NHS HR and OD programme board.

All national actions to be **co-designed with people profession.**

The **national team will support delivery.** The role of the team is provided further on in the pack.

How the programme will be delivered: Theory of Change

Starting points vary

- Take a segmented approach, understand context and be flexible to stakeholder needs
- Avoid a 'one size fits all' approach, unless single approach adds real value
- Priorities for change will be different for each system and organisation – focus on the areas of greatest value

Innovation is adopted at different paces

- Encourage and learn from innovators (see the innovation adoption curve on next slide)
- Support early adopters – with expertise and resources
- Spread learning from innovators and early adopters to encourage wider adoption

Momentum is important

- Regular constructive two-way engagement with stakeholders on what is needed and draw out opposition
- Keep high profile for the programme through regular, interesting communications – celebrate successes widely
- Key influencers will vary depending on the action – e.g. role of the board, CEO and CPO

Co-design builds commitment for real change

- Co-design and production is crucial to development approach at national, regional, ICS and organisation level
- Engage people profession in developing and designing change: leading groups and/or projects
- HRD/CPO leadership and people profession delivery expertise co-opted

Impact is created by behaviour change

- Support organisations to enable change; share practices that have had impact
- Create opportunities for joint learning between senior people leaders
- Learn from change that did not deliver planned benefits and adapt approach

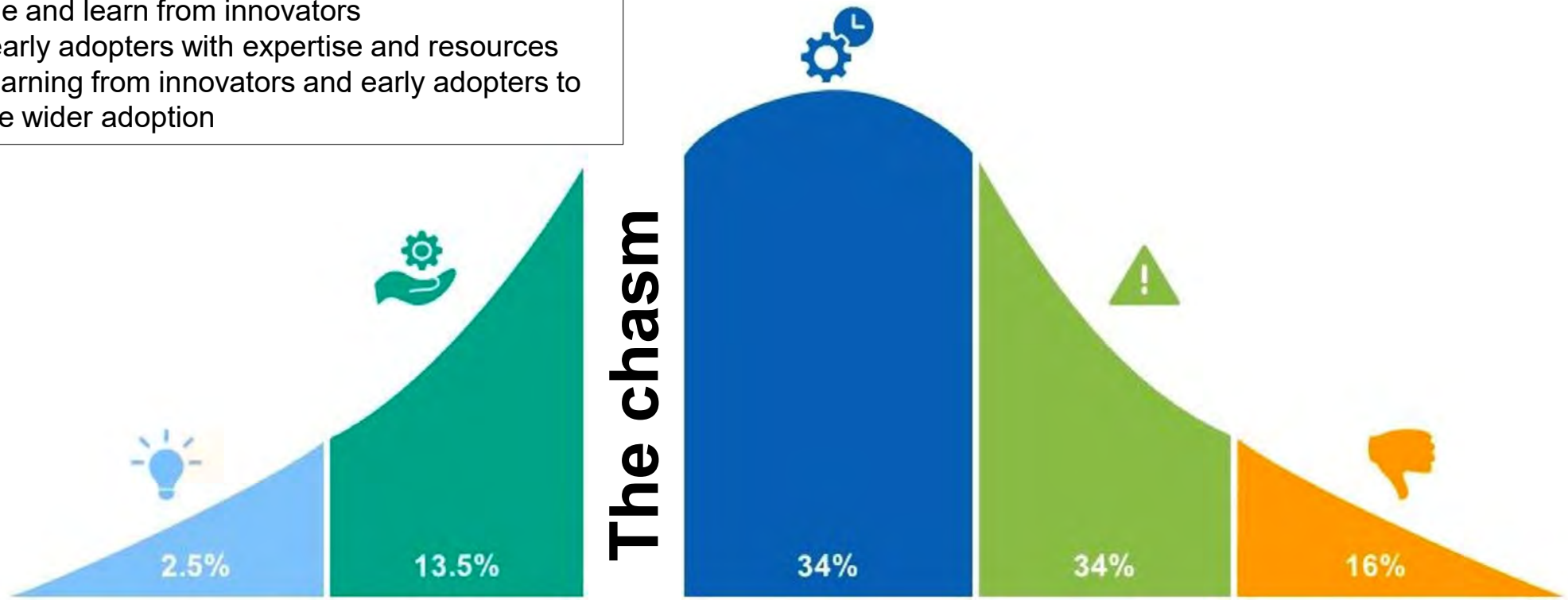
Incentivise action

- Identify the formal and informal levers in the service to incentivise action
- Allocate funding, where available, to the recommended actions to strengthen importance
- Develop measures that makes visible progress and action

Innovation adoption curve

Innovation is adopted at different paces:

- Encourage and learn from innovators
- Support early adopters with expertise and resources
- Spread learning from innovators and early adopters to encourage wider adoption



Innovators
Brave people, pulling the change. Innovators are very important in communication.

Early adopters
Opinion leaders, try out new ideas, but in a careful way.

Early majority
Thoughtful people, careful but accepting change more quickly than the average.

Late majority
Sceptic people, will use new ideas or products only when the majority is using it.

Laggards
Traditional people, caring for the old ways, are critical towards new ideas and will only accept it if the new idea has become mainstream.

How we will engage with you

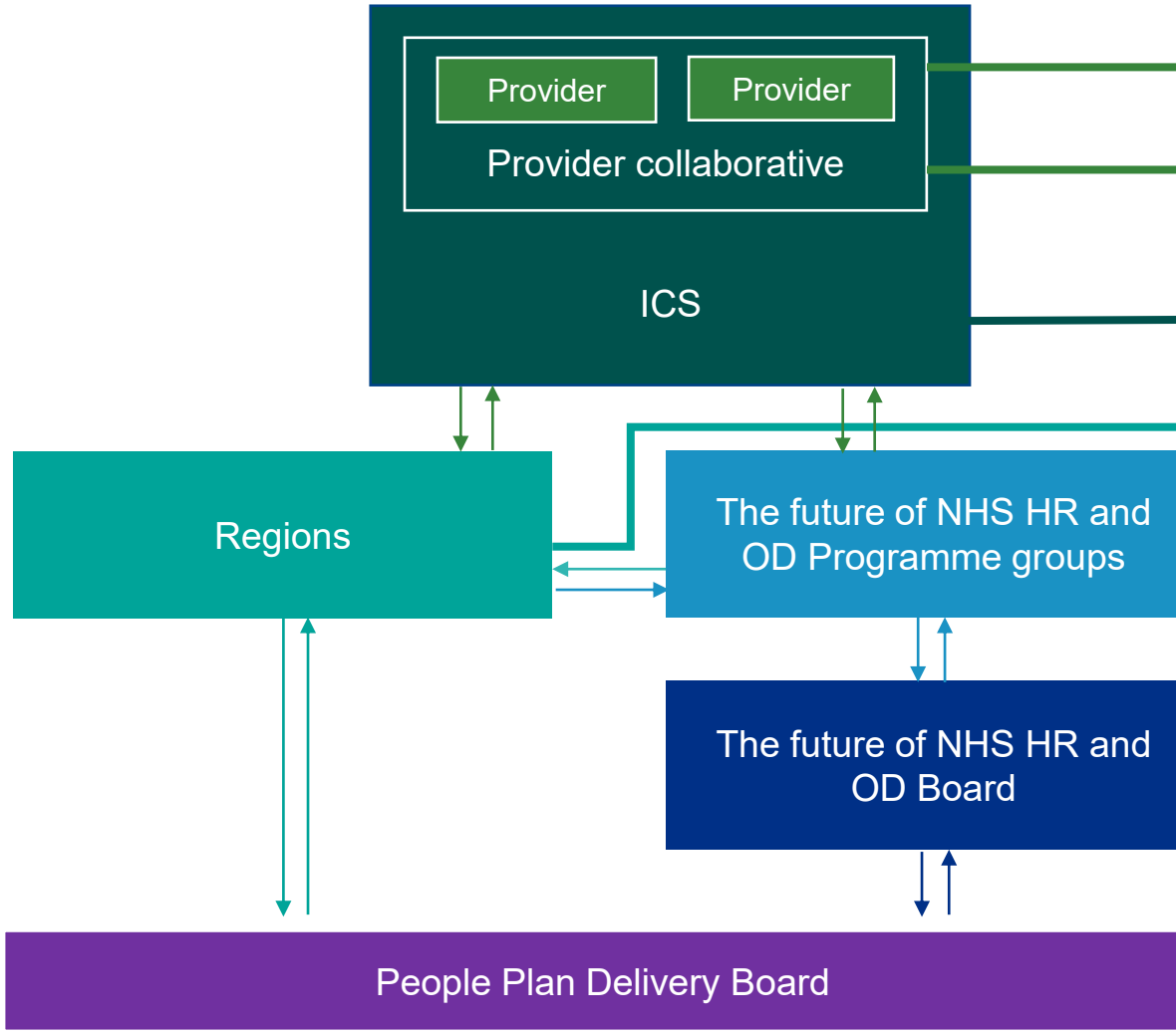
Engagement method	Focus	
Crowdsourcing	• Generating ideas and inputs • Check and challenge proposals	• All people professionals • All customers
Working groups	• Co-design of programme outputs	• Variable – to include a cross-section of leaders, specialists and customers of the service
Regional HRD networks	• Two-way dialogue on the programme with a focus on specific issues to gain input or check and challenge	• Senior people leaders
NHS Chief People Officer webinars	• NHS Chief People Officer and Chief HR & OD Officer sharing strategic updates • Engagement through breakouts, interactive software and chat box	• Senior people leaders
Social Partnership Forums	• Two-way dialogue on the programme. Likely to focus on specific issues to gain input or check and challenge	• National and regional trade union leaders
Website forum	• Facilitate discussions on issues relating to the programme • Sharing of best/good/innovative practice	• Staff registered, primarily people professionals
ICS Connection Sessions – from January 2022	• Two-way dialogue on the programme with a focus on specific issues to gain input or check and challenge	• ICS senior people leaders • Regional directors of workforce and OD • Regional heads of HR • Regional heads of transformation • Regional heads of staff experience and engagement
Briefings for networks / interest groups	• Two-way dialogue on the programme with a focus on specific issues to gain input or check and challenge	• Network/interest group members
Briefings for boards	• Two-way dialogue on the programme with a focus on specific issues to gain input or check and challenge	• Specific audience
One-off events (e.g. conferences, webinars)	• Gain input on one or more aspects of the programme	• Variable – will depend on the focus of the event

How we will communicate with you

	Senior leaders and professionals	HRDs/CPOs	People professionals	Trade unions (SPF)
FutureNHS website		• Launch new products • Promote engagement opportunities • Publicise website material	• Launch of new products • Promote engagement opportunities • Publicise website material	
HRD email updates (Our NHS People leaders inbox)		• Launch new products • Promote engagement opportunities • Publicise website material		
NHS People (previously bulletin CPO bulletin)		• Launch of new products • Promote engagement opportunities	• Launch of new products • Promote engagement opportunities	
NHS CPO email		• Direction to act		
HRD WhatsApp		• Launch of new products • Promote engagement opportunities • Publicise website material		
COO bulletin (Healthcare Leaders Update)	• Action for boards and organisations • Promote opportunities to engage			
Chief Nursing Officer bulletins	• Launch of products • Promote engagement opportunities			
ICS fortnightly bulletin	• Action for Boards/ organisations • Promote engagement opportunities	• Launch of new products • Promote opportunities to engage		• Launch of new products • Promote engagement opportunities
NHS Employers workforce bulletin		• Launch of products • Promote engagement opportunities	• Launch of products • Promote engagement opportunities	• Launch of new products • Promote engagement opportunities

Programme oversight – future of NHS HR and OD

Our new Operating Model provides clarity on complex and interwoven accountabilities. It allow us to maintain the confidence of the public and successfully stand up to external scrutiny. Each part of the system will only be able to meet their accountabilities through collaboration and partnership working.



Providers: remain accountable for people management and people services provision. This includes delivery of the workforce aspects of NHS Long Term Plan, including the People Plan, and future of NHS HR and OD actions for organisations.

Provider collaboratives: some aspects of the future of NHS HR and OD programme delivery may most appropriately be delivered by provider collaboratives.

ICSs: accountable to regions for delivery of the ICS people functions, workforce aspects of NHS Long Term Plan. This includes the People Plan, and future of NHS HR and OD actions for organisations at system level.

Regions: the future of NHS HR and OD programme will liaise with the regions, primarily through the established regional quartet groups. Regional oversight of the implementation of the programme will be through regional people boards.

The future of NHS HR and OD programme: has a dedicated team in the national HR Development and OD team, including PMO. The programme will establish working groups to deliver actions in the report, with leadership by senior people leaders.

The future of NHS HR and OD Board will oversee the programme and provide assurance on progress. Membership of Board is proposed to include organisational senior people leaders, People Directorate SLT leads, HEE, CIPD, HPMA, NHS Employers, and staff side.

People Plan Delivery Board: oversight of the future of NHS HR and OD programme by the Board to ensure alignment with People Plan. It is proposed that a report is provided every four months to the board

Key opportunities for engagement in national actions

HRD/CPO led working groups **All national actions designed with the service**	• We want HRDs/CPOs to lead working groups, and have contributions from all regions on all working groups. • We will work with regional networks to identify leads and members of groups. If you are interested in getting involved please contact thomas.simons1@nhs.net andy.brown12@nhs.net
Engagement through networks	• Regular updates and opportunities to contribute through networks
Crowdsourcing – 2-3 'Big conversations' per year	• Opportunities for the whole people profession and customers to directly contribute to delivery of the Future of NHS HR and OD programme. • Opportunities will be communicated widely through the normal channel.
Workshops and events	• We will share opportunities to engage through workshops and events to help to shape the future (e.g. development of people professional standards)
Sharing how you're developing your people services	•Share your case study for inclusion in our repository FutureNHS network. •Please contact nhsi.futureofhrandod@nhs.net

How the national team will support delivery

The purpose of the national **HR Development and OD function** is to lead the transformation of people services and profession in the NHS. The functions three **strategic priorities** are:

- **transform** people services in the NHS
- **build and increase** the capabilities of NHS people professionals to deliver the NHS People Plan and NHS Long Term Plan
- **engage, support and enable** NHS people professionals to deliver the NHS People Plan and NHS Long Term Plan

The **People Professional Development** team will:

a. deliver national actions in the future of NHS HR and OD report related to the **supporting and developing the people profession** theme
b. deliver in partnership with NHS Employers the DoOD programme and build OD capability in the profession
c. lead communications and engagement of the programme and nationally with senior people leaders (e.g. NHS CPO webinar)

The **People Services Transformation** team will:

a. deliver national actions in the future of NHS HR and OD report related to the **leading improvement, change and innovation** theme
b. work closely with the People Digital Strategy team (to be established) to deliver national actions in the future of NHS HR and OD report related to **embedding digitally enabled solutions** theme
c. co-ordinate overall delivery of the future of NHS HR and OD programme through a programme office

Meet the team

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Summary next steps for trust boards

- Discuss the report and opportunities it provides for the Trust
- Understand how your ICS and/or provider collaborative is planning to achieve the ambitions of the 2030 vision
- Approve the plan to achieve the ambitions of the 2030 vision in your organisation
- Agree how you will oversee delivery of your organisation's plan

Additional resources

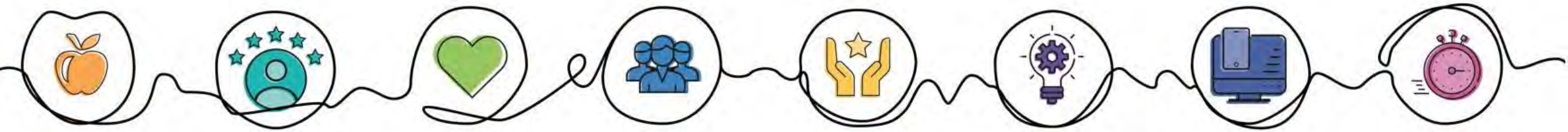
Web version of the report

- including video case studies can be accessed here

Future of NHS HR and OD on FutureNHS network

- Repository of case studies
- Report, presentation and communications assets
- More to follow – including a discussion forum

To access to the site please contact nhsi.futureofhrandod@nhs.net



NLG(21)263

DATE OF MEETING	7 December 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 – M07**
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 07 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**
			✓		✓

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Finance Report Month 7

October – 2021/22

Executive Summary Month 7 2021/22

NHS Northern Lincolnshire and Goole NHS Foundation Trust

The Trust reported a £0.30m deficit for the month of October, which was £0.22m better than plan. The year-to-date position is now a £0.49m deficit, which is marginally favourable (£0.24m) to plan.

Income was £1.85m above plan in month.

- The main reasons for this were 3% pay award funding, Ockenden funding, Pathology ULHT activity, HIV drug recharges, accommodation income, Covid-19 outside envelope funding and an increase in Covid-19 block income, primarily for the 3% pay award. Donated income, excluded from NHSE&I financial targets, was also £0.57m above plan due to EPC/decarbonisation funded schemes commencing later than expected.
- Elective Recovery Funding (ERF) – the trust has achieved an estimated £3.83m ERF income year-to-date, subject to further validation of the activity. The Trust achievement of ERF income is also dependant on the overall ICS position. The ICS did not achieve any ERF income in month due to not achieving the revised activity productivity target of 89% of its total 19-20 completed RTT pathways.

Pay was £0.92m overspent in month.

- Medical staff was £0.65m overspent in month. Approximately £0.15m was due to the 3% pay award, offset by pay award funding described above. The remaining overspend was partly due to Anaesthetic Middle Grade rota delays, and agency premiums for covering vacancies predominantly in Urology, T&O, Stroke, Gastro and Paediatrics. The overspend also includes additional waiting list expenditure in Ophthalmology, ENT, Cellular Pathology and General Surgery, and an estimate for unfunded Middle Grade pay reforms.
- Nursing was £0.09m overspent in month. Approximately £0.3m was due to the 3% pay award, offset by pay award funding. There were some overspends due to use of escalation and surge beds and increased staff absence, offset by continued underspends in Midwifery.
- Other Pay variances include £0.32m due to the 3% pay award, offset by pay award funding. There were also £0.025m Flowers costs, for which the Trust has not been reimbursed (£0.18m year-to-date).

Non Pay was £0.32m overspent in month mostly due to additional activity in Pathology, HIV drugs (recharged as income, see above), Community Wheelchairs, Orthotics, and Cardiology and Gastro drugs.

Post EBITDA items were £0.13m underspent in month on depreciation and dividends due to capital programme delays.

COVID-19 Specific Expenditure

- The Trust has incurred £8.0m expenditure as a direct consequence of the pandemic, marginally within its covid expenditure funding of £8.48m (£8.91m total covid funding less £0.43m funding for loss of car parking income and loss of other income).

Income & Expenditure to 31st October 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	28,842	155	200,808	205,286	4,479
ERF Income	9,761	0	0	0	9,761	3,834	(5,927)
Block Top Up	59,816	4,985	5,566	581	34,892	35,472	580
Covid Inside Envelope Block	13,524	1,127	1,258	131	7,889	8,020	131
Covid Outside the Envelope	690	0	133	133	690	886	196
Other Income	37,182	3,098	3,381	283	21,689	21,996	307
Donated Income	41,638	0	565	565	41,638	6,227	(35,411)
Clinical Pay	(247,987)	(20,482)	(21,315)	(834)	(145,541)	(149,718)	(4,176)
Other Pay	(67,795)	(5,643)	(5,732)	(89)	(39,537)	(40,391)	(854)
Total Pay	**(315,783)**	**(26,124)**	**(27,047)**	**(923)**	**(185,078)**	**(190,109)**	**(5,030)**
Clinical Non Pay	(68,025)	(5,392)	(5,761)	(369)	(40,915)	(39,490)	1,425
Other Non Pay	(68,375)	(5,486)	(5,431)	55	(41,077)	(37,868)	3,209
ERF Expenditure			0	0		0	0
Total Non Pay	**(136,400)**	**(10,878)**	**(11,192)**	**(315)**	**(81,993)**	**(77,358)**	**4,634**
Operating Expenditure	**(452,183)**	**(37,002)**	**(38,240)**	**(1,238)**	**(267,071)**	**(267,467)**	**(396)**
EBITDA	**54,669**	**895**	**1,506**	**612**	**50,296**	**14,254**	**(36,042)**
Depreciation	(12,539)	(1,019)	(927)	92	(6,708)	(6,414)	294
Interest Expenses & Other Costs	(186)	(16)	(18)	(2)	(109)	(264)	(156)
Dividend	(4,939)	(401)	(363)	38	(2,728)	(2,421)	307
Total Post EBITDA Items	**(17,664)**	**(1,436)**	**(1,307)**	**129**	**(9,544)**	**(9,099)**	**445**
Remove Capital Donated I&E Impact	(41,374)	22	(499)	(521)	(41,487)	(5,794)	35,693
I&E Surplus / (Deficit)	**(4,369)**	**(519)**	**(300)**	**219**	**(735)**	**(494)**	**241**

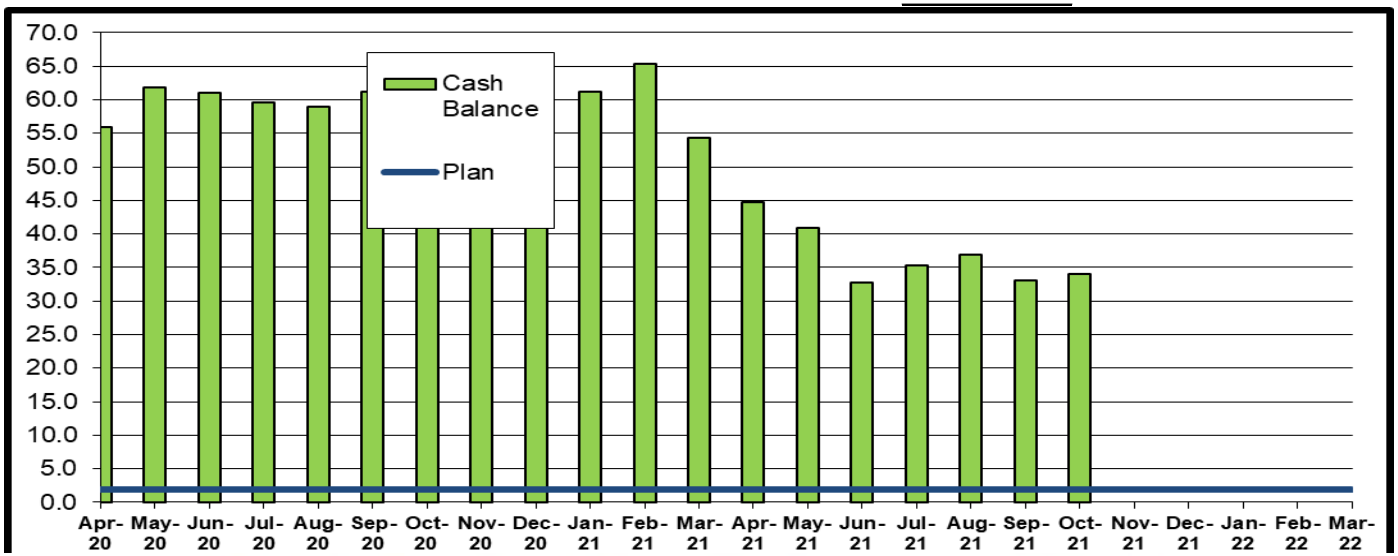
COVID-19 Expenditure

Expenditure Category	Year-to-date 21-22		
	Pay (£k)	Non-pay (£k)	Total (£k)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	1,756	0	1,756
Existing workforce additional shifts to meet increased demand	3,396	0	3,396
Backfill for higher sickness absence	1,369	0	1,369
Total Testing - In Envelope	293	59	352
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	6	0	6
Segregation of patient pathways	0	37	37
Decontamination	0	148	148
After care and support costs (community, mental health, primary care)	0	35	35
Remote working for non-patient activities	0	0	0
Outside Envelope COVID-19 - Vaccination Programme - Provider/ Hospital hubs	96	5	100
Outside Envelope COVID-19 - Deployment of final year student nurses	141	0	141
Outside Envelope COVID-19 - International quarantine costs	0	6	6
Outside Envelope COVID-19 virus testing - rt-PCR virus testing	0	24	24
Outside Envelope COVID-19 virus testing - Rapid / point of care testing - all other locally procured devices	0	598	598
Outside Envelope COVID-19 virus testing - Rapid / point of care testing (for DHSC provided Samba2, DNA Nudge, Primer Design, LumiraDx and Abbott ID NOW)	1	0	1
Outside Envelope NIHR SIREN testing - research staff costs	16	0	16
Total Trust Operating Expenditure (including COVID-19 expenditure and all other operating expenditure)	190,109	77,358	267,467
COVID-19 % of Total Trust Operating Expenditure	3.7%	1.2%	3.0%

Cash

The cash balance at 31st October was £33.98m, an in-month increase of £0.95m.

	£m	£m
Cash Balance as at 31st October		**33.98**
Commitments:		
Income received in advance	5.13	
Capital creditors	6.62	
Grant funding due	-2.00	
Capital loan repayments	0.61	
October PAYE/NI/Pension	10.76	
Public Dividend Capital	0.60	
Annual leave income	4.49	
Invoices due for payment not yet authorised	4.41	
To support other creditors due	1.46	
		(32.08)
NHSi minimum balance		**1.90**



Balance Sheet as at 31st October 2021

	Last Month £mil	This Month £mil
Total Fixed Assets	201.51	207.76
Stocks & WIP	3.65	3.69
Debtors	17.75	10.48
Prepayments	5.85	6.75
Cash	33.03	33.98
Total Current Assets	60.28	54.90
Creditors : Revenue	44.04	38.31
Creditors : Capital	3.38	6.62
Accruals	13.94	15.40
Deferred Income	3.77	5.13
Finance Lease Obligations	0.01	0.01
Loans < 1 year	0.75	0.77
Provisions	1.06	1.37
Total Current Liabilities	66.95	67.61
Net Current Assets/(Liabilities)	(6.67)	(12.72)
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)	180.74	180.93
TOTAL CAPITAL & RESERVES	180.74	180.93

- Stock has again remained stable in month.
- Debtors reduced in month following the receipt of the pay award funding.
- The Trust has seen an increase in deferred income, £3.35m relates to Health Education income for November to January 2022.
- Revenue creditors and accruals have reduced, all invoice payments had cleared by the month end. The increase in capital creditors relates to the Emergency department scheme. The BPPC figures for the Trust are continuing to be above 90% for non-NHS invoices, the in month value paid within 30 days was 93.68% and the number of invoices paid 93.21%. NHS invoices reduced in month to 85.09% relating to the value paid within 30 days and a reduction in the number paid to 72.32%. All invoices need to be authorised promptly in order to comply with this target. NHSE/I are now monitoring Trusts on their performance, the target is 90%.

NHS
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NLG(21)264

DATE OF MEETING	7 December 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Gill Ponder, Chair of Finance & Performance Committee
CONTACT OFFICERS	N/A
SUBJECT	Highlight Report from Committee Meetings on 27 October and 24 November 2021
BACKGROUND DOCUMENT (if any)	Minutes of meetings
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	• Both the Trust and ICS had achieved the H1 financial plan. • The Trust continued to overspend on temporary staffing. • Grant funded capital would underspend and agreement had not been given to roll EPC funds into 2022/23. • The H2 plan had been submitted, with risks to delivery. • The assumptions and draft long-term plan to reduce the underlying financial deficit were reviewed. • Use of Resources report highlighted areas where the Trust benchmarked favourably, as well as potential opportunities. • Proposal for new PAS supported to enable collaboration. • Assurance received on progress with Digital Strategy.

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	SO1 1.2 SO1 1.3 (now realigned to Strategic Development Committee) SO1 1.4 SO1 1.5 SO1 1.6 SO3 3.1 SO3 3.2 SO4 (now realigned to Strategic Development Committee)				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	✓

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	7 December 2021
Report From:	Finance & Performance Committee 27 October and 24 November 2021

Highlight Report:

- Both the Trust and ICS had achieved the H1 financial plan.
- High levels of spend on temporary staffing continued due to vacancies, additional activity and quality measures to improve patient safety. This presented a risk to achievement of the H2 plan.
- Concern continued about the level of non-recurrent CIP savings.
- The Trust would achieve the Capital CDEL measure, but would underspend on the grant-funded energy efficiency schemes due to supply chain issues. Until funding arrangements for 2022/3 were clarified, it had not been possible to place large contracts that would carry over, adding to delays and it had now been confirmed that the funding would not roll forward to 2022/23.
- The biggest risks to the delivery of the H2 financial plan were the ability to constrain the cost of labour, an additional efficiency challenge and the achievement of the 89% threshold to qualify for Elective Recovery Funding.
- The Committee reviewed the assumptions and draft long term financial plan to reduce the Trust's underlying deficit, as this plan was one of the criteria to be met to exit from the Recovery Support Programme for finance.
- The Use of Resources report was reviewed by the Committee. The Trust's cost per WAU would be investigated to see if savings could be made.
- The Committee supported the proposal to invest in a PAS that would enable sharing of patient information between NLAG and HUTH.
- The 3 year CDIP programme would conclude in 2022. Assurance was received on progress with the Digital Strategy, plans to replace paper records and capture data once only, but clinical engagement was key to success.

Confirm or Challenge of the Board Assurance Framework:

There remained a need to reduce spend on temporary staffing by filling vacancies.
The proposed use of a PAS system to enable patient information to be shared between NLAG and HUTH created a potential future risk if there were further changes to organisations and boundaries but was the right thing to do to improve patient care now.

Action Required by the Trust Board:

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

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)265

DATE OF MEETING	7th December 2021
REPORT FOR	Trust Board (Public)
REPORT FROM	Shaun Stacey, Chief Operating Officer
CONTACT OFFICER	Richard Peasgood, Executive Assistant
SUBJECT	Emergency Care Centre Update and Ambulance Handovers
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The Operational Update details the current position with ED and ambulance waits.

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

Urgent and Emergency Care

Highlights	Lowlights
• The Urgent Care Service (UCS) went live at SGH on 18th October and is showing the following benefits: ➢ First week of November has average UCS performance at 97.7% against the 4hr target ➢ The waiting room is less crowded ➢ Patients are being seen quicker ➢ Reduction in number of investigations carried out ➢ Positive feedback from patients ➢ Positive feedback from clinicians ➢ Increase in SDEC activity	• UCS at SGH unable to operate 24/7 yet due to lack of primary care workforce overnight and shortage of ENPs • October performance against the 4hr target was 52.9% (DPOWH 45.8%, SGH 55.1%) • 115x 12hr DTA breaches during October (78 at DPOWH and 37 at SGH) due to ongoing challenged patient flow (ED exit block)
• Work is underway to implement the UCS model at DPOWH, linking in with NELCCG urgent GP hub appointments pilot to promote redirection of non-ED patients from streaming	• ED attendances continue to be higher than last year with covid-19 implications and social distancing restricting the physical capacity • Increase in walk-in attendances with non-ED patients due to lack of alternative service availability/accessibility
• ED middle grade rota consultation to commence 1st-30th November with expected implementation in January 2022. New posts already started to be appointed to • New clinical leadership structure introduced for ED and UCS	• Workforce sickness, covid-19 isolation, vacancies, low morale and impacts on staff wellbeing continue to challenge rota fill with reduction of bank/agency pick up • High reliance on agency doctors and nurses to support safe staffing numbers but adds challenge of less experience
• The new ED builds are progressing well with DPOWH expected completion in April 2022 and SGH late 2022. Procurement of clinical equipment and digital strategy being finalised	• Delays in diagnostic imaging at times and in specialty in-reach not meeting the less than 30min attendance to review Emergency Care Standards

Risks

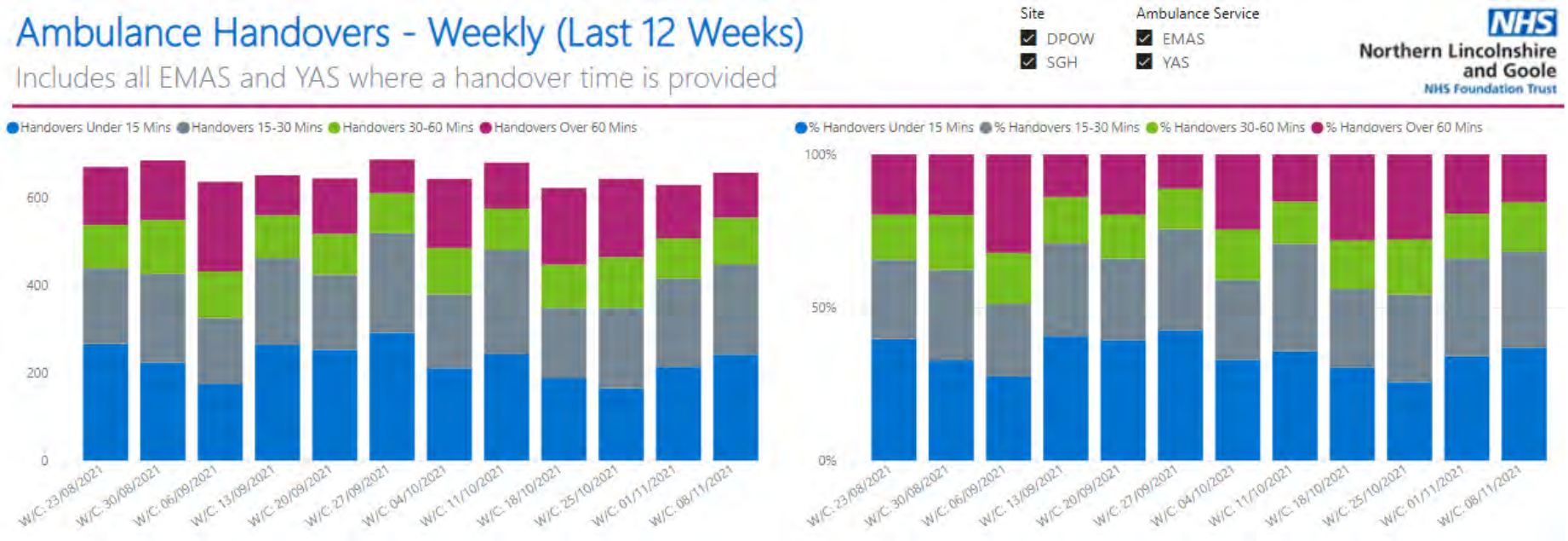
- Shortage in available workforce to meet service needs (skill mix and experience) – Reliance on agency doctors and nurses
- Risk of delays in booking in walk-in patients due to no capacity within ED waiting area to bring more patients into the ED
- Inappropriate attendances and conveyances to ED
- Covid-19 impacting physical capacity within the current ED footprint
- High acuity levels and patients remaining in resus for significant periods of time rather than being stabilised and transferred to a suitable service (ITU/HDU)

Ambulance Handovers

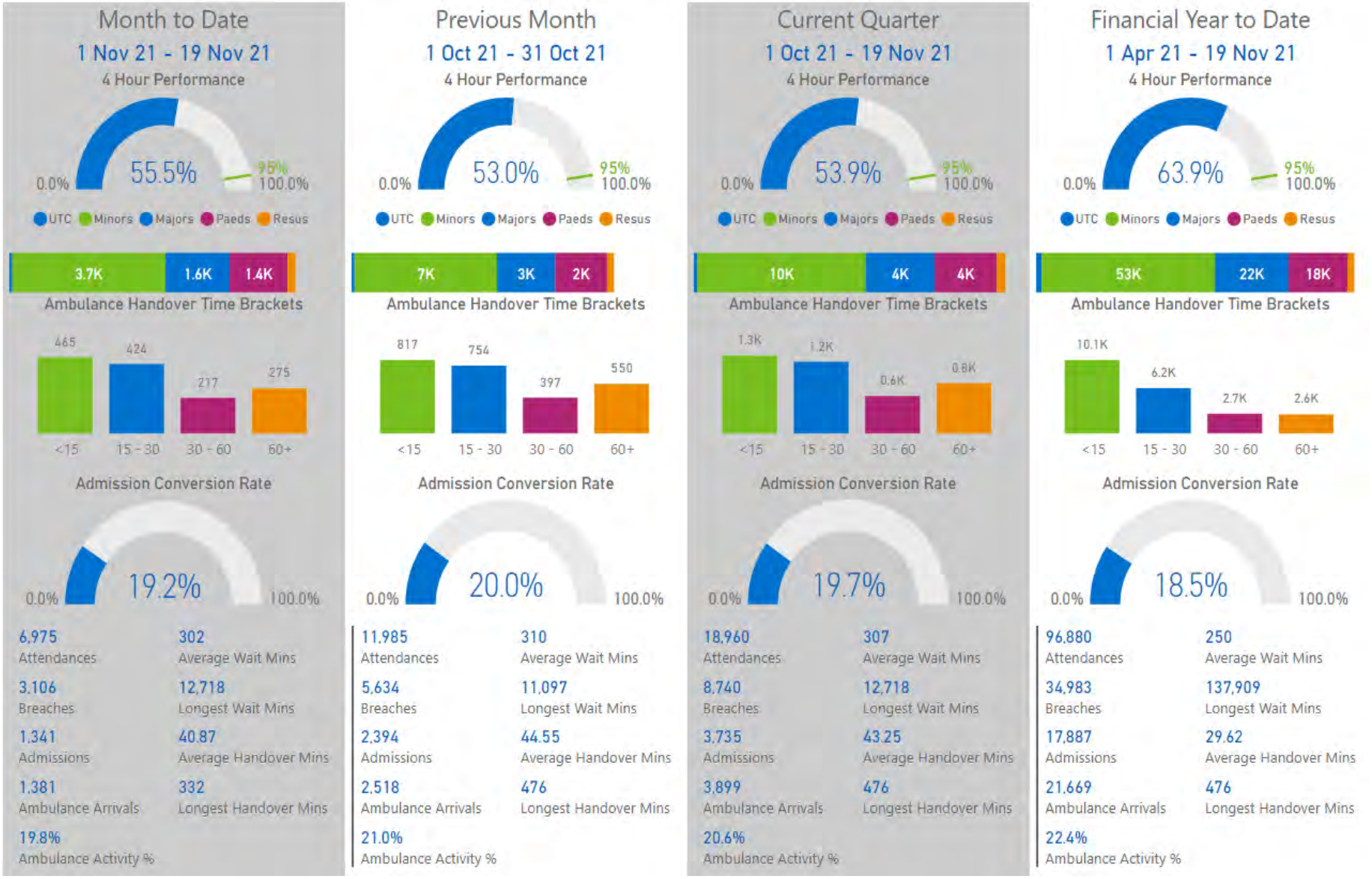
Highlights	Lowlights
• HCV wide ambulance improvement plan in development • Relaunch of 'direct to SDEC' ambulance pathway bypassing ED showing small increase in success referrals • Patient self-handover protocol is compatible with UCS model for patients who meet UCS criteria	• October saw 32% of ambulance handovers completed in under 15mins and 22% taking 60mins+ (DPOWH 294, SGH 345) • Northern Lincolnshire is experiencing highest levels of acuity for EMAS conveyances impacting on resus capacity • Frailty Pathway DPOWH - The SPA service is reporting that this is not being utilised by the ambulance crews. EMAS working on internal promotion of pathway

Risks

- Lack of patient flow through the system is resulting in exit block in ED for patients requiring admission delays in offloading patients from incoming ambulances



ED Performance



NHS
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NLG(21)266

DATE OF MEETING	7th December 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
SUBJECT	**Executive Report - Strategic & Transformation**
BACKGROUND DOCUMENT (if any)	
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 Programme 1 Interim Clinical Plan and Programme 2 Core Service Change • The progress that is being made on the development of a Capital SOC to support major capital investment within NLAG and HUTH • Our continued participation in and leadership of collaborative ventures through partnership working

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)	**Description of Strategic Objective 1 – 1.3**: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. **Risk to Strategic Objective**: 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 **Description to Strategic Objective 4**: To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. **Risk to Strategic Objective**: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			✓

Strategic Service Development and Improvement – December 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 ***(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) 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.

Highlights	Lowlights	Risks
Overall • Progressing Joint Development Board to report to Committees in Common between both NLAG and HUTH to oversee Programme 1 – Interim Clinical Plan • Positive response to the submission of the Humber Hospitals £720 million Expression of Interest (EOI) • Gateway reviews successfully progressing including formal Independent Clinical Reviews for Programme 2 • Circa 8000 responses received through the What Matters to You engagement • Agreement of Primary/Secondary Care Interface Groups as link for Primary Care • Informatics scope agreed (GIS Process and model agreed across programme) • HASR Digital workshop held • Programme 2 Evaluation workshop held (high level advantages/disadvantages) **Programme 1:** • 4/10 Humber clinical leads appointed and in post • Phase 1 specialties strategies drafted and going through internal and external governance for feedback. Strategy workshops for all phase 2 specialties held and drafts being prepared for approval • MoU and SLA finalised and signed off. • Activity, contracting and finance processes all mapped through for Neurology and plan for change completed for approval as test specialty, now being rolled out to Haematology and then Oncology, subject to additional digital resource support. **Programme 2:** • Continued programme of workshops and focus groups for all 3 programmes as we progress into evaluation phase • Workforce skills and new roles workshops for all 3 programmes including HEE/Universities/wide range of clinical, nursing and AHP roles • Data cycles and evaluation including Out of Hospital integration and impact continues • Engagement with, Ambulance (EMAS/YAS), Voluntary Sector to support options development and evaluation • System wide Transport workshop held in September and follow up workshop scheduled end November to develop future opportunities	• Complicated acute review spanning all programmes and aligning to out of hospital and community diagnostic changes • Challenges of continuous engagement and involvement / time commitments for busy operational staff (including key clinical leads during recovery phase) • Capital funding sources not yet agreed	• Alignment of PCBC and Capital SOC – Strategic and Economic Case to ensure successful completion of NHSE/I Gateway 2 Process • Pathways in P2 look beyond hospital boundaries and require OOH transformation • Potential options may be subject to OSC, Public challenge resulting in IRP Review, JR or SoS review • Potential options may displace activity to neighbouring health economies • Aligning all out of hospitals programmes to avoid duplication

- Mental Health workshop scheduled for October and follow up scheduled early Dec to work through issues and opportunities
- Engagement with ICS, HEE and NHSE/I National workforce planning leads on areas to consider for future healthcare skills planning and workshops scheduled for November across all key stakeholders to develop
- Continues engagement with Doncaster and Lincoln health systems re potential displacement activity and EMAS/YAS in terms of potential pathway changes
- Engagement with Primary Care Networks aligning to Out of Hospital programmes in place
- NHSE/I monthly assurance review continue with positive challenge and support
- First high level draft and review of the Pre Consultation Business Case progressing at draft level populating the following areas in readiness for co-production through to December:
  - Case for Change
  - PH Data
- Options – Case for change, benefits, pathways, patient and staff impact, evaluation
- Evaluation Criteria Framework in place. Progressed to high level evaluation of the advantages and disadvantages of the proposed models and options
- Clinical Senate reviews being scheduled for February including evaluation
- Geographical Intelligence System (GIS) spacial mapping in development for the options alongside additional BI data modelling for Planned Care and Diagnostics

Programme 3

- Following submission of EOI, workshops progressed the development of the Capital SOC aligned to the PCBC
- 5-10 year modelling progressing with agreed assumptions linking to PCBC

- 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
- Potential further COVID wave and ability to continue with engagement and evaluation of key stakeholders
- Capacity to roll out activity, contracting and finance processes to other specialties in P1

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 • Linkages and alignment to the ICS Out of Hospital Programme Board and U&EC Network as part of the HAS Programmes. **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

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NLG(21)267

DATE OF MEETING	7 December 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 – 4 November 2021
BACKGROUND DOCUMENT (if any)	HTF Trustees' Committee ToRs
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None
EXECUTIVE SUMMARY	The attached highlight report summarises key issues presented to and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 4 November 2021 and worthy of highlighting to the Public 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:	7 December 2021
Report From:	Health Tree Foundation Trustees' Committee held on 4 November 2021

Highlight Report:

Smile Contract

- The Trustees agreed to extend the end of the current Smile Contract by 3 months, from 31 March 2022 to 30 June 2022. This decision was taken in order to allow for an orderly re-tendering of the contract, which provides the staff for the day to day management of the Health Tree Foundation.

Approval of New Post

- The Trustees approved the funding of a Band 7 post within Community & Therapies Division. The fixed term, one year, post will cost £75,254 and the post holder will join two others in delivering the roll out of End of Life Programme outputs, including The Bluebell Principles, Documentation on Last Days of Life and Pain assessment and administration of analgesia.

ReSPECT Post

- The Trustees received an update on a Band 7 ReSPECT Process Facilitator post that Health Tree Foundation had funded for 2 years in October 2019. The post was filled in August 2020. It appears that NHSE/I wish the post holder to work across other trusts for the remaining 8 months of her tenure, something that was not envisaged when the original funding was approved. Dr Wood agreed to investigate the matter further and to seek recompense for the Health Tree Foundation if appropriate. In addition, the Charity manager undertook to ensure that any positions that the charity has already funded or will fund in the future would have a managerial liaison appointed, who would keep Health Tree apprised of developments with the post and provide Trustee progress reports as necessary.

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

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NLG(21)268

DATE OF MEETING	7 December 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Linda Jackson -Acting Trust Chair
CONTACT OFFICERS	Linda Jackson – Acting trust Chair
SUBJECT	Humber Acute Services Development Committee Highlights from meeting held on 7th October 2021
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	To present the highlights from the HASDC held on 07.10.2021

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

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	7TH December 2021
Report From:	Linda Jackson – Acting Trust Chair

Highlight Report:

Director's Overview Report

Ivan McConnell presented the overview and advised that programmes 1 2 and 3 were progressing well. During October, November and December desk top deep dives will take place. There had been positive feedback and challenge received from the recently held peer and senate reviews.

There was good discussion regarding when Programme 1 would leave the oversight of the HASDC. It was agreed that the oversight of these programmes would sit with the Joint development Board which has representatives from both HUTH and NLAG. This committee will provide a highlight report through to the HASDC and will flag any risks and areas for concern will be escalated

There was concern raised about how the patient pathways will be managed between the different IT systems -Lorenzo at HUTH and Web V at NLAG. It was agreed an informal briefing would be arranged outside of the meeting and there would be a substantial agenda item in the next meeting to address any outstanding concerns

Capital – Expression of Interest

Ivan McConnell advised that as part of the national programme the Trust had submitted the EOI on the 9 September and was currently undergoing an evaluation process; timings have not been released yet. We continue to develop key elements of the Capital Investment SOC with evaluation workshops being held during October and November.

Communication Plan and Engagement

The change programme is supported by ongoing engagement and involvement. Staff, patients, public and their representatives have been asked "What matters to you?" A total of 3883 responses were received; the feedback from these will form the basis of the evaluation framework that will be used to assess the potential options. The key theme that came out of the survey was "been seen and treated quickly" was considered extremely important. Next steps included staff and public awareness, targeted engagement and evaluation workshops

Item: Oncology

Delivering against the plan and access to services are being sustained. There are however, workforce challenges and pressures on breast oncology due to capacity. Feedback from a regional stocktake would be taken to the Alliance Cancer Board next week.

Confirm or Challenge of the Board Assurance Framework:
N/A
Action Required by the Trust Board:
The Trust Board is asked to note the key points made and consider whether any further action is required by the Board at this stage. **Linda Jackson** **Acting Trust Chair/Rotational Acting Chair of HASDC**

NHS
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NLG(21)269

DATE OF MEETING	7 December 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Linda Jackson -Acting Trust Chair
CONTACT OFFICERS	Linda Jackson – Acting trust Chair
SUBJECT	Strategic Development Committee - Highlights from meeting held on 23rd November 2021
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	To present the highlights from the Strategic Development Committee held on 23.11.2021

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

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	7TH December 2021
Report From:	Linda Jackson – Acting Trust Chair

Highlight Report:

The inaugural meeting of the Strategic Development Committee took place on 23rd November 2021. The key highlights from the meeting to the Trust Board are as follows:

- The Terms of reference of the Committee were agreed with just one amendment which was to add the CIO to the core membership

- The draft work plan was approved until the end of March 2021.A full 12-month workplan will be produced in February once the external landscape becomes clearer

- Further work is to be undertaken with the Chairs of the F&PC and ARG to ensure each committee is clear what items will go to which committee to avoid unnecessary duplication between the three Trust Board Sub Committees

- Standard agenda format for the committee was agreed to cover 3 areas.:
    - **External Strategic Relationships** – ICS, Acute collaborative and Place relationships
    - **Implementation of the NLAG Clinical Plan** – HASR Programmes 1&2 and enabling strategies
    - **Capital Funding Development** – HASR Programme 3, Strategic Capital

- There was a good debate and commitment to ensuring that this committee allowed sufficient time on the agenda to horizon scan and incorporate some blue sky thinking and not solely focus on tactical issues

- The committee received an update on the NLaG Clinical Strategy. This update report was well received and gave assurance that the clinical strategy was being reviewed at divisional level. This report will be incorporated into the workplan on a quarterly basis

- The committee received a paper on the Energy Performance Scheme. The paper highlighted that it was unlikely the £40.3m of funding awarded by BEIS through Salix to deliver energy performance contract EPC2 and EPC3 will be fully utilised by the deadline of 31st March 2022. The reason for various delays was covered in the paper, the majority outside of the Trust's control. Salix have rejected the trust's request for a further extension and as things stand there is a risk to the Trust of £5m for the cost for work that is required at the SGH site to replace the steam boilers which will not be concluded by 31st March 2022.

Confirm or Challenge of the Board Assurance Framework:
N/A
Action Required by the Trust Board:
The Trust Board is asked to note the key points made and consider whether any further action is required by the Board at this stage. **Linda Jackson** **Acting Trust Chair/Chair of SDC**

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)270

DATE OF MEETING	7 December 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Simon Parkes, Chair of Audit, Risk and Governance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**Audit, Risk & Governance Committee Minutes Highlight Report – October 2021**
BACKGROUND DOCUMENT (if any)	Audit, Risk & Governance Committee Agenda Papers – 21 October 2021
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The Audit, Risk and Governance Committee received a range of assurance reports at its October 2021 meeting, but did not consider that there were any particular issues to highlight 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)	Oversight of entire BAF process, completion and achievement.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	

Northern Lincolnshire and Goole NHS Foundation Trust

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	7th December 2021
Report From:	Audit, Risk and Governance Committee held on 21st October 2021.

Highlight Report:

The Audit, Risk and Governance Committee received a range of assurance reports at its October 2021 meeting, but did not consider that there were any particular issues to highlight to the Trust Board.

Confirm or Challenge of the Board Assurance Framework:

The Committee received an updated Q1 BAF/SRR report from that received at its July 2021 meeting, to reflect the updated Strategic Objective 3 entry. It discussed the issue of whether Divisions/Directorates were owning their risk registers and whether they were responsive enough. The new ARG Committee Chair advised that he would welcome the opportunity to discuss the BAF/SRR outside of the meeting with the Director of Corporate Governance, to discuss the various sources of assurance feeding into the document.

The new timings for the production of the BAF/SRR on a quarterly basis was noted to be out of sync with the ARGC meeting dates. It was agreed to revisit this as necessary.

Action Required by the Trust Board:

The Trust Board is asked to note the report.

Simon Parkes
Non-Executive Director and Chair of Audit, Risk and Governance Committee

NLG(21)271

DATE OF MEETING	7 December 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 Quarter Two
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Quality and Safety Committee – 19 November 2021 Finance and Performance Committee – 24 November 2021 Workforce Committee – 30 November 2021 Trust Management Board – 6 December 2021
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The Trust Board is asked to: a) receive for assurance the Board Assurance Framework (Appendix A) which details the progress against the delivery of the Trust's strategic objectives, b) note the above Committees have considered the Board Assurance Framework at their meetings, c) note the detailed report below and note the controls, assurances, planned actions and the underpinning high level risks associated with each strategic risk.

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 (BAF) – Quarter 2 Review (1 July – 30 September 2021)

1. Purpose of the Report

1.1 To present the BAF to the Trust Board. The BAF brings together all of the relevant information on the risks to the delivery of the board's strategic objectives, highlighting risks, controls and assurances. It is an essential tool for the Board seeking assurance against delivery of key organisational objectives. It is envisaged that through appropriate utilisation of the BAF the Trust Board can have confidence that they are providing thorough oversight of strategic risk. It is used to support the Board in receiving confidence about the likely achievement of each of its strategic objectives

1.2 The Trust Board Sub Committees are responsible for reviewing the relevant objectives and risks and providing assurance to the Trust Board on progress.

1.3 The Trust Board is responsible for setting its assurance framework, to capture the key risks to achieving the Trust's strategic goals, and detail the level, or lack, of assurance during the year as to what extent the level of risk is being managed.

1.4 The Trust has in place a 'ward to board' process for risk management 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.

2. Background

2.1 The Trust's strategic objectives are:

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

2.2 Summary of Current Risk Ratings by Strategic Objective Risk is:

Strategic Risk Ratings

Strategic Objective	High Level Risk Description	Risk Consequence / Impact Assessment	Risk Rating 2021-22 Q1	Q2	Q3	Q4	Owner	Assurance (Committee)
		Catastrophic 25 / Major 20 18 16 15 / Moderate 12 10 9 8 / Minor 6 5 4 / Insignificant 3 2 1						
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard		15	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	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	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	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	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	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	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	12			Chief Financial Officer	Finance and Performance
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital		12	12			Chief Financial Officer	Finance and Performance
SO4	The risk that the Trust is not a good partner and collaborator		12	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	12			Chief Executive	Workforce / Trust Board

KEY	
◆	Initial risk score
◆	Current risk score
◆	Target risk score

3. Quarter Two Review of all Strategic Objective Risks (1 July to 30 September 2021)

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 (by national comparison) of safety, clinical effectiveness and patient experience.

The Medical Director and Chief Nurse reviewed the strategic risk on 20 October 2021. The strategic risk score remains at 15. The following amendments have been made to SO1-1.1:

3.1.1 Gaps in control:
- Risk stratification not complete (remove).
- Progress with End of Life Strategy (wording amended).

3.1.2 Internal assurance:
- Patient Safety Specialist and Patient Safety Champions Group (new).
- Risk Stratification Report to Q&SC (new).

3.1.3 Planned Actions:
- Mandatory Training Report to Workforce Committee (by CQC Domain) by 31 July 2021. The Workforce IPR is presented on a bi-monthly basis to the Committee (action to be removed).

- Platform for FFT reporting at local and trust level developed by 31 August 2021 (complete, action to be removed).
- Workforce Committee overseeing recruitment (linked to BAF SO2). A deep dive was undertaken on 27 July 2021 on workforce recruitment and planning (complete, action to be removed).
- Ophthalmology Action Plan 2021-22 to be developed by Division of Surgery and Critical Care by August 2021. The Chief Operating Officer was requested by the Committee at its meeting on 19 November 2021, to provide an update to the Quality and Safety Committee as the action remains outstanding.
- Develop a NLAG Patient Safety Incident Response Plan by Spring 2022 (new).
- Workforce Committee undertaking Workforce Planning linked to Business Planning (new).

3.1.4 High level risks:
- Reduction in some of the high level risks.
- The risk register details 27 moderate and 10 low risks linked to quality and safety. These risk are monitored by Clinical Divisions and reported to the Risk Register Confirm and Challenge Meeting.

3.2. SO1 - 1.2: The risk that the Trust fails to deliver constitutional and other regulatory performance or waiting time targets.

The Chief Operating Officer assessed the controls, assurances, planned actions and current scoring of the strategic risk on 2 November 2021. The risk remains at 20 due to a significant number of planned actions, gaps in controls and gaps in assurances. Amendments to the strategic risk are as follows:

3.2.1 Planned Actions

a) New actions to support the achievement of the strategic objective are:
- Community 2 Hour Urgent Crisis Response reporting to be implemented by March 2022
- Continued development and usage of independent section through H2.

b) Actions completed and to be removed:
- 40 Week RTT recovery plan to be costed and implemented by July 2021
- RTT / Cancer Recovery Plan costed and implemented by April 2021
- Develop a joint NLAG/HUTH cancer transformation plan by Q1 2021-22.

3.2.2 Current Controls now include Divisional Executive Review Meetings.

3.2.3 'The unexpected business changes from the revised EU transition' is to be removed as no longer perceived as a strategic threat.

3.2.4 The Finance and Performance Committee undertook a deep dive into Risk Stratification, at its meeting on 24 November 2021. In summary the deep dive identified: 67 Outpatient new pathways with no risk stratification, 39,865 Outpatient follow ups with no risk stratification of which 11,227 are overdue with no booked appointment.

Monitoring reports have been developed on Power BI, to track and monitor risk stratification at every step of the patients pathway, these are closely monitored and Divisions report their position weekly at the PTL and Operational Management Group Meetings, they are also reported at PRIM. The Medical Directors office provides a monthly update to Quality Governance Group on risk stratification and clinical harm.

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 Director of Strategic Development reviewed the strategic risk on 2 November. The current risk scoring remains at 12. Amendments to the strategic risk are as follows:

3.3.1 A Committees in Common (NLAG and HUTH) has been created (current control) with assurance being provided through the minutes of the meeting.

3.3.2 An additional planned action is the continuous engagement with public and staff.

3.3.3 Future opportunities is joint workforce solutions, including training and development.

3.3.4 The Trust Board at its meeting on 2 November approved the establishment of a Strategic Development Committee (SDC).

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 Director of Estates and Facilities reviewed the strategic risk on 3 November and considers the current risk score at 20 to remain due to the significant high level risks pertaining to the physical infrastructure and engineering equipment being inadequate. Amendments to the strategic risk are as follows:

3.4.1 There is a significant strategic threat within the next three years of the proportion (60%) of the Trust-wide estate falling into major repair or replacement - 6 Facet Survey Categorisation.

3.4.2 Current Controls now include Specialist Technical Groups, with assurance being provided through the minutes from this group.

3.4.3 A future risk within Estates and Facilities is the sufficient number and adequately trained staff. This risk has been added to the directorates risk register as a high level risk.

3.4.4 An Expression of Interest has been submitted for the New Hospital Programme – Future Opportunity.

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.

A thorough review has taken place by the Chief Information Officer. The current risk score remains at 12. Amendments to the strategic risk are as follows:

3.5.1 Assurances

a) All Digital and IT policies are current (classed as a new assurance).
b) Internal assurances to be removed as not relevant:
   - Digital Strategy approved by Board January 2021
   - CIO in post November 2020
   - CMIO in post May 2021
   - CN&AHP IO in post August 2021
   - Reporting Schedule approved May 2021.

c) External assurances: External audit of DSPT plan and action was submitted to NHSD and was completed by 31 July 2021, therefore marked for removal from the BAF).
d) Positive Assurances: These positive assurances are not considered relevant due to them being undertaken in 2019:
   - Audit Yorkshire internal audit: Clinical Coding / Activity Recording: Significant Assurance, Q2 2019.
   - Audit Yorkshire internal audit: GDPR Compliance (cfwd 18/19): Significant Assurance, Q1 2019.

3.5.2 The following planned actions are to take place:
- Patient Admin System Options Appraisal, Board approval for Trust Board by November 2021. PAS project to commence in November 2021.
- Data Warehouse options appraisal to be approved through governance structures by February 2022.
- IPR - further development of Digital, Finance and Estates KPIs to be reported, by September 2022.
- £250k NHS/X/D Cyber Security Capital Funding Bid Approved - Improving Cyber Security and Management over Medical Devices and other unmanaged IT devices on the Trust network. The team are currently working through the procurement process.

3.5.3 The review of the ToR / recruit wider representation to the Digital Strategy Board & Digital Solutions Delivery Group has been completed and can be removed from Gaps in Controls.

3.5.4 The Posture Assessment (cyber) was presented to AR&G June 2021 and the Digital Strategy project plan have both been completed and are no longer gaps in assurances.

3.5.5 The following high level risks are to be removed from the BAF strategic risk as they are no longer considered to be a high risk but will continue to be monitored by the directorate:
- The IT Operations Department require a comprehensive IT Service Management System (2675) - New ITSM System was purchased on 5 year contract, has been implemented. Risk has been closed.
- Unsupported software, hardware and applications (2369), Moderate (12).
- Cyber security risk (windows 10 implementation) (2463) upgrading Windows 7 to Windows 10 has been mainly completed with a handful of remaining Windows 7 under management plan. Scored as a Low Risk.

3.5.6 A future risk to the Trust is it that it may be issued with an Information Notice requesting specified steps to be undertaken as per the Network and Information Systems regulations 2018. There are eight assertions on the Improvement plan with the end date of the 31st December 2021. Six will be completed before the December deadline, however two still require further work. The two that will not be completed by December are:

Evidence number DSPT7.11 – Business Continuity/Disaster Recovery will require additional resource which is currently being scoped. This requirement also feeds into the additional detailed audit on Business Continuity/Disaster Recovery.

Evidence item DSPT9.6.10, links in to 3.5.2, - £250k NHS/X/D Cyber Security Capital Funding Bid Approved - Improving Cyber Security and Management over Medical

Devices and other unmanaged IT devices on the Trust network. The Team are currently working through the procurement process.

In January 2022 NHSD will review final improvement plan updates. Where a Trust has met the standard:

- It will be assigned 'Standard Met' status.
- Where a Trust has still not met the DSPT standard:
  - The Trust will have their DSP Toolkit status amended to 'Standards Not Met' status.
  - NHSD Regional Security Leads will direct the Trust to appropriate Data Security services and identify any exemplar organisations within the Region in order that best practice can be shared.

As all NHS Trusts and Foundation Trusts are classified as Operators of Essential Services under the Network and Information Systems (NIS) Regulations 2018. The Regulations require organisations identified as Operators of Essential Services to take appropriate and proportionate measures to:

- manage risks posed to the security of the network and information systems on which their essential services rely;
- prevent and minimise the impact of incidents on the delivery of essential services; and
- report serious network and information incidents that impact on provision of the essential service.

The DSPT is a requirement for Operators of Essential Services to demonstrate their fulfilment of the security duties of the NIS Regulations, and failure to engage with the improvement plan process may result in regulatory action being taken under the regulations. For example, a 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 regulations

3.6. SO1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope.

The Chief Operating Officer reviewed the current risk score, which remains at 16. Amendments to the strategic risk are as follows:

3.6.1 An annual table top exercise to be undertaken by October 2021 remains as an outstanding planned action.

3.6.2 A review of capacity to meet demand of workforce by September 2021 action remains as an outstanding planned action.

3.6.3 PODs for urgent and emergency care outside of the acute hospital unavailable (UTC gaps) were installed by January 2021, thereby the action to be removed from the BAF.

3.6.4 Bed capacity challenges in Northern Lincolnshire, East Riding and Lincolnshire are due to Acute Services Collaborative workforce challenges being seen and likely to continue into January 2022. This is currently a gap in control.

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.

3.7.1. The current risk score remains at 20 due to, gaps in control, gaps in assurance and the number of planned actions as follows:

a) Planned Actions:

- Continue collaboration between NLAG and HUTH and the HCV wider network.
- Implementation of new directorate structure and recruitment to vacant positions.
- Continued review of the Health and Wellbeing offer to staff
- Review of the Educational /Leadership Development offer
- A Culture and Engagement deep dive was recently conducted, the findings presented at an Executive Team time out.
- Board sessions were held in July and November 2021 covering Freedom to Speak Up, the wider Equality Diversity and Inclusion agenda, and the proposed approach to the Culture and Engagement Transformation programme

b) **Gaps in Control:** Due to visa backlogs the Trust is seeing a slower international recruitment of clinical staff (new). The restructure of the People Directorate and internal recruitment of clinical staff due to visa restrictions are no longer a gap in control.

c) Gaps in Assurance: Increase in nurse staff vacancies and conversion of the 50 overseas nursing recruits (new). Staff morale barometer, value and health & wellbeing are no longer gaps in assurance.

3.7.2. Actions Progressed and to be Undertaken:

- The recruitment team have started 1724 staff in post during the 20/21 financial year, in comparison to 1438 in the previous financial year, an increase of 19.88%.
- The vacancy factor has remained steady due to significant investment in establishments which have seen increases across all staff groups.
- We want to continue to develop the capability of the Talent Acquisition team and develop enhanced methods for sourcing medical staff.
- We want to continue to refine our customer experience and develop effective metrics to measure this and apply actions to continuously improve.
- We want to continue to support the organisation through looking at new ways of working.
- We want to complete our QI project which is currently underway to review all processes and develop first class experiences for our customers.
- We want to support the organisation in our part in developing the organisation as an employer of choice.

- We want to continue to develop relationships with external partners including educational establishments and share best practice.

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.

3.8.1. The Chief Financial Officer reviewed the strategic risk and of note:
- the clinical strategy is required to inform the finance strategy and this remains a gap in control.
- there are a number of planned actions to be undertaken during quarter three and four 2021/22 – metrics for the integrated performance report, H2 plan, financial special measure actions, HASR P2/P3 work and the AAU full business case.
- future risks are seeing the saving programme not being sufficient and the deteriorating underlying run rate exacerbated by the elective recovery programme; and the impact of external factors ie. Residential care causing hospitals to operate at less than optimum efficiency.

3.8.2. The current risk scoring remains at 12 due to gaps in control of the finance strategy, the number of planned actions required to deliver during quarter three and four and the future risks.

3.8.3. The Trust Board at its meeting on 2 November approved the establishment of a Strategic Development Committee (SDC), which will result in part of strategic risk 3.1 being reviewed at SDC.

3.9. SO3 - 3.2: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate.

3.9.1. The significant changes to the strategic risk are the number of planned actions to be undertaken during quarter three and four: the forecast spend for the current year, securing approval for the AAU full business case, the development of a capital plan for 2022/23 and the HASR P3 proposition.

3.9.2. A future opportunity is the announcement of multi-year, multi-billion pound capital budgets for the NHS.

3.9.3. The Chief Financial Officer proposes the current risk scoring remaining at 12 due to the number of planned actions to be undertaken before the 31 March 2022.

3.10. SO4: The risk that the Trust is not a good partner and collaborator.

The Director of Strategic Development reviewed the strategic risk on 20 October 2021. There is no change to the risk score of 12. Amendments to the strategic risk are as follows:

3.10.1 A recruitment process is underway for an Associate Medical Director to support the IC collaboration.

3.10.2 The Trust Board at its meeting on 2 November approved the establishment of a Strategic Development Committee (SDC).

3.11. 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.

The current risk score remains at 12 due to the number of planned actions being progressed and a future risk:

a) Planned Actions:

- Continued contribution to the Trust Priorities quarterly report and supporting People Plan which outlines plans to scope out a Leadership Development Programme for leaders at all levels by December 2021.

- A Trust-wide Leadership Deep Dive is scheduled for review with the Executive Team and Workforce Committee in November/December 2021.

- We are aiming to introduce a leadership and career development portfolio governance board in 2022 with representation from all stakeholder staff groups, to align with our People Strategy aims of attracting, developing and retaining leaders as a preferred employer.

- The refresh of our PADR process referred to in the Training & Development submission.

- We will be refreshing our coaching model with the move towards a Coaching and Mentoring Bureau, offering staff at all levels, opportunities for coaching and mentoring.

- As part of both leadership development and succession planning, we will be seeking collaborative team working across the ICS for the introduction of a HCV Shadow Board programme.

- Introducing a managerial core skills programme for newly appointed managers 2022 and beyond.

- Providing further knowledge and skills for all leaders and managers towards building a culture of compassion-centred, collective leadership.

b) Future Risk: Vacancy for the Head of Education is being covered by temporary resource.

4. Recommendations

The Trust Board is asked to:

a) receive for assurance the Board Assurance Framework (Appendix A) which details the progress against the delivery of the Trust's strategic objectives,

b) note the above Committees have considered the Board Assurance Framework at their meetings,

c) note the detailed report, and note the controls, assurances, planned actions and the underpinning high-level risks associated with each strategic risk.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Board Assurance Framework - 2021 / 22

Strategic Objective	Strategic Objective Description
1. To give great care	● To provide care which is as safe, effective, accessible and timely as possible ● To focus always on what matters to our patients ● To engage actively with patients and patient groups in shaping services and service strategies ● To learn and change practice so we are continuously improving in line with best practice and local health population needs ● To ensure the services and care we provide are sustainable for the future and meet the needs of our local community ● To offer care in estate and with equipment which meets the highest modern standards ● To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.
2. To be a good employer	● To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: - inclusive values and behaviours - health and wellbeing - training, development, continuous learning and improvement - attractive career opportunities - engagement, listening to concerns and speaking up - attractive remuneration and rewards - compassionate and effective leadership - excellent employee relations.
3. To live within our means	● To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse ● To keep expenditure within the budget associated with that income and also ensuring value for money ● To achieve these within the context of also achieving the same for the Humber Coast and Vale Health Care Partnership ● To secure adequate capital investment for the needs of the Trust and its patients.
4. To work more collaboratively	● To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan ● To make best use of the combined resources available for health care ● To work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally ● To work with partners to secure major capital and other investment in health and care locally ● To have strong relationships with the public and stakeholders ● To work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: - make best use of the human capabilities and capacities locally; - offer excellent local career development opportunities; - contribute to reduction in inequalities; - contribute to local economic and social development.
5. To provide good leadership	● To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk 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 national 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		
Possible (3)	3	6			
Likely (4)	4				
Certain (5)	5	10			
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)	

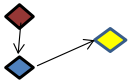
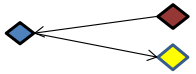
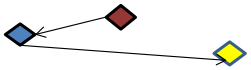
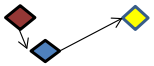
Based on this scoring methodology broadly the Trust's risk appetite is:

• 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	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	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	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	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	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	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	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	12			Chief Financial Officer	Finance and Performance
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital		12	12			Chief Financial Officer	Finance and Performance
SO4	The risk that the Trust is not a good partner and collaborator		12	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	12			Chief Executive	Workforce

Risk Consequence / Impact Assessment

Catastrophic	Major			Moderate			Minor			Insignificant		
25	20	18	16	15	12	10	9	8	6	5	4	3	2	1

KEY	
	Initial risk score
	Current risk score
	Target risk score

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.1: To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards nationally.

Risk to Strategic Objective 1 - 1.1: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.

	Initial	Current	Target
Consequence	5	5	5
Likelihood	3	3	2
Risk Rating	15	15	10

Initial Date of Assessment: 1 May 2019
Last Reviewed: 19 November 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 (Q&SC)
- 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
- Risk Stratification Report
- Board Development Sessions - Monitoring CQC Progress
- Risk Stratification Report to Q&SC
- Patient Safety Specialist and Patient Safety Champions Group.

External (positive):
- Internal Audit - Serious Incident Management, N2019/16, Significant Assurance
- Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance

Planned Actions

- 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 March 2022
- Update IPC BAF as national changes and requirements (ongoing)
- Continued management of COVID19 19 outbreaks (ongoing).
- Ophthalmology Action Plan 2021-22 to be developed by Division of Surgery and Critical Care by August 2021. Chief Operating Officer to provide update to the next Quality and Safety Committee meeting in December 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.
- CMIO to review clinical engagement of results acknowledgement, through Digital Strategy Board, by Q3 2021/22.
- Develop a NLAG Patient Safety Incident Response Plan by Spring 2022
- Workforce Committee undertaking Workforce Planning linked to Business Planning.

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 4 (previous risk rating 8, before that 15)
- Management of formal complaints (2659) - Risk Rating 12 (previous risk rating 12, before that 15)
- Risk to overall cancer performance - Clinical Support Services (2244) - Risk Rating 16 (previous risk rating 16)
- Inequitable division of LD Nurses (2531) - Risk Rating 12 (Previous 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 6, (previous risk rating 15)

(27 Moderate Risks and 10 Low Risks linked to quality and safety; previously 28 Moderate and 5 Low).

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints.

Adverse impact of external events (ie. Britain's exit from the European Union; Pandemic) on business continuity and the delivery of core service.

Workforce impact on HASR.

Gaps in Controls

- Estate and compliance with IPC requirements - see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Fully funded Learning Disabilities team across both sites
- Attracting sufficiently qualified staff - see BAF SO2.
- Progress with the End of Life Strategy
- Ophthalmology Waiting List
- Delays with results acknowledgement

Gaps in Assurance

- Mandatory training
- Sepsis Web-V Tool
- Risk stratification

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- International recruitment
- Shared clinical development opportunities
- Development of Integrated Care Provider with Local Authority.

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.2: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.2: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.

	Initial	Current	Target
Consequence	5	5	5
Likelihood	4	4	1
Risk Rating	20	20	5

Initial Date of Assessment: 1 May 2019
Last Reviewed: 24 November 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
- Divisional Executive Review Meetings

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 Q4 2022-23.
- 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.
- Diagnostic breach tracker tool by Q1 2022-23.
- Outpatient transformation plan by 2022.
- Development of Phase 2 three year HASR Plan by 2022.
- Consultant job plans to be updated by Q3 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.
- Develop divisional dashboards Q3 2021-22.
- Consultant led ward rounds, further development and implementation (ECIST) by Q4 2021-22.
- Development of an independent sector activity plan by Q2 2021-22.
- Community 2 Hour Urgent Crisis Response (UCR) service and performance reporting to be implemented by March 2022
- Continued development and usage of independent sector through H2

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.

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)
- Instability of ENT Service (2048)
- Overdue Follow-ups (2347)
- Shortfall in capacity with Ophthalmology service (1851)
- Accuracy of data of business decision making for RTT (2515)
- Delayed or missing internal referrals (2826)
- Shortage of radiologists (1800)
- MRI Equipment (1631)
- Replacement of X-Ray Room (2646)
- SGH Main MRI Scanner capacity and waiting lists (2499)
- Failure to meet 6 week target for CT/MRI (2210)
- Failure to review ophthalmology patients in specified timescales (2347)
- JAG Accreditation in housing enema room within clinical area (2694)
- Impact on Medicine Divisional business plan / service delivery (2700)

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 Business changes from the revised EU transition

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 52 week waits and Diagnostics Constitutional Standards.
- Capacity to Reduce 52 week, 104 day and over 18 week waits to meet the trusts standard of 0 waits over 40 week in 2022.
- Cancer Board and MDT Meetings not quorate.
- Limited single isolation facilities.
- Urgent Treatment 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.

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.3: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

Risk to Strategic Objective 1 - 1.3: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.

	Initial	Current	Target
Consequence	4	4	4
Likelihood	3	3	2
Risk Rating	12	12	8

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 November 2021

Target Date: 31 March 2025

Lead Committee:
Finance and Performance / Strategic Development 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)
- Committees in Common (CIC)

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 HASDEC
- Minutes from CIC

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.
- To undertake continuous engagement process with public and staff
- Citizens Panel held Quarterly.
- Strategic Development Committee

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 2924).
- 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.
- Joint workforce solutions inc. training and development Humber wide

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.4: To offer care in estate and with engineering equipment which meets the highest modern standards.

Risk to Strategic Objective 1 - 1.4: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.

	Initial	Current	Target
Consequence	5	5	5
Likelihood	4	4	2
Risk Rating	20	20	10

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 November 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)
- Specialist Technical Groups

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
- Specialist Technical Groups

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 future surge and impact on the infrastructure.
- National policy changes (HTM / HBN / BS); Ventilation, Building Regulation & Fire Safety Order.
- Regulatory action and adverse effect on reputation.
- Long term sustainability of the Trust's sites.
- Clinical Plan.
- Adverse publicity; local/national.
- Workforce - sufficient number & adequately trained staff

Links to High Level Risk Register

There are approximately 22 Estates and Facilities risks graded 15 or above recorded on the high level risk register. Of which there are a significant number of risks pertaining to the physical infrastructure and engineering equipment being inadequate or becoming inadequate. Of particular note, there are a number of high risks relating to workforce, water infrastructure, medical gases, electrical and fire compliance that place increased risk to the Trust's overall strategic ability to provide patient care in a safe, secure and suitable environment.

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.
- Within the next three years a significant (60%) proportion of the trust wide estate will fall into 'major repair or replacement' 6 facet survey categorisation.
- A further breakdown of strategic risk detailed in the 2019/20 6 Facet Survey Report: 22% of SGH total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'.
- 19% DPoW total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'.
- 29% GDH total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'.

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR.
- Insufficient Capital funding.
- Timeline to deliver the decarbonisation projects.

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities.

Future Opportunities

- Closer ICS working.
- Humber Acute Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.
- Expression of Interest Submitted for New Hospital Programme (NHP)

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.5: To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.

Risk to Strategic Objective 1 - 1.5: The risk that the Trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the Trust vulnerable to data losses or data security breaches.

	Initial	Current	Target
Consequence	4	4	3
Likelihood	4	3	2
Risk Rating	16	12	6

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 November 2021

Target Date: March 2024

Lead Committees:
Finance and Performance Committee

Risk Owners:
Chief Information Officer

Current Controls

- 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

Assurance (internal & external)

Internal:
- Highlight reports to Trust Board from Audit Risk and Governance Committee, Finance and Performance Committee, Digital Strategy Board, TMB.
- Digital / IT Policies all current.
- IT Security Manager in Post
- CIO/Executive Director Report (6 monthly) to Trust Board.

External:
- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Limited Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Limited Assurance, Q3 2019.

Positive Assurance:

Planned Actions

- Recruit Digital Leadership to drive change & engage with frontline (3rd & 4th Qtr 20/21)
- Establish Digital Reporting schedule/Work plan for Board Committees (4th Qtr 20/21)
- Apply for Digital Aspirant Funds to Support funding Digital Programs (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 by 31 December 2021.
- Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Plus Accreditation (2nd Qtr 22/23 -July 2022).
- Secure resources to deliver Digital Strategy and annual Priorities (PAS; EPR; Data Warehouse; RPA; Doc Mgmt; Infrastructure upgrades).
- Patient Admin System Options Appraisal, Board approval for Trust Board by November 2021. PAS project to commence in November 2021.
- Data Warehouse options appraisal to be approved through governance structures by February 2022.
- IPR - further development of Digital, Finance and Estates KPIs to be reported, by September 2022.
- £250k NHS/X/D Cyber Security Capital Funding Bid Approved - Improving Cyber Security and Management over Medical Devices and other unmanaged IT devices on the Trust network.

Future Risks

- COVID-19 surge and impact on adoption of digital transformation.
- National policy changes.
- Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards.
- IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG specific agenda.
- Ongoing financial pressures across the organisation.
- The 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). There are eight assertions on the Improvement plan with the end date of the 31st December 2021.

Links to High Level Risk Register

- Accuracy of Data of Business Decision Making. Finalizing spec to procure new data warehouse. High Risk (2515)
- Risk of non-compliance with the Data Protection Act 2018 due to the Trust not having sufficient resource and technical tools to conduct forensic searches on use of data. Currently rolling out 365 and discussing wiht NHS D on recommened search tools. oderate Risk (2676)
- Data & Cyber Security: (2) Cyber Infrastructure (2408) - Risk High (20) - No Change
- Updated Business Continuity & Disaster Recovery Procedure (#).

Strategic Threats

- Capital funding to deliver IT solutions.
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve.

Gaps in Controls

- Address the assertions without evidence in the DSPT
- Develop policy and procedure to address the gaps noted in the IT Business Continuity audit in April 2020.
- Achieve DSP Toolkit and mandatory training compliance . - in progress (target 4th qtr 21/22)
- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.

Gaps in Assurance

- Data Warehouse solution to support outcomes from BI review.
- Integrated Performance Report - Digital.

Future Opportunities

- Humber Coast and Vale ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Collaborative working with HASR and Acute Care Collaborative.

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.6: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).

	Initial	Current	Target
Consequence	4	4	4
Likelihood	2	4	2
Risk Rating	8	16	8

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 November 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 ongoing.
- Annual table top exercise by October 2021.
- Half yearly telephone exercise completed by March 2022.
- Business Intelligence monitoring re: pandemic.
- Capacity to meet demand workforce) by September 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.

Gaps in Controls

- Capacity to meet demand (workforce).
- Bed Capacity challenges in Northern Lincolnshire, East Riding and Lincolnshire due to ASC workforce challenges being seen and likely to continue into January 2022

Gaps in Assurance

- Not undertaking internal audit review of the standards.

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)
- Instability of ENT Service (2048)
- Overdue Follow-ups (2347)
- Accuracy of data of business decision making for RTT (2515)
- COVID-19 Isolation (2794)
- C-19 Equipment (2793)
- C-19 Patient Safety (2792)
- COVID -19 pandemic - surgery & critical care (2706)
- COVID -19 pandemic - community and therapies (2708)
- COVID -19 pandemic - risk to IT Operations (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.

Future Opportunities

- Closer Integrated Care System working.
- Provider collaboration.

Strategic Objective 2 - To be a good employer

Description of Strategic Objective 2: To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations.

Risk to Strategic Objective 2: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.

Risk Rating	Initial	Current	Target
Consequence	5	5	4
Likelihood	3	4	2
Risk Rating	15	20	8

Initial Date of Assessment: 1 May 2019
Last Reviewed: 30 November 2021
Target Date: March 2024

Lead Committees:
Workforce 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.
- Implementation of new directorate structure and recruitment to vacant positions. Outputs from the currently live Staff Survey and quarterly Pulse Survey
- Continued review of the Health and Wellbeing offer to staff
- Review of the Educational /Leadership Development offer and future roll out of programmes
- A Culture and Engagement deep dive was recently conducted, the findings presented at an Executive Team time out, JNCC, Workforce Committee, and now being socialised more broadly for widening participation from all staff groups
- We held a Board session in July 2021 focused on the role of the FTSU Guardian, the role of unconscious bias in discrimination, and plan a follow up session November 2021 covering the wider Equality Diversity and Inclusion agenda, further awareness of the role and value of FTSU, and the proposed approach to the Culture and Engagement Transformation programme

Future Risks

- COVID-19 third surge and impact on staff health and wellbeing.
- National policy changes.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Provide safe services to the local population.
- Succession planning and future talent identification.
- Visa changes / EU Exit.
- Staff retention and ability to recruit and retain HR/OD staff to deliver people agenda

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) that place an increased risk to the Trust's overall strategic ability to provide a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) and to provide the levels and quality of care which the Trust needs to provide for its patients.

Strategic Threats

- ICS Future Workforce.
- Integrating Care: Next Steps.
- Future staffing needs / talent management

Gaps in Controls

- Slower international recruitment of clinical staff due to visa backlogs

Gaps in Assurance

- Increase in nurse staff vacancies and conversion of the 50 overseas nursing recruits.

Future Opportunities

- Closer ICS working.
- Provider collaboration.
- International recruitment.

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.1: To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP.

Risk to Strategic Objective 3 - 3.1: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.

Risk Rating	Initial	Current	Target
Consequence	5	4	5
Likelihood	2	3	2
Risk Rating	10	12	10

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 November 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, Model Hospital.
- National benchmarking and productivity data constantly reviewed to identify CIP schemes.
- Engagement with Integrated Care System on system wide planning.
- Humber Acute Services Review (HASR) engagement to redesign fragile and vulnerable service pathways at system and sub system level.
- Monthly ICS Finance Meetings
- Finance Meeting - HASR
- Operational and Finance Plan 2021-22 (approved at Trust Board June 2021)
- Financial Special Measures Meeting with NHSE/I.
- Counter Fraud and Internal Audit Plans.

Assurance (internal & external)

Internal:
- Minutes of Audit Risk & Governance Committee, Trust Management Board, Finance and Performance Committee, Capital Investment Board, PRIMs.
- Non-Executive Director Highlight Report (bi-monthly) to Trust Board

Positive:
- Letter from NHSE/I related to financial special measures and achievement of action plan. On track to deliver the requirements set out by NHSEI.

External:
- Financial Special Measures Meeting - Letter from NHSE/I related to financial special measures and achievement of action plan.
- ICS delivery of H1 financial plan.
- HASR Programme Assurance Group

Planned Actions

- Agree H2 plan, November 21
- Agree Finance metrics for inclusion in the Trustwide IPR, Q3 2021/22.
- Develop financial (incl comprehensive CIP plan) and service plan for 22/23 - target by end of Feb 2022
- Develop costed metrics to support HASR P2/P3 work by end December 21.
- Agree financial implications of P1 completed specialties for transacting in qtr 4 21/22.
- Complete FSM actions in line with FSM timetable and agree exist from FSM process - December 2021.
- Secure approval for AAU FBC January 2022

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.
- Savings Programme not sufficient and deteriorating underlying run rate which is execerbated by the elective recovery programme
- Impact of external factors such as problems with residential care, causing hospitals to operate at less than optimum efficiency and cause finaical problems

Gaps in Controls

- Systems plans may not address individual organisational sustainability
- Challenges with HASR, CIP Delivery
- Uncertainty on H2 & long term financial framework.
- Clinical strategy required to inform 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.

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.

Future Opportunities

- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.2: To secure adequate capital investment for the needs of the Trust and its patients.

Risk to Strategic Objective 3 - 3.2: The risk that the Trust fails to secure and deploy adequate 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

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 November 2021

Target Date: 31 March 2024

Lead Committees:
Finance and Performance Committee

Risk Owners:
Chief Financial Officer

Current Controls	Assurance (internal & external)	Planned Actions	Future Risks
● Capital Investment Board ● Agreed Capital programme and allocated budget 2021/22 ● Financial Special Measure Meeting with NHSE/I	**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	●Agree forcest spend for current year as part of wider ICS capital planning exercise. ● Find a solution to address BEIXS/Salix funding issues with regards to year end cut off. ● Secure approval for AAU FBC - Qtr 4 21/22 ● Develop 22/23 capital plan as part of comprehensive service planning exercise - to be completed by end Feb 2022 ● Develop HASR P3 proposition to PCBC stage - qtr 4 21/22	● 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	**Strategic Threats**
		● AAU / ED Business Case approval not yet received	● ICS Future Funding. ● Government funding allocations
Gaps in Controls	**Gaps in Assurance**		**Future Opportunities**
● Systems plans may not address individual organisational sustainability. ● Challenges with Estate.	● Delivery of Cost Improvement Programme Plan. ● Individual organisational sustainability plans may not deliver system wide control total. ● Committees in Common		● Provider collaboration ● System wide collaboration to major capital development needs. ● Announcement of multi year, multi billion pound capital budgets for NHS

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

Initial Date of Assessment: 1 May 2019
Last Reviewed: 24 November 2021

Target Date: March 2025

Lead Committees:
Finance and Performance / Strategic Development 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 December 2021.
- Recruit to Strategic Development - Associate Medical Director to support the ICS collaboration - Dec 21

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.2924).
- 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 legislative 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 clinical strategy, capital and service developments, including attendance at programme boards / clinical sign off of proposed plans.
- Local Authority, primary care, community 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

Initial Date of Assessment: 1 May 2019
Last Reviewed: 30 November 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.
- Continued contribution to the Trust Priorities quarterly report, by Q2 2021 and supporting People Plan which outlines plans to scope out a Leadership Development Programme for leaders at all levels by December 2021.
- A Trust-wide Leadership Deep Dive is scheduled for review with the Executive Team and Workforce Committee in November/December 2021, to set out an integrated programme of leadership development pathways and activities supporting the Culture and Engagement Transformation Programme and feeding in to our aims for talent identification and succession development. The scope includes a range of initiatives addressing: establishing more effective line manager skills in leading people for existing line managers (building on the work of the HRBPs).
- We are aiming to introduce a leadership and career development portfolio governance board in 2022 with representation from all stakeholder staff groups, whose purpose is to ensure any and all leadership development programmes we design in-house, commission, or subscribe to, align with our People Strategy aims of attracting, developing and retaining leaders as a preferred employer.
- The refresh of our PADR process referred to in the Training & Development submission, will include process components and skills training to enable identification of talent, development of potential, and proactive planning for succession. Refer to the Leadership and Career development draft schematic in the Appendices for concept.
- We will be refreshing our coaching model with the move towards a Coaching and Mentoring Bureau, offering staff at all levels, opportunities for coaching and mentoring. All participants on leadership development programmes will have a coach for the duration of their development course. We aim to introduce mentoring, both peer to peer, role and career, and reverse, during 2022 with some small scale pilot programmes including a pilot EDI-centric reverse mentoring programme to further strengthen inclusion.
- As part of both leadership development and succession planning, we will be seeking collaborative team working across the ICS for the introduction of a HCV Shadow Board programme.
- Introducing a managerial core skills programme for newly appointed managers 2022 and beyond.
- Providing further knowledge and skills for all leaders and managers towards building a culture of compassion-centred, collective leadership. This programme, modular in approach, will include Leading with Kindness, Courage and Respect, underpinned with processes and skill development in difficult conversations, embodying the Trust values, and improving what it feels like for staff to work at NLaG.

Future Risks

- COVID-19 third surge and impact on finance and CIP achievement.
- National policy changes.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Current vacancy for the Head of Education which is currently being covered by temporary resource

Strategic Threats

- Non-delivery of the Trust's strategic objectives;
- Continued quality/financial special measures status;
- CQC well-led domain of 'inadequate'.
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives;
- Failure to obtain support for key changes needed to ensure improvement or sustainability;
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.

Gaps in Controls

- No investment specifically for staff training / courses to support leaders work within a different context and to be effective in their roles as leaders within wider systems.

Gaps in Assurance

- Financial Special Measures
- Quality Special Measures

Links to High Level Risk Register

None

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration
- System wide collaboration to meet control total
- HASR

NLG(21)272

DATE OF MEETING	7 December 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 25 August & 29 September 2021
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee –29 September & 27 October 2021.
EXECUTIVE SUMMARY	Minutes of the Finance & Performance Committee held on 25 August & 29 September 2021 and approved at its meetings on 29 September and 27 October 2021 respectively.

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: **25 August 2021 – via Teams Meeting**

PRESENT:	Gill Ponder	Non-Executive Director / Chair of F&P
	Andrew Smith	Non-Executive Director
	Linda Jackson	Acting Trust Chair
	Fiona Osborne	Associate Non-Executive Director
	Lee Bond	Chief Financial Officer
	Peter Reading	Chief Executive
	Shaun Stacey	Chief Operating Officer
	Shauna McMahon	Chief Information Officer
	Ivan McConnell	Director of Strategy & Planning
	Brian Shipley	Deputy Director of Finance
	Ian Reekie	Lead Governor
	Simon Tighe	Deputy Director of Estates & Facilities
IN ATTENDANCE:	Richard Winter	Director / Head of Use of Resources, NHSE/I
	Jenny Marsh	Head of Locality Finance (Humber Coast & Vale)
	Angie Legge	Associate Director of Governance (for item 5.2)
	Jennifer Moverley	Head of Compliance and Assurance (for item 5.2)
	Anne Sprason	Finance Admin Manager/PA to CFO (Minutes)

Gill Ponder welcomed to the meeting Richard Winter and Jenny Marsh from NHSE/I, and Fiona Osborne to her first meeting.

Gill Ponder thanked Andrew Smith for his contribution to the F&P meetings and as this was his last meeting wished him well for the future.

Gill Ponder stated that the Committee's purpose was for assurance but it was also conscious of the extreme pressure that this Trust and others around the Country were under, particularly in ED with the increase in Covid cases. Gill Ponder added that the Committee members did need to ask questions for challenge and assurance but that did not mean that they were not aware of the pressures the Trust were facing.

Item 1 08/21 Apologies for absence were noted from: Stuart Hall; and Jug Johal (Simon Tighe Deputising)

Item 2 08/21 **Declarations of Interest**

There were no declarations of interest made.

Item 3 08/21 **To approve the minutes from the previous meeting held on 28 July 2021**

The minutes from the meeting held on 28 July 2021 were agreed as an accurate record.

All actions from the minutes were included either on the agenda or the action log.

Item 4 08/21 **Matters Arising**

4.1 Action Log

The action log was reviewed as follows:

5.1 (26 05 21) – BAF – Discussion between Andrew Smith and Shaun Stacey. Andrew Smith advised that he would pick this up with the new Chair of Audit, Risk & Governance Committee and to enable the action to be closed down by the next meeting.

6 (26 05 21) – IPR SPC charts – analysis of review. Shaun Stacey advised that work was ongoing to develop the IPR in order to make it user friendly and to include the charts to show current position against the trajectory. That could be included as supplementary information in the short term. A meeting was due to take place later that day with a draft expected in September for Trust Board in October 2021. It had been agreed by Trust Board that the more pertinent issues would be brought to the front, but it was hoped that the report would be more condensed with a clearer score card included for review.

6 (30 06 21) – IPR – Finalisation of bed base. Included on the agenda. Action closed.

10.1 (30 06 21) – Deep Dive – Medical Gases. Simon Tighe advised that the SI report would be taken to a private Trust Board in September. Peter Reading stated that as the report would need to also be taken to other sub-committees it was decided to take to Trust Board to avoid duplication. Item to be closed on the Action Log.

4.3 (28 07 21) – Self Assessment Results – Action Plan included on the agenda. Action closed.

5.1 (28 07 21) – BAF – Agreed one deep dive at each meeting on a strategic risk; the first one was on the agenda. The workplan also updated to include a different risk each month. Gill Ponder added that the Committee would still review the BAF on a quarterly basis and suggest any changes necessary. Action closed.

Fiona Osborne queried the reference within the BAF to 40 week RTT recovery plan and Cancer Recovery plan to be costed by July and April 21 respectively, but had not seen the project plan. Shaun Stacey explained that the recovery plans for cancer and electives had been presented to Trust Board but the two items not updated from the actions pending section in the BAF. He explained that the IPR was the updated report identifying the current position and within the Finance report income related to recovery would also be reported. Fiona Osborne agreed that this answered the query and the information had been completed.

6.5 (28 07 21) – IPR / Planned Care – to include more details on theatre utilisation and productivity within the IPR. Shaun Stacey highlighted the ongoing issues and therefore would remain as part of the IPR to manage all actions; supplies, workforce and major equipment were areas of concern. Action closed.

7.1 (28 07 21) – Finance Report – Medical Staff and agency costs. Brian Shipley explained that a piece of work was ongoing. Update in October with a summary of efficiency improvement and plan.

7.1 (28 07 21) – Covid spend, risk to financial plan and exiting FSM. Lee Bond explained that this had been included with the Finance report from last month for both Covid costs and FSM and asked if the Committee were content or would require a separate item. The Committee agreed to include with the Finance report. Action closed.

14 (28 07 21) – Highlight Report – Gill Ponder completed the highlight report at the last meeting and circulated to the Committee for agreement. It was subsequently submitted to Trust Board. Item closed.

Following review the action log was noted.

4.2 Draft F&P Workplan 2021/22

The updated workplan had been agreed at the last meeting, however there had been some additional amendments made in the Strategic Development section. Ivan McConnell explained that the amendments were to align to the HASR timelines for reports to Committees. The dates had also been agreed with NHSE/I and ICS.

Fiona Osborne asked when papers had been updated late for the Committee that the amendments could be highlighted specifically, which was noted.

The amended workplan was agreed.

4.3 F&P Committee Self-Assessment Results

The action plan of the self-assessment exercise had been completed and Gill Ponder noted that some of the actions had already been done. Following review the action plan was approved.

Item 5 08/21 Presentations for Assurance

5.1 The Board Assurance Framework was not due to be presented to the Committee this month but a deep dive on one specific risk was on the agenda. Gill Ponder proposed not discussing the BAF at this point but if there were any changes required to any risk scores the Committee could review at the end of the meeting.

Fiona Osborne suggested it would be helpful to have a matrix at the front of the BAF of what actions were due and when. It was suggested that Fiona Osborne contact Helen Harris and discuss outside of the meeting.

Action: Fiona Osborne

The next item was taken out of sequence.

Item 6 08/21 **Review of NLAG Monthly Performance and Activity Delivery (IPR)**

6.1 Unplanned Care

Shaun Stacey presented the report and highlighted issues to note.

- In July A&E performance dropped to just above 60% due to a sudden increase in demand as well as further change in flow of patients due to Covid. The loss of capacity had resulted in significant deterioration in the 4 hour standard.
- There were circa 500 front line staff not at work for Covid related reasons on top of short term sickness and annual leave which was almost 9% of the workforce.
- During the summer the usual default position would be to backfill with agency staff but unable to fill the demand required with less than 5% of rotas covered. That position continued in August.
- Actions taken to mitigate and primarily working with partners looking for opportunities for treating patients elsewhere.
- A&E ambulance performance deteriorated due to demand. Continued to work on improving, noting from a national perspective we were in the better quartile but further improvement was still required. The key was not to have patients being brought in unnecessarily and seeing the benefits of having GP in place.

Ivan McConnell asked if community primary care was still an issue that led to the

increase in demand. Shaun Stacey explained the difficulties of changing community practice including the surgery working hours, workforce and acceptance of the modernisation work around GP in the SPA. They were looking at a piece of work at the front door to change practices. Whilst there was a workplan in place the traction to implement was not where it needed to be. A lot of the issues were down to public perception that they need to come to A&E so communication around that had been sent out.

Linda Jackson highlighted that social care had flagged a shortage of staff over the coming months which would have an impact on the Trust. Shaun Stacey confirmed that there was a challenge for community services generally particularly with recruitment. He explained with the change in rules for EU workers and also young people put off entering into care as they needed transport. Local providers were addressing these issues but not having a positive impact. Shaun Stacey added that Covid had increased since July particularly in North Lincs, with four care homes closed to admissions.

Fiona Osborne asked if there was any work with receptionists at GP practices as this was the first port of call for patients. Shaun Stacey explained that in both localities a "secret shopper" audit was undertaken by CCGs which had been reviewed and evaluated and a programme of work was being undertaken to correct errors or where poor practice had been identified. There were also some good practice and decision making identified using the triage system. In North Lincs, other than A&E and primary care, there were fewer opportunities as very few pharmacies offered an emergency service. North Lincs did however have a good community hub which offered support. Shaun Stacey added that none of that stopped public response of attending straight to A&E so still seeing high number of walk-ins; i.e. 12-13% increase since 2018/19, seeing +400 per day at each ED.

The next item returned to the order of the agenda.

Item 5 08/21 Presentations for Assurance

5.2 CQC Progress Report

Angie Legge and Jennifer Moverley attended to present the CQC Progress report. The report was taken as read and Jennifer Moverley highlighted that two actions had changed from green to blue with five other actions due to be closed but due to change of process, as described at the last meeting, were not reflected in this month's report but progress was continuing.

Jennifer Moverley highlighted that the quarterly reviews were going well with a stream of evidence showing that improvements were still compliant.

Focus was being given to the red actions with community nurse staffing being discussed in various forums.

Mandatory training and appraisals work was ongoing with a commitment from the Divisions on recovery plans and sustainability. Work was also ongoing on the new BI report which would enable the Trust to see where we were. The next engagement meeting would focus on that area and the self-assessment from Divisions.

Linda Jackson referred to the change of process and final sign-off and asked if that had created the back log that was being worked through. Jennifer Moverley confirmed that was the case, adding that whilst close to the threshold it was also about sustainability which was why quarterly reviews were held.

Peter Reading noted that mandatory training and appraisals was part of Workforce Committee's remit, but was more about releasing staff to undertake the training.

Gill Ponder referred to the risks in Section 3 – 3c and current funding and asked what had been done to mitigate the risk and whether it was built into H2 financial planning. Lee Bond advised that conversations were taking place between local commissioners, NHSE/I support teams and the Trust and this was included in the underlying position. Some decisions had not been finalised such as the community nursing. There were some things that the organisation had done at risk whilst conversations were being held. It was unlikely however that there would be any further income in the current financial year but it would be picked up in the 2022/23 process which would commence in October 2021.

Linda Jackson asked that a cross referral to Workforce Committee be done to highlight that the F&P Committee had discussed mandatory training and appraisals.

Following the discussion Jennifer Moverley was thanked and she left the meeting.

The Committee returned to Item 6

Item 6 08/21 **Review of NLAG monthly performance and Activity Delivery (IPR)**

Shaun Stacey continued with the presentation of the IPR.

Planned Care

- RTT continues to deliver the recovery plan by treating patients with longest waits or priority 2. The current performance position was 67% and it looked likely this would continue in August.
- Continued to deliver against trajectory for 52 ww i.e. July and August would be below 500 with September below 400. The plan was to be at 600 by September so the Trust were ahead of that plan.
- Struggled with theatre capacity due to critical care position. Additional capacity created using Goole and the Independent sector for treating urgent and cancer patients.
- Cancer – 2ww achieved at 97% in July. 62 day performance was below the standard.
- Elective Diagnostics – tried to maintain using internal capacity. Below 20 day faster diagnostics standard, but expecting improvement. Some challenge to ensure new capacity maximised as the new CT scanner was now operational.
- Performance against H1 performance saw 91% achievement, with over achievement in first attendances and under achievement in other areas due to Covid reasons.

Gill Ponder asked if the waiting list backlog was on track for the end of year target and Shaun Stacey explained that performance would be just below the previous year's performance; noting the challenge was the follow-up backlog. It was anticipated there would be a 15000 backlog against a target of 9000 by March 2022 so during H2 would be pushing as much activity as possible.

Lee Bond noted that one of the potential changes in national level funding for H2 was the omission from calculations for outpatient follow-up activity, so increase in activity would need to be internally funded which may be a challenge.

Lee Bond referred to P1, P2, P3 and P4 and would like to understand what the sustainable waiting list size would be for NLAG for the coming months/years. He also asked about Diagnostics and whether the MRI and CTs now online would improve the position and what the impact would be on performance in other areas.

Shaun Stacey explained the difference of treatment timescales for the P1, P2, P3 and P4 patients and agreed to provide a breakdown of the numbers for Lee Bond.

Action: Shaun Stacey

Shaun Stacey also explained that sustainable waiting lists would be around 11,000-12,000. Follow-up work was done through activity with connected health and 80% back to primary care. Currently working on Gastro; Respiratory and Rheumatology and should be in a better position over the next couple of months.

Peter Reading and Shauna McMahon left the meeting at 10.00am to attend another meeting.

Shaun Stacey responded to the MRI/CT question advising that these would improve the position. It was the intention that mobile CT scanners would be placed, and managed, in the community for direct access. Focus in July and August was on follow-ups with a view to moving patients back out to community rather than being brought back in on an annual basis.

Lee Bond also referred to the scorecard (page 3) and the inpatient waiting list numbers, which were 10,000 in July with a target of 11,365, noting that outpatient numbers had increased and would like to know the total waiting list size within the report.

Action: Shaun Stacey

Ivan McConnell asked about the medium term and if everything was moving at the right speed. Shaun Stacey advised that P1 was progressing well; noting Oncology was a challenge due to general lack of workforce across the Country. The plan was to continue through P1 with Cancer Board to keep moving forward. Other work through region and cancer networks looking at capacity; a conference had been established to look at the baseline.

Shaun Stacey added that Ortho in NLAG would be at 20ww by October and anticipated offering the capacity to partners to transfer their waiting lists across to Goole. Work had commenced to deliver improvements in elective and emergencies for a number of services.

Andrew Smith raised a concern where the mitigations had not reduced the risk score and questioned if that was out of our hands suggesting that it should be a focus for the Trust Board if that were the case.

Ivan McConnell explained that a number of issues were managed through the newly formed Committees in Common, with a joint development board, chaired by the COO from HUTH, sitting underneath that Committee. A number of Execs from each organisation were on those groups so mechanisms would be in place to discuss those concerns. Andrew Smith asked for the risks in this Trust if Shaun Stacey had all levers available to him or if he was dependent on other organisations.

Lee Bond noted that there was some degree of control with the governance structures so a mutual reliance on each other so if there were risks that Shaun Stacey could not manage those formal and informal structures would be used. Ivan McConnell added that those committees have delegated power from their respective boards for strategic direction, escalation etc. Andrew Smith still felt that the Trust Board should have more focus and it was agreed to discuss outside of the meeting.

Action: Andrew Smith / Shaun Stacey / Lee Bond / Ivan McConnell

There were no further questions raised and the IPR was noted.

6.6 IPR Deep Dive – Cancer

Shaun Stacey presented the report which was taken as read and highlighted issues to note as follows:

- Failure to meet constitutional standards with a number of mitigations in place through the Humber and NLAG transformation programme. A 12 month review would be undertaken in October.
- Oncology work continued to be challenging which was directly linked to workforce; this was the regional and national picture with insufficient access in a number of modalities.

Linda Jackson referred to the 2ww referrals exceeding previous levels and asked if this was due to lack of people during Covid and if scanners would improve the situation to get to target. She also queried colorectal waits.

Shaun Stacey agreed that 2ww was a direct result of Covid as people were unable to access the service and primary care treated symptoms conservatively and now being referred. He noted however that conversion rates remained the same as pre-covid.

Shaun Stacey added that faster diagnostic access was key, but the challenge was balancing primary and secondary care access and treatment of P2 patients together. Modelling showed the return to DM01 by the end of March and would see an improvement in faster access, noting a significant challenge with funding.

In terms of colorectal waits an agreed programme of improvement was in place but required GPs to undertake a fit test, at the same time as the referral, for a decision to be made by the Consultant as to which pathway the patient needed to be on. Unfortunately that was not happening with all GPs.

Fiona Osborne asked for clarification if numbers had peaked or if more should be expected in H2. Shaun Stacey advised that it would continue for 18months-2 years, with a sizeable risk to early diagnostics for cancer. He highlighted a programme for lung cancer in the use of a mobile scanner to encourage the public to be tested; this was already in place in Hull and was about to commence in our area. This could result in an increase of cancer demand.

Lee Bond noted the costs could be £4m i.e. £1.5m for lung programme and £2.5m for other cancers found.

6.7 BAF Deep Dive – SO1 – 1.2

Shaun Stacey presented the report which detailed the constitutional and regulatory performance targets with a risk rating of 20. He explained why, despite mitigations put in place they were not reducing access and waiting times. The risks needed to remain until the mitigations started to produce a significant change.

Andrew Smith commented that it was a good paper and he understood the direction being taken. It was suggested that more information within the BAF should be added to show if the mitigation was working. Gill Ponder asked if it would be helpful to have target scores throughout the year where there were very high risk scores and where the target score could not be achieved in one year. This would show progress towards reducing the risk.

Action: Shaun Stacey

Lee Bond was not sure that a risk scoring of 20 was appropriate if assuming risk was to clinical harm. Shaun Stacey gave an example of where clinical harm had occurred to a number of patients due to lack of treatment. He confirmed that clinical harm was still possible given the numbers of patients not yet reviewed and where specialities had patients waiting over 52 weeks for treatment. Shaun Stacey explained that the target needed to be reduced gradually with an overall ambition to reduce to 5 but aiming for 15-12 in October.

Gill Ponder asked if, given the deep dive discussions, the current risk score on the BAF accurately reflected the position and if the Committee were content with the proposed actions for the scores to reduce over time. The Committee agreed.

Item 7 08/21 **Finance Report – M04**

Brian Shipley presented the report and highlighted key issues to note as follows:

- Deficit £170k behind plan with YTD slightly ahead of plan at £700k
- Income £10.5m below plan. This included £10.13m adverse donated income variance excluded from NHSE/I financial performance targets and re-profiling of EPC capital funding grants.
- ERF – Income was £0.73m below plan in month mostly due to low elective and outpatient activity and the revised thresholds that came into effect from July where the requirement had increased from 85% to 95% of 2019/20 activity levels. The Trust was close to hitting the target and similar to the rest of the ICS, with only York hitting the target.
- Pay was £0.52k overspent in month, partly due to Anaesthetic Middle Grade rota delays and agency premiums for covering vacancies mainly in Surgery division. Nursing under similar pressures through international recruitment from August and the opening of surge beds, which were only partially offset through underspends in Midwifery and slippage on other investments.
- Covid Expenditure – The Trust incurred £5.1m additional expenditure YTD which was just within the funding envelope.

Peter Reading and Shauna McMahon re-joined the meeting at 11.00am

- Forecasting - the bed base was now agreed with the only outstanding element being the nursing establishment reviews which were being concluded.
- The Trust forecast expenditure would be influenced by national guidance on Infection prevention and control and staff risk assessments for on-call exemptions. Relaxation of national guidance could potentially reduce the Trust's Covid forecast expenditure.

- Expected outturn position reduced in value, with a question from the centre whether the Trust could operate within a reduced funding envelope in H2 if asked to do so.
- Temporary staff – increased year on year, with some attracting additional funding. Nursing seen improvement in price cap compliance but usage considerably higher than the equivalent period in 2020/21.
- Cost pressures would be seen unless the Trust addressed the issue of surge beds being opened as well reducing agency usage. £188k overspent but once recruitment took place, it would put pressure on achieving plan.
- Medical Staffing - Compliance in core hours rates remained a low percentage but usage was considerably higher than the equivalent period in 2020/21. Surgery was the main area for premium agency increases.
- Savings programme – £2.95m of savings delivered against a plan of £2.75m an over delivery of £0.21m.
- Key element was the level of non-recurrent delivery, which if continued would be a problem. The main risk around CIP was recruitment predominantly in Nursing but also Medicine.
- ERF – original plan would deliver £3m reduced to breakeven position. Delays to planned insourced/outsourced additional capacity and summer annual leave also affected it; the recent increase to 95% threshold was going to be hard to achieve.
- Capital spend was £8.38m i.e. £29.24 behind plan.
- Balance sheet – no concerns to highlight to the Committee. BPPC figures showed over 97% of in month value invoices paid within 30 days and the number of invoices paid was over 92% and well above targets. Some of the delays were the timely authorisation and finance teams were pushing communications on this.
- Underlying financial position was presented at the start of the H1 planning process and had an underlying deficit of £20.5m, which included ongoing recovery funding support of £46m; without additional funding support the underlying deficit would be circa £66.5m.
- Middle grade pay reform could give £0.5m cost pressure; no additional funding support would be provided
- The Trust was successful in securing additional funding of £1.48m to support the Ockenden review recommendations, which replaced investment already made.
- Flowers – additional spend likely but no additional funding so another pressure.

Lee Bond referred to previous discussions on the high levels of variable pay compared to previous months with most of the increases being anticipated or covered in additional income. It was reassuring that better VFM was being seen for agency use but this would need to continue. Lee Bond explained that he would like to triangulate medical staff and corresponding workforce report by specialty to understand where locum spend was and where exposed to long term locum.

Lee Bond added that one of the key issues was reduction in Covid funding with an average spend of just under £1m per month, reducing to £600k but the challenge was to reduce even further which linked into the discussions around emergency activity. Beds had been opened as a direct response to activity pressures and still needed to see reduction in flex beds across the two sites. This would help reduce staffing costs associated with Covid even further, particularly in Nursing.

The other piece of work required was the nurse establishment review which would help to understand the drivers of the costs needed for 2022/23 planning.

CIP non-recurrent savings set at 2%, which was more than the national target and was done as part of FSM. Unfortunately due to Covid cost pressures, the 2% only resulted in a stand-still position.

Fiona Osborne raised a number of queries as follows:

- The variable pay for a number of the staff groups were high percentages and asked if that was driven by bank incentives or agency
- If vacancy coverage in Surgery was affecting all local Trusts
- Family Services and Surgery fell short of target and asked what support they were receiving
- Underlying financial position, in particular corporate back office functions for savings
- The CIP document embedded within the report was for M03

Responses to the questions as follows:

- Variable pay, admin and support staff was predominately bank incentives but should see improvement as incentives had stopped.
- Scientific, Therapeutic & Technical related to community therapies and linked to ERF
- There were a high number of vacancies in the corporate areas. Corporate benchmarking returns just submitted and once results known the Trust would be able to focus on outliers and convert non-recurrent to recurrent savings.
- Vacancy coverage – Lee Bond explained there were significant vacancies across the whole of the Humber ICS. This time of year saw students joining as well as overseas recruitment, so needed to see the nursing establishment review.
- Shaun Stacey explained that the Surgery outlier related to anaesthetic middle grades, which historically had been appointed at different levels. A review was undertaken to re-profile and get improved obstetric rotas and also review the job plans; this work was ongoing and was expected to be reported at the October performance meetings.
- Shaun Stacey highlighted that a percentage of Surgery's plan related to theatre efficiency, which should be seen by September. A significant proportion of CIP programme in Family Services was full closure of their two elective wards. They had not been able to achieve that and had had to open up 12 beds due to issues raised by the CCGs on patient safety.

Ian Reekie referred to the Family Liaison Assistants and the difference they had made on the wards during Covid and queried why the posts had only been extended until January, rather than the end of the financial year in order to source funding to continue with the roles.

Lee Bond explained that the request to extend was for 6 months and to be able to continue would be included within the prioritisation programme for 2022/23. The roles were originally put in on the back of Covid and if funding ceased then the posts would be removed, but that would be considered as part of the prioritisation process.

Shaun Stacey concurred with Lee and added that the nurses concentrated on caring for patients whilst the ward clerks also featured within patient liaison and currently there were no full-time ward clerks. A piece of work had commenced to look at ward clerks / family liaison assistants beyond January.

Ivan McConnell asked if consideration was being given to reviewing running multiple sites and rotas. Lee Bond commented that geographical isolation and the ability to recruit linked to isolation of the sites had been identified previously, as well as the underlying position of the organisation and reliance on agency as a result of not being able to recruit were also factors. There were two fairly small hospitals as well as the community and Goole. As the HASR process evolved, options would identify the structural problems.

Ivan McConnell also asked about the impact of running two EDs and Lee Bond explained that benchmarking had been undertaken with HUTH, NLAG and also York and Scarborough, which identified a cost premium in small services. This information would be brought back to this Committee once completed.

Action: Lee Bond

Following the discussions and review the Finance Report was noted.

7.2 Capital Investment Board Minutes

The Capital Investment Board minutes had been provided for information and were noted.

Lee Bond highlighted that capital was £10m behind plan which reflected the energy schemes which had been given an extension of time to deliver all aspirations of the energy efficiency programme; also had to scale back on the scope due to cost increases, which were externally driven by market forces. All money was treated as grant money and therefore did not impact on the Trust's capital.

Ward refurbishment expected to be completed in the current year but issues around design and agreement of scope may cause delays. The aim would be to complete it in the current year.

The AAU business case was a major issue for the organisation. This was due to be presented to Trust Board in October and would be brought to the F&P Committee at the next meeting.

Action: Lee Bond

7.3 Financial Special Measures (FSM) Update

The FSM letter from August was provided for information and Lee Bond highlighted that regular conversations around process and exit from FSM were taking place. Everything was on track to hit H1 trajectories and the H2 planning process would soon commence.

Lee Bond explained that everything that was being asked of the Organisation to exit FSM was in train and he was confident that by the end of October the Trust would have delivered what we could and hopefully have FSM removed.

7.4 H2 Planning Process – For Information

Lee Bond explained that divisions had been asked for a plan based on a minimum of 98% of baseline; acknowledging that it would be a challenge.

The draft ICS submission for H2 was due to commence in October for submission in November, so quite short timescales. It was expected that H2 would be similar to H1.

7.5 Finalisation to Bed Base – For Information

Shaun Stacey presented the paper which gave an explanation of the position of beds currently and for 2022/23 when a further review would be undertaken. All the flexed beds in SGH were now closed and working to close them on the Grimsby site. Lee Bond added that the costs of flex beds were in the financial plan and given there were 80+ beds, this was a significant cost.

Item 8 08/21 **Strategic Development**

There was no update due that month.

Item 9 08/21 **Digital Strategy**

There was no update due that month.

Item 10 08/21 **Estates & Facilities**

There was no update due that month.

Item 11 08/21 **Items for Information**

11.1 PRIMs letter

The letters from June and July 2021 had been provided for information and were noted.

Item 12 08/21 **Any Other Business**

Ivan McConnell highlighted, for information, that an expression of interest would be submitted through the ICS to be included in the new hospital programme. Priority 1 – SGH; Priority 2 – HUTH; Priority 3 – DPOW. The submission was currently going through governance. Ivan McConnell thanked all those involved in getting to this stage.

Item 13 06//21 **Matters to highlight to other Trust Board Assurance Committees**

Cross referral to Workforce Committee regarding mandatory training and appraisals. Peter Reading stated that this was within the Workforce Committee's remit in terms of CQC compliance and he would ask Dr Kate Wood to clarify which areas each Committee covered; it was not for one Committee to ask for a report from another Committee.

Gill Ponder explained that her intention was to highlight to the Workforce Committee that the Committee had had a discussion on mandatory training and appraisals and she had not intended to ask for a report, but she noted Peter Reading's comment.

Item 14 08/21 **Matters for Escalation to the Trust Board**

Gill Ponder agreed to pull together the highlights for the Trust Board and circulate to members of the Committee, noting the tight time scales and asking for timely responses. She would include the discussions around risk and the risks from a financial perspective.

Action: Gill Ponder / All

Item 15 08/21 **Review of Meeting**

Lee Bond commented that it would have been a struggle to get through the agenda if updates had been received from Strategic Development, Digital and Estates. Gill Ponder stated that given those updates were not due that month, it had allowed more time to be spent on the other areas.

Ian Reekie stated as an observer, he found the quality of the debate had given him a good level of assurance.

Item 15 08/21 **Date and Time of next meeting**

Wednesday, 29 September 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	✓	✓	Apols	✓							
Stuart Hall	✓	✓	✓	Apols	Apols							
Andrew Smith	✓	✓	✓	Apols	✓							
Michael Whitworth				✓	-							
Lee Bond	✓	Apols	Apols	✓	✓							
Peter Reading	✓	✓	Apols	Apols	✓							
Shaun Stacey	✓	✓	✓	Apols	✓							
Jug Johal	✓	✓	Apols	Apols	Apols							
Ivan McConnell	Apols	✓	Apols	✓	✓							
Shauna McMahon	✓	✓	Apols	✓	✓							
Helen Harris	✓	Apols	-	Apols	-							
Brian Shipley	✓	✓	✓	✓	✓							
Simon Tighe	-	-	✓	✓	✓							
Ab Abdi	-	-	-	✓	-							
Ian Reekie	✓	Apols	✓	Apols	✓							
TOTAL ATTENDEES	**12**	**11**	**8**	**8**	**11**							

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **29 September 2021 – via Teams Meeting**

PRESENT:	Gill Ponder	Non-Executive Director / Chair of F&P
	Simon Parkes	Non-Executive Director
	Fiona Osborne	Associate Non-Executive Director
	Lee Bond	Chief Financial Officer
	Jug Johal	Director of Estates & Facilities
	Shaun Stacey	Chief Operating Officer
	Shauna McMahon	Chief Information Officer
	Brian Shipley	Deputy Director of Finance
	Ivan McConnell	Director of Strategy & Planning (For item 8.2)
	Helen Harris	Director of Corporate Services (For item 4.2 & 5.1)
IN ATTENDANCE:	Jennifer Moverley	Head of Compliance and Assurance (for item 5.2)
	Mike Simpson	Associate Director of Capital Development (For Item 8.1)
	Anne Sprason	Finance Admin Manager/PA to CFO (Minutes)

Item 1 09/21 Apologies for absence were noted from: Stuart Hall; Peter Reading; Linda Jackson and Ian Reekie

Item 2 09/21 **Declarations of Interest**

Gill Ponder welcomed Simon Parkes to his first meeting. Simon Parkes declared an interest as he was Deputy Vice-Chancellor of the University of Lincoln, with links to the Trust in Nursing and Education; and also a Non-Executive Director at a Social Housing Partnership in Lincolnshire with links to the Trust on housing.

Item 3 09/21 **To approve the minutes from the previous meeting held on 25 August 2021**

The minutes from the meeting held on 25 August 2021 were agreed as an accurate record.

All actions from the minutes were included either on the agenda or the action log.

Item 4 09/21 **Matters Arising**

4.1 Action Log

The action log was reviewed as follows:

6 (26 05 21) – *IPR SPC charts – analysis of review*. The IPR was being developed with a new version being presented to the Trust Board in October and would be brought to the F&P Committee from next month. This item to be closed.

10.1 (30 06 21) – *Deep Dive – Medical Gases. A supplementary note on lessons learned.* This would be included in the update to the private Trust Board meeting and therefore could be closed on the action log.

10.1 (30 06 21) – *Training* – Shaun Stacey advised that the training had commenced for nursing staff with 75% at DPOW and 65% at SGH now trained. Medical staff training was currently in the planning stage. The Duty Nursing Officer (DNO) was a priority and on track to complete mid-October. Action to remain open until concluded.

5.1 (28 07 21) – *BAF – A number of concerns on high risks and Alison Hurley was to discuss with Helen Harris.* Helen Harris advised that she would be meeting with Exec Directors at the end of October and agreed to pick up then. Update to be provided to the Committee in November.

Action: Helen Harris

5.1 (25 08 21) – *Fiona Osborne had asked if a matrix could be included at the front of the BAF and it was suggested that she contact Helen Harris outside of the meeting*. Helen Harris explained that the planned action needed to be monitored by each Executive Director and having a separate action log did not feel like the right approach. Helen Harris agreed to pick up with each Executive Director at the end of October. Fiona Osborne agreed that this approach made sense. Action closed on action log.

6 (25 08 21) – *IPR – Shaun Stacey to provide a breakdown of numbers against P1, P2, P3 & P4 to Lee Bond*. Action completed.

6 (25 08 21) – *IPR - Shaun Stacey to provide the total waiting list size within the report.* Shaun Stacey advised that the breakdown of out-patients and in-patients were not reportable functions and therefore not included within the IPR; the information was available if required. Lee Bond was content that the minutes reflected the discussions at the last meeting and Shaun Stacey had provided a broad statement and was therefore assured at the time. Action closed.

6 (25 08 21) – *IPR – Risk Scores and the balance between BAF risk on access and flow versus mitigations and whether they reduced the score*. Shaun Stacey commented that it would be wrong to say mitigations reduced the risk. Shaun Stacey had spoken with Andrew Smith before he left and it had been agreed that this would be left with Simon Parkes as incoming Chair of the ARG Committee. Action closed.

6.7 (25 08 21) – BAF Deep Dive – SO1-1.2 – Duplicate of item above therefore action closed.

7 (25 08 21) – *Finance Report – Benchmarking on the running of two EDs*. Information to be provided in October 2021.

Following review the action log was noted.

4.2 Draft F&P Terms of Reference

Helen Harris presented the draft Terms of Reference following a request from Peter Reading and Linda Jackson for Helen to review all sub-committees' TOR in terms of quoracy and membership. Helen Harris highlighted areas to note including Section 5 which was now broken down into sub-sections; voting membership changes in section 6.1; and asked if there were any non-voting members that needed to be included. Lee Bond asked that Brian Shipley, Deputy Director of Finance should be included as a non-voting member as he attends all meetings.

Fiona Osborne referred to the reference of NED and Associate NEDs in particular section 3.1.1 which stated "*approve Trust Strategies*" and noted that Associate NEDs have voting rights at Committees but not at Trust Board level and suggested the wording should state "Review" rather than Approve.

Shaun Stacey also added that reference to approving policies, procedures and guidelines was under the remit of Exec Directors and not sub-committees. It was suggested that the wording should only refer to Trust Strategies.

Gill Ponder referred to the wording in section 7.4.3 and suggested it should read … *joint Trust roles such as CFO the attendance required is 50% with appointed deputies covering remaining.*

Simon Parkes was concerned that each Committee was looking at risk but there was a risk and assurance committee and was unsure how this fits together. Gill Ponder suggested that this could form part of the discussion by way of introduction meeting between her as Chair of F&P and Simon as Chair of ARG Committees.

Following the discussion and subject to suggested changes the TOR were approved to be presented to the Trust Board.

4.3 Workplan 2021/22 (v3 – For Information

The current workplan was provided for information. Anne Sprason to update to the new template for the next meeting.

Action: Anne Sprason

Item 5 09/21 **Presentations for Assurance**

5.1 Board Assurance Framework (BAF)

The BAF was not due to be presented to the Committee until November 2021 but a deep dive on one specific risk was on the agenda. Gill Ponder proposed that if there were any changes required to the BAF ratings following discussions at this meeting these could be included in the next quarterly report.

Helen Harris left the meeting.

The next item was taken out of sequence.

Item 6 09/21 **Review of NLAG Monthly Performance and Activity Delivery (IPR)**

6.1 Unplanned Care

Shaun Stacey presented the report and referred to the highlights clearly outlined in the summary (page 3) and noted specifically:

- Difficulties with high volumes of attendees in A&E with workforce being a major challenge in this area.
- Improvement continued to be seen in emergency care although overall performance was well below national requirements and the Trust's previous performance.
- Ambulance handover continued to be a concern with a high number of over 60mins being seen. Despite 68% handover within 30 mins of arrival the Trust was still a major outlier.

Fiona Osborne queried the A&E waiting time noting a huge amount of actions and support planned from other organisations to improve flow and asked that after the "perfect storm" in September what timescales were anticipated to turn that around.

Shaun Stacey highlighted that the 111 initiative had not resulted in improvement and the Trust was still seeing GP appropriate attendees through the emergency route. EMAS improvement plans were in place with specialty bed waits due to long waits in cubicles. There were plans in October to have an ED holding area within the assessment unit and also plans to introduce a new model at the front door to include senior clinicians in place; and Consultant or GP doing triage to make immediate assessment i.e. streaming. Difficulties with this model were the lack of confidence of staff to push back to primary care after a treatment plan was in place. The plan going forward was to have eight clinicians in place during the day with fewer at night. It was anticipated therefore that a significant improvement should be seen by November.

Shaun Stacey explained the difficulties with funding and the need to balance against delivery risk. Lee Bond agreed it was an expensive model with the labour costs reflecting the scarcity of labour itself. The funding was not yet secured so the Trust were proceeding at risk but had received positive verbal encouragement from the CCGs. The Committee would receive a further update next month. It was agreed that this should be added to the highlight report.

Shaun Stacey referred Fiona Osborne and Simon Parkes to pages 12 and 13 which described in detail the issues highlighted above.

Post Meeting Note: *Shaun Stacey provided the ambulance handover improvement plan and the urgent care service improvement plan to Fiona and Simon by way of useful background information.*

The next item returned to the order of the agenda.

Item 5 09/21 Presentations for Assurance

5.2 CQC Progress Report

In light of discussions held at the last meeting, Gill Ponder reminded Committee members that only elements of the report that fell within the remit of the F&P Committee could be discussed.

Jennifer Moverley attended the meeting to present the CQC progress report and highlighted that eleven actions had been signed off last month with 74% being either green or blue; eight remained at red, noting the community nurse staffing had not progressed and remained a priority within the Divisions. Confirm and challenge meetings had taken place with Divisions and final amendments to the self-assessment were being made before providing to the CQC. Good progress was being made with preparation for the impending inspection.

Lee Bond queried the community nursing staffing and Jennifer Moverley explained that an ongoing recruitment drive was being undertaken. Conversations were being held with the CCG regarding funding with a view to a resource increase. Jennifer Moverley also advised that a digital tool that monitored workflow had been implemented in one of the teams which she would like to see rolled out across all areas to get a sense of triangulation when looking at workforce and workload; so whilst progress was being made the key risk remained existing workloads.

Jennifer Moverley highlighted a complex area was the inclusion of a second anaesthetic tier to support obstetrics as well as theatres and emergency pathways, which was something picked up by the CQC previously. Agreement had been reached with CCGs to commission an independent opinion on whether a second tier was required and, if so, the size required. This resulted in the expectation of two tiers given the geographical split of the organisation. Once the size had been agreed, that would inform ongoing discussions around funding.

Following the update there were no further questions and Jennifer Moverley left the meeting at 9.55am.

The Committee returned to the order of the agenda

Item 6 09/21 **Review of NLAG Monthly Performance and Activity Delivery (IPR)**

Shaun Stacey continued with the presentation of the IPR.

6.2 Transformation Projects – Integrated Urgent and Emergency Care, AAU Scheme and Patient Flow

Shaun Stacey presented the paper which was an update on the integrated urgent and emergency care schemes which were covered in the Unplanned Care item earlier. This paper looked at the patient flow element. Improvement could be seen along with benchmarking against colleagues. It showed a real positive story in being able to reduce emergency length of stay acknowledging more needs to be done around SDEC and AAU.

Simon Parkes acknowledged the success story and asked what the impact had been on performance with the delays of the completion of the ED. Shaun Stacey explained that as well as the physical changes there were also people changes in terms of using a more costly approach to assessment at the front door. The biggest risk was workforce which was already a struggle when had absences of Drs and nurses - partnership working was key. The risk was that demand would increase because of a better service but that was reliant on having the right clinicians at the front door.

It was hoped that ambulance numbers returned to where they were previously and whilst ambulance flow was better than our peers we saw more from Lincolnshire. There was longer LOS for those patients, due to their location and lack of Local Authority support.

Lee Bond asked if there was a case to have conversations with stakeholders of the organisation employing a primary care workforce. If on a large enough scale, was this something that could be provided, acknowledging the risk of a better service increasing demand. Shaun Stacey stated that this had previously been considered with one of the issues being around governance. The Trust now included a GP in the management structure but would need the financial discussion on what that could look like, but he agreed that it could be revisited. It was agreed that Lee Bond and Shaun Stacey would discuss it outside of the meeting and update the Committee accordingly.

Action: Lee Bond / Shaun Stacey

6.3 Planned Care

- RTT continued to see an increasing number of patients waiting, with unvalidated performance of 68.2% for August.

- Cancer 2 week waits continued to achieve at 97.7%, with 100% for breast symptomatic for August.
- Diagnostic service performance increased overall despite still prioritising urgent and cancer pathways.
- Continued to deliver elective care with performance holding, although not improving

Gill Ponder referred to the 62 cancer day standard and asked when this would see improvement. Shaun Stacey referred to the slide on page 20 of the report which highlighted improvement in delivery of the standard in colorectal; direct treatment was improving month on month. Oncology was causing delays and affecting performance. Also pushing complex diagnostics through HUTH so hoping to see improvement but that was not expected until 2022/23. Joined up cancer services and creating a single cancer centre would also result in improvement, but the management of the entire pathway was complex.

Gill Ponder recognised that workforce was a challenge but, hearing of potential cases now coming through the door, suggested the problem was continuing to build rather than having clear sight of when would be delivered. Shaun Stacey highlighted some of the positives including 28 day standard had improved and implementation of the "lung bus" as detailed at previous meetings. This would provide access for patients where primary care had not had the opportunity to pick up potential cancers early enough. It was acknowledged this was costly but it would provide real improvement. Shaun Stacey also referred to the "fit test" being performed by GPs prior to being assessed by consultants for diagnosis, which was being implemented in NEL.

Shaun Stacey also highlighted a North Yorkshire workshop being held in October which would include independent providers. Lee Bond commented that Trusts should not be looked at in isolation but Humber wide which was helpful to identify where bottlenecks were.

One of the major factors was access to diagnostics and the ICS had funded £350k for small pieces of medical equipment which would support diagnostic intervention. Also £3m for mobile scanner/CT scanner which would be an ICS facility. On the revenue side £2m-£3m funding had been allocated for outsource of MRI and working with imaging network to ensure contracts were placed to help with reducing back logs.

6.4 IPR Deep Dive – Long Waiting patients – 52 weeks and 104 days

Shaun Stacey presented the report which he hoped provided a level of assurance and demonstrated what was being done to achieve the required targets in the individual specialties. The 62 day position was low and the teams constantly tried to maintain the position without cancelling electives. Gill Ponder commented that, as NED lead for Surgery, she felt that this triangulated well with the discussions she had had with the Division and she felt assured as a result that progress was being made.

Fiona Osborne queried oral surgery and that HUTH were not meeting the SLA and the Division were not assured that they could fulfil the contract and recovery plan. Shaun Stacey explained that work was ongoing with community dentistry but work had slowed because of a staff consultation on pay, which should conclude in the middle of October. That would enable the service to get those patients off the waiting list.

6.5 OPD Transformation Project

Shaun Stacey presented the report and highlighted that progress was being made despite other pressures. He highlighted specifically that the Connected Health Network model had recently won an award from HSJ. Non- face to face clinics had reduced and some promotion of those was ongoing. Gill Ponder stated that progress on the project came through the paper loud and clear.

Lee Bond referred to discussions at PRIMs and the difficulties being encountered with PCNs (Primary Care Network) in North Lincolnshire. Shaun Stacey explained that good engagement was being seen in network meetings but risks with the introduction of technology platform to ensure information flowed more easily across primary and secondary care than it did now; and the extra workload on primary care admin staff. The initiative would require a more directive engagement through Medical Directors and COO forums.

Jug Johal asked how confident Shaun Stacey was on the cost of postage reducing as he was seeing in E&F costs increasing. Shaun Stacey was sure that cost savings were there using a significant number of technologies. Lee Bond commented that more letters were being sent because of cancellations and problems getting outpatient clinics, which was similar to the North Bank as admin processes were really stretched in reacting to the post-Covid environment. Shaun Stacey explained that the SAT teams at NLAG discussed with patients the best way to correspond with them and determined if email could be used and they then updated the system with that information. However, there were some areas that were not using the same tool so he suspected it was the different approaches to digital solutions that were affecting those postage savings.

Shauna McMahon highlighted that close to 60% of letters were now digital and patients could also cancel appointments and rebook that way. If not seeing printing numbers reduce, it was suspected that it was people not transferring day to day practices to digital. She also noted that PKB (Patient Knows Best) was being rolled out which should also see a reduction in paper. Shaun Stacey proposed asking Jackie France to include the numbers of email addresses captured in the report. The postage costs would also be reviewed.

Action: Jug Johal / Shaun Stacey / Finance

6.6 BAF Deep Dive – SO1-1.2

The report provided was an updated version of last month's report and should have been SO1-1.3 that month.

Item 7 09/21 **Finance Report – M05**

Brian Shipley presented the report and highlighted key issues to note as follows:

- The Trust reported a £40k surplus in August which was £30k adverse to plan. Key variances continued as in previous months.
- ERF – behind plan but offset by underspends in planned outsourced capacity.
- Key pressures remained workforce with medical staff, predominantly in surgery, for agency cover for vacancies.
- Nursing overspent in Medical Division due to use of surge beds and staff absence, partly off-set by underspend in midwifery.
- Covid expenditure - Slight reduction in month due to stopping bank incentives. The remaining material expenditure due to ward reconfigurations and surge bed increases and staff isolation/sickness.

- Nursing reviews and bed configuration completed and to be presented to TMB
- Temporary Staffing - The Trust had spent £7.4m more than the same period last year. Medical and Nursing staffing groups had seen the largest increases in spend.
- Savings programme – Slightly ahead of plan in month of £431k. It was anticipated that the required savings of £300k to achieve H1 plans would be successful. There were still some unidentified savings but over delivery in other areas mitigated that.
- Some improvement in recruitment in surgery which should help with agency spend
- Reduced fill rate for doctors in August was a risk going forward.
- ERF – Failed to hit 95% so no additional funding earned therefore ERF income was a neutral position due to corresponding reductions in spend
- Capital – SGH MRI was 10 weeks behind plan with expected completion by the end of December. The current spend was £1.79m behind plan.
- Digital Aspirant funding - The programme had now been signed off by NHSX and confirmation was awaited of when the funding could be drawn down.
- Underlying Financial Position – Some improvements had been seen due to coding gains as part of the 3 year programme with Grant Thornton and non-clinical income recovery due to increases seen in private patients and pathlinks.

The key headlines were delivery and maximising activity; anything over 95% threshold to keep as close to tariff; the revised framework guidance was expected in the next couple of days; stretched delivery target over and above the core programme; and reduce Covid spend as much as possible.

Lee Bond added that workforce issues were ongoing and whilst improvement in pricing and framework compliance for agency staff had happened, usage was considerably higher than in the previous year. A reduction in Covid expenditure would be a challenge and removing Covid funding could be problematic for the organisation.

Capital was the biggest issue at £33m slippage on BEIS and energy efficiency schemes due to not being able to complete all the work in the timescale. Accounting treatment of the funds needed to be agreed and he would be speaking with Auditors.

Fiona Osborne queried staff sickness noting that the base line was higher than the previous two years and was seeking assurance that sickness levels would be considered as part of H2 plans. Lee Bond assumed this was short term sickness and stated that the local supply and agency availability was almost saturated. Fiona Osborne asked if the sickness levels continued to rise how the service would be provided. Lee Bond stated that the plan would be sense checked against current expenditure and trends.

Fiona Osborne also queried the balance sheet and improvement in paying invoices. It was explained that it was a “blip” in relation to the elective recovery plan, but accruals were made on expected expenditure.

Gill Ponder referred to the coding improvement programme and the Q1 variance which she noted was a sizeable sum and asked if it was expected that the programme had just slipped in time but would still deliver. Brian Shipley explained that the Q1 variance was not linked to the coding improvement programme as block contracts were in place. He advised that the CNST element had caused the slippage.

Simon Parkes queried the energy grant and whether this was a risk given the delays. Lee Bond stated from a financial aspect he had not quantified any expected impact of all initiatives within Estates & Facilities and therefore not included in the financial plan, but where there would be a potential problem was slippage on unidentified efficiencies.

Jug Johal explained that every energy scheme was delayed due to the tight timelines set and extensions had been agreed with SALIX and BEIS to March 2022. Costs had increased by 30% and currently looking to de-scope schemes which had meant taking out schemes for Grimsby and changing others. A further extension had been sought to September 2022. Simon Parkes asked if energy prices had been fixed given current issues, which Jug Johal confirmed.

Lee Bond also highlighted inflation costs and explained that a number of contracts for clinical consumables were fixed for 18 months-2 years but as these contracts were due for renewal sizeable inflation figures were being seen from clinical suppliers. Therefore some risk in 2021/22 but definitely in 2022/23.

Post Meeting Note from Jug Johal: *It is in times like the current gas price crisis where the benefits of being in the CCS framework really come into play. The Trust were part of a huge energy basket (with 100s of other large public organisations) where energy is purchased as much as 2 years in advance. The CCS buy blocks of energy (electricity and gas) at regular intervals and whenever it was the most favourable time to buy. This protected us from the sudden spikes that we are seeing right now.*

CCS have advised us that all the gas we would require, even through to Winter 2022, had already been purchased. Therefore, during this period, the Trust would not be subject to the inflationary pressures the energy market was currently experiencing. If those pressures continued, then we should inevitably experience higher gas prices beyond 2022. However, the basket system again should alleviate this as the gas would generally be purchased at the lowest rates possible.

Please note that current price issues are by and large around short-term gas shortages and will not directly affect our electricity costs. There may be some indirect impacts (CCGT power stations) that could affect us in the longer term but again, the CCS basket system would alleviate against any cost spikes.

Following the discussions and review the Finance Report was noted.

7.2 Capital Investment Board Minutes

The Capital Investment Board minutes had been provided for information and were noted.

7.3 Financial Special Measures (FSM) Update

The FSM letter from September had not been received by the Trust and Lee Bond advised that a relationship meeting was due to take place the following day.

7.4 Cost Efficiency including Reference Cost Submission

Brian Shipley explained that unlike previous years, where committee sign-off was required, the rules had changed and the paper was brought for information purposes only. He advised that the submission was completed and submitted at the beginning of the week. Brian Shipley explained that it was proposed that data quality issues were addressed through the costing steering group.

7.5 Upgrade to the Trust's Financial Systems – For Information

Lee Bond explained that the paper was provided for assurances purposes and the Committee were aware of future plans.

By way of background, Lee Bond advised that the ledger system contract was due to expire and, pre-Covid, an exercise was undertaken resulting in ABS being identified as the preferred option. ABS also provided the financial system to HUTH delivered by ELFS Shared Service.

The proposal was therefore to introduce ABS ledger system through ELFS. A small number of staff would be affected but would expect to relocate the vast majority within finance, procurement or elsewhere within the organisation. Consultation was currently underway with staff.

E-requisitioning would be introduced as well as electronic authorising of invoices.

Fiona Osborne stated that whilst both positive and negative aspects she asked for assurance that the SLA would cover 1% of the invoices that are problematic and need Trust staff attention. Lee Bond highlighted that when implemented at HUTH, bold assumptions were made on the staff required and subsequently had to recruit additional staff to provide a link with the provider. One of the considerations being made was to have a joint post as interface to manage the contract. The staffing structure was being discussed and supported so was confident that Fiona's concerns would be addressed.

Simon Parkes agreed that Option 3 was the right one and asked about the costs of implementing. Lee Bond explained that once posts had been amalgamated he would expect to break-even but had not included any opportunity costs if not implemented. Reference was made to education and compliance and Lee Bond explained that the plan was to have better joined-up working with management accounts and the financial accountant team to ensure complete visibility of where invoices/orders were for accrual purposes.

Following review the paper was noted.

Item 8 09/21 **Strategic Development**

8.1 Wave 4 Capital Bid Update – AAU & ED (FBC due October 2021)

Mike Simpson presented the paper and by way of introduction gave a brief background summary for the benefit of Fiona Osborne and Simon Parkes as new NEDs.

The paper was taken as read and Mike Simpson highlighted additional information since the writing of the paper. The main focus was on the clinical bed reduction and Mike Simpson highlighted that from the 813 bed base, 199 would be reduced with 161 contributed to the model. Of the 161, 57 beds were put back in due to the impact of Covid. As such, the benefits aligned to the AAU model was the total reduction of 104 beds by 2024/25, which reduced the bed base to 671, noting the remaining 38 beds removed were for patient zoning and segregation purposes.

Lee Bond highlighted the amount of work that had been undertaken internally and with CCGs and NHSE/I to provide a greater level of confidence for the organisation to deliver the scheme and make the changes to clinical models that drive the figures included within the paper. The impact between the OBC and the FBC was the inclusion of 57 beds for Covid and now working in an environment of post-Covid. The Cost Benefit Ratios (CBR) in the FBC was above 2 and was unsure if those measures would be acceptable to NHSE/I and DoH for support going to Treasury. There may be some minor tweaks to the table before Trust Board sign-off and also CCG colleagues.

Simon Parkes suggested there would be a substantial risk in realisation of the bed removal but it was a reasonable degree of risk. Mike Simpson stated that the clinical model was phased over three stages with the FBC requiring the investment to enable phase 3; current trend reporting shows good performance. He added that it was reassuring that the model was working and would improve once the estate was in place to fully enable.

Shaun Stacey noted the improvement in LOS which was now 4.4-4.8 days whereas 3 years ago was an average of 10 days. The SDEC was all part of the business case how beds were removed. He added that the Trust was only one of eleven hospitals in the UK who had continued to manage elective work over the last eleven months, explaining that ring fencing beds had been the right thing to do although acknowledging there had been times when medicine beds were used for surgical patients, but as a rule this would not be allowed.

Ivan McConnell added that the removal of beds would get delivered over time but cautioned against double counting; pathways would need to change which would also contribute.

Following the update and brief discussion the Committee were content for the paper to be presented to Trust Board for approval.

8.2 Programme 3 – Expression of Interest

Ivan McConnell presented the paper which was for information purposes and explained that a joint bid with Hull University Teaching Hospital (HUTH) was submitted for £720m i.e. £350m SGH; £250m HUTH; and £120m DPOW. The SGH bid was for provision of a new build hospital and if successful would be one of eight new hospitals across the Country.

Ivan McConnell explained that work had been undertaken with local partners and in the case of the SGH new build, North Lincs Council and also aligned to the HAS programme. The economic and social impact should see a £1.5b return and over a good few years contribute to the economy and regeneration. The new build would not be based on a like for like basis but reduced square metre footage. There was also lobbying taking place on our behalf from the local MP, Holly Mumby-Croft.

Ivan McConnell explained that the process may be in two stages which would see the long list of applications reduced to circa 30 organisations; that was anticipated by the end of October/November 2021. Those organisations would need to submit a Strategic Outline Case (SOC) and following evaluation a final shortlist of eight would be selected. It was anticipated that the process would be complete by the end of March 2022. ICS support was in place but there were still a number of unknowns to the process.

Simon Parkes referred to the £6k per square metre and noted given the inflation in building costs what level of optimism bias was included. Ivan McConnell explained that the requirement was to work on April 2021 prices but already know that £6k was a good ballpark figure but too early in the process for optimisms which would come through the SOC.

Lee Bond stated that one of the problems was delays in getting the business case approved, mobilisation of contractors and the need to extend further than expected, which was why not asked for more numbers at this stage, including optimism bias. He added that obviously politics plays a part and a number of other dynamics to be considered.

Following the update the Committee noted the report.

Ivan McConnell left the meeting at 11.45am.

Item 9 09/21 **Digital Strategy**

There was no update due in September.

Item 10 09/21 **Estates & Facilities**

10.1 BAF Risk Review – Asbestos

Jug Johal presented the report which referred to the control of Asbestos Regulations 2021 and Code of Practice (page 6). In terms of governance an Asbestos Group was in place.

Premises Assurance Model (PAM) was a mandatory management tool and became a requirement this year although the Trust had completed the PAM for the last 5 years and approved at Trust Board. Vince Tennison, E&F Compliance Manager sat on the national team. Overall management was rated good based on a number of self-assessment questions.

Jug Johal referred to the Risk Register (page 8) noting there was only one entry which covered all three sites. An asbestos register was in place and whilst undertaking construction work asbestos was removed. There were a number of key personnel (page 9) who were all trained and held appropriate certificates.

Jug Johal noted that the action plan (page 10) was light as surveys were currently being undertaken and may change over time.

In terms of asbestos incidents, assurance was given that lessons had been learned and people had been briefed on actions to take if asbestos was found. Jug Johal advised that all appropriate staff undertake asbestos training however given the number of contractors coming onto site, the team had to rely on their assurance that they and their staff were trained.

10.2 Medical Gas Action Plan

Jug Johal presented the action plan which had now been updated following a report from the Authorised Engineer. Jug Johal referred to the key included within the report and noted that it was missing “blue” i.e. assured. Going forward the action plan would include actual evidence to gain assurance for E&F going forward.

Following review the report was noted.

Item 11 09/21 **Items for Information**

11.1 Performance Letters to Divisions following PRIMs Meetings

The letters from August 2021 had been provided for information and were noted.

11.2 Self-Assessment Review – Action Plan

Gill Ponder advised that this would be reviewed post Committee.

Item 12 09/21 **Any Other Business**

There were no matters raised.

Item 13 06//21 **Matters to highlight to other Trust Board Assurance Committees**

There were no items to highlight to other Trust Board Assurance Committees.

Item 14 09/21 **Matters for Escalation to the Trust Board**

Gill Ponder agreed to pull together the highlights for the Trust Board and circulate to members of the Committee, noting the tight time scales and asking for timely responses.

Action: Gill Ponder / All

Item 15 09/21 **Review of Meeting**

Gill Ponder sought views on the meeting. Shauna McMahon commented that good discussions had been held with open dialogue

Lee Bond commented that the risk was the size of the agenda.

Simon Parkes commented that some issues were quite significant in the medium and longer terms and some papers were presented and no questions were raised which he suggested showed the Executive had a grip.

Gill Ponder suggested that as a group there was a need to focus on reducing length of papers to save time for authors and authorisers. This would also help to ensure timely distribution of papers to Committee members.

Item 15 09/21 **Date and Time of next meeting**

Wednesday, 29 September 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	✓	✓	Apols	✓	Apols						
Stuart Hall	✓	✓	✓	Apols	Apols	Apols						
Andrew Smith	✓	✓	✓	Apols	✓							
Michael Whitworth				✓	-	-						
Fiona Osborne					✓	✓						
Simon Parkes						✓						
Lee Bond	✓	Apols	Apols	✓	✓	✓						
Peter Reading	✓	✓	Apols	Apols	✓	Apols						
Shaun Stacey	✓	✓	✓	Apols	✓	✓						
Jug Johal	✓	✓	Apols	Apols	Apols	✓						
Ivan McConnell	Apols	✓	Apols	✓	✓	✓						
Shauna McMahon	✓	✓	Apols	✓	✓	✓						
Helen Harris	✓	Apols	-	Apols	-	✓						
Brian Shipley	✓	✓	✓	✓	✓	✓						
Simon Tighe	-	-	✓	✓	✓	-						
Ab Abdi	-	-	-	✓	-	-						
Ian Reekie	✓	Apols	✓	Apols	✓	Apols						
TOTAL ATTENDEES	**12**	**11**	**8**	**8**	**11**	**10**						

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DATE OF MEETING	7 December 2021
REPORT FOR	Trust Board of Directors – Public or Private
REPORT FROM	Mike Proctor, Non Executive Chair of Quality & Safety Committee
CONTACT OFFICER	Mike Proctor, Chair of Quality & Safety Committee
SUBJECT	Quality & Safety Committee (QSC) minutes September & October 2021
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The paper includes the minutes of the Quality and Safety Committee meetings for September and October 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 17 September 2021**
Time: **9.30am – 12pm**
Venue: **Virtual meeting via MS Teams**

MINUTES

Mike Proctor	Non-Executive Director **(Chair of the meeting)**
Michael Whitworth	Non-Executive Director
Maneesh Singh	Associate Non-Executive Director
Fiona Osborne	Associate Non-Executive Director

In attendance

Diana Barnes	Governor
Abdi Abolfazi	Deputy Chief Operating Officer
Dr Peter Reading	Chief Executive
Dr Kate Wood	Medical Director
Mel Sharp	Deputy Chief Nurse
Jan Haxby	Director of Quality & Nursing SIRO, CCG
Helen Harris (item 226/21)	Trust Secretary
Jo Loughborough (item 217/21)	Patient Experience Lead
Maurice Madeo (item 219/21)	Assistant Chief Nurse / Deputy Director of Infection & Prevent Control
Simon Priestley (item 220/21)	Chief Pharmacist
Anne Marie Hall (item 215/21)	General Manager, Medicine
Simon Buckley (item 215/21)	Head of Nursing, Medicine
Vicky Thersby (item 218/21)	Head of Safeguarding
Jennifer Moverley (item 223/21)	Head of Compliance & Assurance
Kelly Burcham (item 221/21)	Head of Risk and Clinical Audit
Laura Coo	PA to the Medical Director (for the minutes)

207/21 **Apologies for Absence:** *Shaun Stacey, Anwer Qureshi, Angie Legge, Ellie Monkhouse, Ian Reekie*

208/21 **Chair's opening remarks:**

Mike Proctor thanked members for the improvements in the timeliness for submitting their papers. The IPR was still work in progress, Mike attended a meeting last week where they were looking at the development of the quality and safety elements of the report which was really positive and they were certainly making progress.

Kate Wood thought it was really important to note that it was World Patient Safety Day today and there was a lot of focus this time round on Maternity Services and the Trust would be lit up orange later in the day to mark the event.

209/21 Declarations of Interest

There were no declarations of interest.

210/21 Minutes of the previous meeting held on 27 August 2021

Manesh Singh noted his title should be Associate Non-Executive Director.

Page 4 - Fiona Osborne clarified a recorded statement from ‘’some items with no target’ to, ‘some items were without a target so no goal to aim for’.

The minutes were otherwise approved as an accurate record of the previous meeting.

211/21 To approve minutes of the Extra-ordinary meeting held on 12 July 2021

The minutes were approved as an accurate record.

Matters Arising

212/21 Cancer update

Kate Wood has previously noted that although concerns for Oncology were being escalated, the risk on the Trust Risk Register was in the amber region. Following a discussion with Denise Gale, Associate Director of Cancer that had been re-rated to red.

It was agreed at the last meeting that Peter Reading would share the Committees in Common (CiC) Cancer Services update which was included with the papers of this meeting under items for information. Mike Proctor asked if Peter could report any concerns by exception to this Committee.

213/21 Review of action log

25/21, February 2021, Ophthalmology performance - The next Ophthalmology update was due to come to this Committee in October.

Regular Reports

214/21 IPR

Kate Wood referred to the report distributed which was taken as read and asked for any comments in addition to what Mike Proctor had mentioned earlier.

Kate drew member’s attention to VTE which had been a continuing concern, there had been long discussions about this and for months they had been implementing incremental changes. There was a discussion at a Clinical Leads meeting the previous week which Kate chaired where it was agreed there would be a roll out through EPA which would mean individuals could not go any further until they had completed the assessment. This would improve compliance.

Fiona Osborne referred to the structured judgement reviews (SJRs) and the training and asked how soon there was likely to be an improvement.

In response Kate acknowledged that Fiona was right in that the whole reason for doing SJRs was for learning but it was important to note that we were not seeing patients dying because of patient care however there were definitely lessons to be learnt but we were increasing the pool of staff being able to do them which would hopefully be in the next few weeks.

Mike asked if this Committee had sight of the issues and the lessons that had been learned from the SJRs. Kate informed that they were discussed in depth at the Mortality Improvement Group (MIG) and those discussions were reflected through the highlight report to this Committee but Kate would pull together an update for this Committee.

Action: Kate Wood to provide a summary report of quality improvements developed through SJR's at a future meeting.

215/21 Medicine & Urgent Care update

Anne-Marie Hall and Simon Buckley joined the meeting at 9.45am

Simon referred to the report distributed which was taken as read.

Mike Proctor noted that the QSC membership and attendees sometimes struggled with the use of acronyms and would appreciate it if there could be an explanation in future reports to ease understanding.

Simon referred to the media story about the local Emergency Department (ED) which showed the queue out the door. The report might be misleading and cause anxiety for our service users. Simon summarised the measures in place to maintain quality and safety at times when high attendance at the department was overwhelming. Joint SOPs had been developed for the number of people waiting to get into ED, which also included Ambulance services. Those SOPs included the nursing teams assessing the urgency of the people in the queue which had identified some risks where they had pulled people out of that queue and they had been triaged. Also for Ambulances doctors were going into the back of ambulances to assess patients when required.

The air flow had been improved so more patients could be waiting in ED but there were still a number of things being considered in preparedness for the winter weather.

Peter Reading thanked Simon for mentioning the article in the press, that particular incident in the Daily Mirror was about a patient having a heart attack but still having to wait in ED. Peter reassured members that this work did not start because of the publicity they had already looked at temporary facilities for canopy's, seating and possibly outdoor heating in readiness for the colder months.

Kate Wood informed that this report was taken to the Quality Governance Group (QGG) to make everybody aware of the work that was happening within the whole of the Medicine Division not just in ED. With regards to Fiona's earlier comments about SJRs that was included in the report to raise awareness of any issues.

Kate mentioned the Divisional morbidity/mortality meetings and asked for reassurance that they would be reinstated. Anne-Marie Hall informed that the Division had cancelled a lot of meetings when the Trust were on Opel 3/4 but they were very determined to continue with business as usual where they could and were really committed to making sure meetings were happening.
Fiona Osborne asked about the 15 steps and the easy things to resolve. Simon agreed there were a number of consistencies picked up through 15 steps across the areas and some were very simple; things such as posters being updated and Some 'safe and secure' that needed to be focused on, however, whilst there was nothing on the report that gave them grave concern they were all small improvements to be made.

Fiona asked about Electronic Prescribing and if those issues identified in the report were something that could easily be resolved or would require more work. In response Simon indicated that there were some challenges with the system, when they examined medication errors they ranged from prescribing across to administration so some of the issues were with implementation. Mike added that Electronic Prescribing should lead to better patient safety and more accurate prescribing and wondered if it picked up issues that would not usually have been noticed. Due to the long waits ED staff could not use the EP system so there were some challenges with the initial stages of implementation with duplicate (written and electronic) prescribing but agreed that the system gave better information.

Fiona noticed from the report that the clinical area seemed to be struggling with workforce and staff management and asked for Simon or Anne-Marie's opinion on where they thought the issue was. Anne-Marie thought that nursing had improved and they had got to a good point with mandatory training and PADRs but then were faced with the pandemic and could not provide face to face training, could not let people have the time away due to low staffing levels so from a nursing perspective it had been significantly affected by the pandemic. Simon added that they were aware as a Division they had not been good on compliance for PADRs, but they had put the emphasis on mandatory training and were managing to maintain a high level of compliance so were reassured their staff would be trained from a safety point of view. Training for AHPs and making sure they could do their training prior to starting in the role helped and they were working with the Clinical leads to enforce the need to complete their mandatory training.

With regards to Junior Doctors Kate had asked for them to have mandatory training passports to avoid them repeating training on each rotation. There was a very robust process in place for Medical appraisals this year, but it was put on hold last year which would explain why it did not look so good at the moment. Kate and Christine Brereton were looking at reporting that in a slightly different way going forward.

Mike recognised and congratulated the work done by the Division on reducing length of stay and thought that was a great improvement.

Mike noticed that on a medical staff point of view the report talked about a conversion of medical staff posts to ACP's and indicated that he would really welcome a visit to develop deeper understanding of this change.

Anne-Marie Hall and Simon Buckley left the meeting at 10.05am

216/21 Nursing Quality Report

Mel Sharp referred to the report distributed which was taken as read.

Mel highlighted that the staffing levels continued to remain a concern and a challenge to providing care as well as staff wellbeing. They had seen a lot of sickness, and staff needed to take their annual leave. Nights were still a challenge for staffing, but still managed to maintain RN safe levels, they also block booked agency so they became familiar with our Trust. The report identified a decrease in RN vacancies.
There was unfortunately the first increase in falls for five months which was a concern and was likely that was linked directly to staffing challenges

Mel invited any comments or questions.

Fiona Osborne thought one thing that stood out was about the substantive fill rates on Disney ward and asked if there was a problem with recruiting to Paediatrics. Mel confirmed there was a local and national problem with recruiting to Paediatrics, although our two Paediatric units were very good at cross-covering each other.

Mike Proctor noticed there were further establishment reviews and asked for an update. Establishments were under constant review and adjustments to staffing establishments required change to meet new challenges.
Abdi Abolfazi agreed that vacancies were a factor and community staffing levels were an extreme challenge. A combination of sickness and lack of skill mix had not been a good combination for NLaG, the Trust needed more Doctors and more medics to provide quality care. Peter Reading noted that Mel and Jo had mentioned how low morale was at the moment and wondered what their thoughts were about that as it caused him enormous concern.

In response Mel and Jo said Staff were exhausted and generally very tired and were ok for a long period but then we experienced wave three of the pandemic which had impacted significantly and detrimentally on morale The Division were looking at incentives and there was a real focus on looking after our staff.

Jo Loughborough was manager on call at the weekend and she thought it was important to note the positive impact on staff from the increased presence of Managers on-call and senior staff on the shop floor, this was appreciated and well received with staff. Abdi agreed with Jo and thought that it was important for people to try to look after each other and feel they were wanted as part of the team. The same also applied to the Doctors, they were aware of the fact that they did not want morale to be low and had arranged some team bonding but Doctors had described the day to day clinical pressures as ‘frightening’. Mike knew maintaining morale was really difficult and one of the temptations as a manager was to stay in their offices but the fact that they were coming to talk to the staff, coming in at weekends etc. was the type of morale boost that kept staff going.

217/21 Combined Patient Experience report

Jo Loughborough referred to the report distributed which was taken as read, the report was for quarter one and some of the things in the report had already been discussed at length earlier in the meeting.

Learning lessons from complaints was a key area of focus which was being facilitated by a change in the move to the Ulysses system. Jo was working with the learning group to triangulate the complaints and would produce a report from the central complaints team.

The use of Volunteers had been paused during the pandemic and the team were now very sensitively working through the process to offer people to return, noting there would be significant changes to the volunteer's role due to social distancing. A new band four role had been established which would boost the team's position in recruiting and training of new volunteers this year.

The Family Liaison Assistant Role had been well received and had made significant contributions to the Ward areas where they were placed. Unfortunately as the role was time limited they had already had two leavers but wanted to explore the options of how to fill the gap that would be left from losing this role and the possibility of using them differently. One of the areas they wanted to focus on was ED and the team was looking to have a Family Liaison in our ED.

Jo invited any comments or questions.

Fiona Osborne mentioned the Family Liaison role that had had a lot of really positive comments and was interested in how that role could progress. Jo noted that the people who had been recruited were in temporary posts so a lot of people had moved on to other permanent roles but the Family Liaison role had now been extended to January. Ellie Monkhouse was committed to supporting that role as it had improved quality and would be having conversations to drive that forward. Peter Reading agreed the roles had been a fabulous success and Peter and Lee Bond were talking through the efficiency programme to try to fund the continuation of the role. Their initial objective would be to support this in terms of the post being extended to January but Peter was reasonably optimistic it could be extended to March and hopefully beyond.

Fiona noted the number of complaints for all Divisions was falling and asked if the recent increase linked with restrictions on visiting being lifted. The allocation of investigation and lead investigator and in some instances response delays being attributed to their annual leave but she believed the allocation of leave was completely controllable so wondered why that was a problem.

Kate Wood informed that last year there was a huge number of people who could not take annual leave so the Government directive was they were allowed to carry it forward meaning people had double the amount of annual leave this year so people could not be refused their annual leave again as they were tired and needed a break.

Jo Loughborough left the meeting at 10.30am

218/21 Annual Safeguarding Report

Vicky Thersby referred to the report distributed which was taken as read which was for 2020/2021 providing an overview of the national and local context of safeguarding, vulnerabilities and associated agendas related to safeguarding adults and children.

Vicky highlighted the key points;

Liberty Protection Safeguards (LPS) - this would replace DoLs. The aim for full implementation of LPS would be April 2022 which the team felt was unlikely but the Board needed to be aware of its increased responsibilities going forward. The change would also have implications across the Trust, staff would need to be trained as there would be new referral pathways and authorisation processes.

The impact of Covid 19 on Safeguarding - there had been an increase of domestic abuse and the affect lockdown had on families.

Vulnerable children - last year was extremely traumatic for a lot of children. A robust dashboard had been developed but they had seen a sharp increase in children with mental health issues which Vicky believed was related to the pandemic.

Peter Reading thanked Vicky for the report and update noting Vicky had made a significant difference to her department and the way the trust responds to Safeguarding challenges

The report would be forwarded to the Board of Directors and Mike Proctor would support Vicky in making the Board aware of the changes the Trust was facing.

Vicky Thersby left the meeting at 10.36am

219/21 IPC Annual Report

Maurice Madeo referred to the report distributed which was taken as read and summarised the key points;

- *C.difficile* cases - the reduction of *C.diff* cases was one of the key parameters the Trust was judged. This year there had been 28 cases which was a 23% reduction compared to last year.
- *MRSA* Bacteraemia - the Trust had gone 20 months without any cases but had one case in December.
- *E.coli* bacteraemia - had a seen 19% reduction.
- Good performance with Orthopaedic primary hip and knee surgical site infections.
- Been linking in with different teams setting up the Incident Control Centre with excellent clinical engagement and innovative ways of working.
- The IPC Board assurance framework was informally assessed by CQC and deemed satisfactory.

Maurice invited any comments or questions

Fiona Osborne asked about the ready rooms mentioned in the report which stated they were temporary and asked about a long term plan to improve infection control facilities. Maurice referred to the diagram on page 37 of the report. The infrastructure in NLaG in terms of isolation was very poor therefore they introduced the ready rooms just before Christmas and those rooms would be utilised until the building work had been completed. They had some electronic aids for staff in terms of swabbing etc. Ward 24 had been identified as the next area to increase beds but that needed to be reviewed as it was not the right time to do that.

Fiona referred to the areas for improvement and the last paragraph about the Microbiologists and asked when things went back to normal would there still be a vacancy gap. It was agreed that this was a major issue as there was a national shortage of Clinical Microbiologists, particularly now one key member of staff. Peter Cowling had gone back to two days a week on a locum post. The Trust had only one full time Microbiologist.

Kate Wood thanked Maurice and the team for the fantastic work they had been doing and commented that our Trust were in a very privileged position to actually have Microbiologists as a lot of organisations did not have any. It was also really good that we had managed to recruit an Antimicrobial Pharmacist as a key member of the Pharmacy team.

Peter Reading thanked Maurice and his Team for all of their work, it had been an extreme time and at times they had a lot of very difficult situations to manage but Maurice's personal resilience had been fantastic and Peter found Maurice's advice very helpful and he knew everybody else felt the same.

Given the pandemic it was agreed that the report should go to the Trust Board as it was a genuine public interest however it was noted that it was requirement for this report to to the Board anyway.

Maurice Madeo left the meeting at 10.47am

220/21 Annual Medicines Optimisation Report

Simon Priestley referred to the report distributed which was taken as read. The report provided an account of the medicines management and optimisation activities undertaken over recent months. Simon highlighted the progress plans for change and areas of concern;

Key achievements

- Progress with the implementation of ePMA - the changes for adult in-patient wards was being rolled out and had just gone live with the adult model in ePMA
- As part of quality and assurance a report came through last week and they had maintained our status.
- Funding had been secured for the Pharmacy Robot - the main robot was now up and running hopefully giving us some resilience going into winter planning.
- The recruitment of the new pharmacist had meant they had already managed to make some significant changes.

Fiona Osborne asked if the Medicines and Therapeutic Committee and Safer Medication Committee reported to this Committee. Simon clarified that both fed through to the Quality Governance Group (QGG) which provided a highlight report each month to this committee where any issues would be flagged.

Fiona saw there was a 50% spike in errors for the electronic prescribing and that was partly because of ED prescribing on paper and duplication but wondered where that was evidenced. Simon was working with Medicine to put together a business case and they were trying to find a solution for ED prescribing.

Kate Wood asked for the Committee to note that for the next years report they would make sure there was a link to the Pharmacy strategy

Simon drew member's attention to section 3.2.1 Safe and Secure Handling of Medicines Audit. Simon would provide more information on this in his update to the Committee in November.

The Committee approved and ratified the Annual Medicines Optimisation Report.

Simon Priestley left the meeting at 10.55am

221/21 Annual Report & Key SI Update, including Maternity

Kate Wood referred to the report distributed which was taken as read and Kelly Burcham joined the meeting for this item.

The number of SI's the organisation was reporting had reduced and since Kate started in post there had been weekly SI meetings and an increase focus in this area. As the number of SI's came down it meant that we could improve the quality of the learning from the SI's and they could be looked at in more depth, the quality of the reports and the learning that had come out of them had improved.

Documentation had come out as a common theme and Nathaniel Steadman was developing proposals to improve practice in this area. .

Kate invited any comments or questions.

Fiona Osborne thought the report was very thorough and the data was very clear but asked if the report would be made public at the board, if so there were a few typos that needed correcting before it went anywhere else. There were only a small number of cases and themes and anything under five cases would not be reported.

It was confirmed that the report would not be going to the Board.

Kate thanked Kelly for all the work that had gone into getting this new report into the format.

Monthly report

Kate referred to the report distributed which was taken as read. The report ensured the committee was focussed on key SI's and particularly on the detail of the Maternity SI's. Sadly there had been one further Never event related to a retained swab in theatre at SGH. It had been identified and there was no patient harm as a result of that.

In terms of SI's Mike Proctor noted that the Maternity SI reported which was a particularly difficult and involved a very rare condition and enquired if the patient had recovered. Kate was personally involved in the case as was the anaesthetist on call and confirmed the lady had been discharged. Manesh Singh added that placenta acreta was not usually diagnosed pre-natal and the fact that she had survived was fantastic. Kate thought the team were indeed fantastic and worked together for the benefit of the patient there were so many people involved, behind the scenes including the Hull Vascular Surgeon who came to operate in our theatres.

Kelly Burcham left the meeting at 11.09am

222/21 Deviations NICE Guidance

None

223/21 CQC update Report

Jennifer Moverley referred to the report distributed which was taken as read and highlighted the key points. Over the past month two actions had moved from green to blue and a further nine actions were approved and uploaded to the CQC between 2nd August and 8th September which had not been reflected in the report due to the timing of the report being produced but the report was now in real time.

Eleven were uploaded to CQC last month.

The focus remained on the red rated actions;
Community nurse staffing remained under pressure, there were multiple controls in place which were monitored at PRIM level.

All Divisions remained committed to working through those actions and there was some preparedness in place for the impending CQC inspection as well as a hub page dedicated to it.

Jennifer Moverley left the meeting at 11.11am

224/21 Quality Priorities for 2022/23

Kate Wood referred to the document distributed which was taken as read. The paper was a long list of issues that were to be considered as quality priorities for next year. It was only in the early stages of the process and would be brought back here as things developed. Kate was happy to take suggestions at any point.

225/21 Whistle Blowing Report

Peter Reading referred to the report distributed which was taken as read.

In January 2020 Peter Melton and Peter Reading received a very disturbing email relating to a number of serious concerns about the way the Emergency Department was operating that afternoon. The person concerned was actually working on behalf of CCG rather than NLaG which was why Jan Haxby was involved. The report included what improvements had been made since then.

Jan gave a brief overview, but noted that the whistle blower was working on behalf of the GP out of hours not the CCG. The amount of time lapsed since receiving the email was significant, there were some initial investigations and interviews set up but then COVID hit so was not where we wanted to be in terms of timescales. The response had been broken down into nine themed areas;
The report set out the context, including the fact that the acuity of the patients coming into ED was really high that weekend, there were some escalations made by staff, the usual actions you would have expected were taken.

Two lines of the enquiry were upheld the others were partially upheld.

There were some things about the environment and the facilities of the department which were being addressed with the new building. The flow of patients was being addressed and some initiatives were underway. The report proposes some actions, one being to share the report with the whistle blower and finally in terms of monitoring and oversight of the actions and whether it sits with this group or another group in monitoring that oversight.

Mike Proctor invited any comments or questions.

The thing that stood out for Mike was the symptom of an overcrowded A&E department, managing space and flow. Now waiting in the department, evidenced by further deterioration in the performance against the four hour standard was probably even worse. Mike asked for assurance that the experience of patients had not deteriorated further since the events described by the whistleblower.

In response Anne-Marie Hall said that at the time there was corridor nursing, which was no longer the case because of social distancing which also meant the department was no longer as overcrowded.

Abdi Abolfazi added that it was extremely important that although we did not have patients in corridors patients were now waiting longer for assessments and treatments. There was regular monitoring and overview of the area for patients waiting in the queue, and those held in back of the ambulances etc. and were being monitored on a three tier system. The Department now had a 24/7 coordinator. The three tiers were working on a rota to maintain safety to try to avoid overcrowding, it was a fragile atmosphere but was not unsafe. Additional senior doctors had been put in place all of the measures in totality ensured the safety of that department.

Referring back to the report at the time they had acknowledged that they were struggling with nurse staffing which had since improved. The department now had additional Nursing staff, senior staff and Heath Care Assistants to help with the hands on care.

Fiona Osborne commented that the report showed there had been a huge amount of work so clearly the whistle blowing process had been responded to positively. The report mentioned the mental health of the staff, concerns about some going home crying and not wanting to do their next shift and Fiona wondered if that should be aligned to this event or a separate exercise.

In response to Fiona's comments Peter Reading pointed out that the actions taken had not been in response to the whistle blower report they had already been started and the staffing had already been worked up,
Jan Haxby picked up the point from Mike about ED performance, her view was that we should not just look at ED performance other areas should be used for patient experience as well. Kate agreed with Jan but added that the length of time spent in ED gave an increased risk of mortality which we must not lose sight of.

In response to the morale question from Fiona Osborne, Anne-Marie informed that at that time the staff were feeling very low but since the Pandemic it had been a very different difficult time and staff were struggling. They had a lot of input / support from Navigo etc. but it was still a daily struggle for staff.

In terms of this report Mike thought it was fundamental for it to be shared with the whistle blower and was happy to discuss outside of this meeting how they might monitor the actions from that with Jan and Peter.

Mike asked for the Committees thanks to be passed on to the teams for their hard work through this difficult time.

226/21 Quality & Safety Committee ToR

Mike Proctor referred to the ToR distributed which were taken as read.

The Committee was asked to make comments on the changes to the ToR rather than approval so that the Board could approve the changes.

Helen Harris had been asked to streamline the ToR's for the Board sub-committees and ensure consistency. Peter Reading had made some suggestions about core membership which Helen needed to make a further reflection on. Helen was happy to take any comments or suggestions.

With reference to 7.2 Fiona Osborne commented that it had been discussed incorporating the Directors and NEDs and thought Associates should be included throughout as well.

Fiona also suggested for seven day deadline rather than five days for papers as she appreciated it was difficult for the administrator to collate everything and for the membership of the Committee to have sufficient time to read papers and digest the contents.

Kate Wood noted that it had been agreed within the team that the Medical Director title would not be changed yet to keep the consistency throughout the documentation.

Peter Reading referred to the Quoracy and whether the Associate members should be full members. This would be the only Committee that required a Clinical Executives for quoracy.

An Assistant NED can vote at a Committee but not at a Board so an associate NED could be the Deputy Chair.

Mike suggested for an attendance record to be kept for future meetings.

Research sat within Ellie Monkhouse's portfolio and Kate knew she had not been involved in any of the discussions however there was agreement that Research needed to report into a Board sub-committee and that QSC appeared to be the most appropriate home for this area.

Helen Harris left the meeting at 11.49am.

227/21 Secondary Malignancies Mortality Outlier findings

Kate Wood referred to the paper distributed which was taken as read. The Trust is an outlier against the official SHMI data release in two areas one of which was Secondary

Malignancies and Kate felt it was important for this Committee to have sight of the report on the review of that. The other area was Cancer of Bronchus and linked access to Specialist Oncologist at Hull and the other part was the decisions about advanced care planning. The reason this was looked in through a deep dive was to see if we could understand and develop our patient pathways for this. The Trust were working hard with all of our provider colleagues to really bring home the message that we were using the data we receive to make improvements and these were two of Kate's biggest concerns within the Trust.

Mike Proctor added that there were two elements; these issues make our numbers worse in terms of the SHMI and it also meant that patients were not getting the care they should have with the latter being the most important.

Kate thought that firstly we needed to think about patient experience and about the families it was not saying they received bad care but it could be done differently. Through our CiC we were looking at the Oncology services, advance care planning and there was some really good traction for our EoL work across the system. Recently there had been some excellent news regarding some additional investment going into Palliative Care across the patch. Kate was very confident that things were moving across our system but it was not showing in the data.

Jan Haxby commented that the EoL programme was vast and covered all the partners, hospices, community services ambulance and was a system wide approach. Jan recognised there was a gap in the EoL post N E Lincs side and that was being worked on. There was a lot of work still to do had been had been a lot of work in the Trust to really push Respect and EPAC and an additional post to drive that work had been agreed.

Mike recognised the challenges of developing change across many organisations and agencies and hoped the new direction of 'system working' would develop greater traction and deliver faster change in this area.

Highlight reports

228/21 Mortality Improvement Group (MIG)

The highlight report was taken as read.

229/21 Quality Governance Group (QGG)

Kate Wood referred to the report distributed which was taken as read. Kate drew member's attention to the very last sentence about operation pressures which had been very robustly covered through discussions today.

230/21 Patient Safety Champions

Items for Information

231/21 Cancer Services report

232/21 Quality Governance Group (QGG) minutes

233/21 Mortality Improvement Group (MIG) minutes

234/21 Any Other Business

235/21 Matters to Highlight to Trust Board or refer back to QGG

To refer to the Trust Board;

- Nurse staffing
- ED changes
- Safeguarding
- IPC report
- Medicine Optimisation reassurance
- The Maternity SI
- Discussion about the whistle blower and assurance
- QSC ToR
- Good discussion about patient and family experience relating to end of life and how it was a significant challenge to new system working.

To refer back to QGG

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236/21 Meeting review

Date and Time of the Next Meeting:

Friday 15 October 2021 at 9:30am - 11.30am (tbc) to be held virtually

Michael Whitworth will be chairing the meeting as Mike Proctor will be away.

The meeting closed at 12.05pm

Northern Lincolnshire and Goole NHS Foundation Trust

Minutes

Meeting: **QUALITY & SAFETY COMMITTEE**
Date: **Friday 15 October 2021**
Time: **9.30am – 12pm**
Venue: **Virtual meeting via MS Teams**

MINUTES

Michael Whitworth	Non-Executive Director **(Chair of the meeting)**
Maneesh Singh	Associate Non-Executive Director
Fiona Osborne	Associate Non-Executive Director

In attendance

Abdi Abolfazi	Deputy Chief Operating Officer
Angie Legge	Associate Director of Quality Governance
Diana Barnes	Governor
Dr Kate Wood	Medical Director
Dr Peter Reading	Chief Executive
Ellie Monkhouse	Chief Nurse
Jan Haxby	Director of Quality & Nursing SIRO, CCG
Jennifer Moverley (item 250-1/21)	Head of Compliance & Assurance
Nicola Foster (item 243/21)	Deputy Head of Midwifery
Rachel Stanton	Observer from CCG
Simon Buckley (item 247/21)	Head of Nursing, Medicine
Laura Coo	PA to the Medical Director **(for the minutes)**

237/21 **Apologies for Absence:** *Mike Proctor (Michael Whitworth to chair), Shaun Stacey (*Abdi Abolfazi to rep*), Jane Warner (Nicola Foster to rep, Kishore Sasapu*

238/21 **Chair's opening remarks:**

Michael Whitworth informed the group that he would be chairing the meeting today in the absence of Mike Proctor. A revised late agenda was distributed.

239/21 **Declarations of Interest**

There were no declarations of interest.

240/21 **Minutes of the previous meeting held on 17 September 2021**

Page 6 – Fiona Osborne asked for her sentence to include 'with exception of CTS' otherwise it did not make sense.
Page 9 – Item 221/21, the last sentence to add that 'it was agreed the report would not be going to the Board'.

Page 8 – Ellie Monkhouse noted that the Antimicrobial Pharmacist sat with Pharmacy and not the Chief Nurse Directorate and there was a requirement for the report to go to board each year, so it was not a one off.

Matters Arising

241/21 Summary report of quality improvements developed through SJRs

Kate Wood referred to the paper distributed which was taken as read and briefly highlighted the key points.

Kate invited any questions or comments.

Michael Whitworth asked for an explanation of the charts. Kate clarified the charts were a tally put together based on people's opinions. Michael commented that admissions for various reasons were high in the findings, but Kate advised that the bulk of those were being picked up through the strategic EoL work.

Michael noted that the report included a good element around Medicine and ED performance and issues going into winter and suggested for the Committee to look at those issues further at the next meeting as Michael thought it was a really good summary. Kate agreed it was an excellent report and should be of interest and was a good opportunity to build on that.

Action: Laura Coo to add to the action log for a future meeting, next meeting if possible.

242/21 Review of action log

25/21 - February 2021 meeting, Ophthalmology performance – item deferred to the November meeting.

182/21 – August 2021 meeting, Cancer Services – This was discussed at the previous meeting and agreed that this should be taken through the Committees in common meeting (CiC) and Peter Reading had provide a cancer services update report from that meeting for information. Peter fedback that what this Committee thought might happen at CiC had not happened and therefore Peter thought the subject should be brought back to this Committee for further discussion. Kate Wood suggested that the action should be for Shaun Stacey to work out a way forward from the operation perspective.

Action: Kate Wood to contact Shaun Stacey with regards to Cancer Services.

Regular Reports

243/21 Family Services with Maternity / CNST

Nicola Foster referred to the paper distributed which was taken as read and summarised the key points.
They were now in year four of CNST and out of the 10 safety standards there were three areas of concern.

- Safety action 3 - backlog of MDT audit of cases to April, avoiding admissions in NICU. There was an action plan in place, it had been added to the Risk register and twice weekly meetings had been introduced.
- Safety action 6 - Saving Babies Lives non-compliance training.
- Safety action 8 – Multi disciplinary training requirements. This was twofold as the training required the anaesthetist to attend to train but also, they had to be part of the training faculty. Last year was ok as the training was online which was why they had suddenly come across this issue.
- The financial impact – used Attain to ensure they were compliant also had an Obstetrician and Neonatologist two hours a week and were assessing whether they needed more staff in midwifery.

Ellie Monkhouse added that this was a regular quarterly report and the team were ahead of the game with CNST and were already working towards next year's submission. They had worked alongside the Ockenden submission that was made and Nicola was highlighting where the focus needed to be in the coming months.

Fiona Osborne asked what the comment about commitment from the multi-disciplinary teams meant with regards to Safety action no. 3. Nicola clarified it meant they needed an Obstetrician and Neonatologist, Preeti Gandhi the DCD would have been able to give a better explanation but was unable to attend today's meeting.

With regards to Safety action 3 Michael Whitworth commented that although you get drawn into it with a red-light page 20 gave quite a lot of assurance yet on page 27 looking at the process there was a lot of work to be done. In response Nicola explained that Saving Babies Lives was probably one of the most challenging elements they had, the Attain issue came to light and as soon as they recognised there was an issue, they put in things to support that. Some were marked as amber as those elements were not achieved. Ellie added that that we had our Maternity improvement advisor on site once a week and felt that the team were incredibly harsh on themselves. The fact that it had been identified and articulated meant we were in a much better place than we had been previously. Maneesh Singh thought there seemed to be a lot of work to do and asked what the deadline for this work was. Ellie and Nicola agreed it was a huge piece of work and the standards had different due dates, but all the dates were next year.

Michael Whitworth thought it was a good report that included the relevant amount of awareness and transparency.

Nicola Foster left the meeting at 10.02am

244/21 Integrated Performance Report (IPR)

Kate Wood referred to the report distributed which was taken as read. Kate drew members attention to the key points.
Venous Thromboembolism (VTE) - An update had already been provided to the Board to advise that there had been some very distinctive changes made with regards to how patients were identified and assessed but those changes would not be reflected in the report until at least December time.

Structured Judgement Reviews (SJRs) and the historic backlog – This work was still ongoing; Medicine were going to put an action plan together to see how to address the backlog and new processes had been put in place.

With regards to the performance with blood glucose being recorded in the ED Department, Simon Buckley would be attending later in the meeting to discuss that. Kate added that within the IPR as it stood at the moment there was a front score card, and this was how the Quality priorities were covered off, including discharge. Dual reporting would always be a bit of a risk and Kate proposed those around discharge and flow were extracted out of the report and taken to the Finance and Performance Committee for discussion there. There were no objections to that suggestion, and all agreed.

Fiona Osborne mentioned QS023 - A&E score from Friends and Family test and noted that A&E performance was something that the Finance and Performance Committee spent a lot of time discussing and asked if that should be discussed wider.
Kate explained that part of the discussion at the beginning which tied it all into that and we would not be losing sight of it at all.

245/21 Quality Priorities

Angie Legge referred to the document distributed which was taken as read. This was part of the consultation for the development of priorities for next year and the potential new topics. The appendix outlined the process that was followed which would be narrowed down from there.

246/21 Nursing Quality Report

Ellie Monkhouse referred to the report distributed which was taken as read and summarised the key points.

From a staffing point of view nights continued to be a concern for Ellie. There had been a prolonged period of time using escalation beds and it was quite difficult to capture that information which had an impact on shift fill rates and the matrix. There had been one category four pressure ulcer reported by the short stay ward at SGH. On review it was missed on admission but some more training was required which was partially good news.

The international recruitment campaign continued and there were approximately 70 qualitied nurses joining us so was a lot of activity. The best way to describe the service was fragile and challenged. The service continued to be a struggle considering all the indicators including the much more in-experienced workforce, however standards were being maintained whilst working through a very critical time for the service.

With regards to the overseas nurses Fiona Osborne had heard at previous meetings that there needed to be extended supervision for overseas staff and asked if that would impact the nursing team. They were now working with a different supplier for nursing staff and Ellie was confident the standard of nurses was high. Ellie had also started running Forums for new nurses as well as doing a lot of on boarding into their teams so they were going to stick with the four weeks for now and they got better as a team it was something that would be looked at again in the future. Fiona asked if the

Trust had seen a reduction in the overseas nurses since using the new provider; Ellie thought it was too early to tell but they were doing a lot of pastoral support and felt the position was much better.

Michael Whitworth thought the report helped the committee to join up some of the dots and highlighted the recommendations well. Ellie acknowledged it was a lengthy report, but it gave an open and transparent review of the nursing quality and the view of the patients.

247/21 Diabetes Management update

Simon Buckley joined the meeting at 10.15am

Simon referred to the report distributed which was taken as read.

Simon drew members attention to the congratulations the Paediatric Diabetes Team received from both tertiary centres in Sheffield and Leeds. which was well received based on the hard work that had been put in.
It needed to be acknowledged that the Diabetes Task and Finish Group had not met for two months (August and September) due to operational and staffing pressures but the meetings were back on track to recommence monthly.

Michael Whitworth thought it was a good report and there was a lot of detail but suggested really drawing into mitigation and mandatory training.

Kate Wood thanked Simon and the team for the mandatory training that had been provided for Diabetes Management, this was one of the quality priorities this year due to diabetes related incidents over the last couple of years. Kate felt there was a good grip on it now and was reassured with the fact that there was also a grip on the areas that needed development. Overall, Kate thought it was a good report and thanked Simon for producing it for the Committee.

Simon Buckley left the meeting at 10.24am

248/21 Key SI Update including Maternity

Angie Legge referred to the report distributed which was taken as read. There was one new Maternity SI this month relating to a twin pregnancy, guidance was followed but the wider holistic risk was not taken into account and the twins died in utro

There had also been a Never event following a patient having an unnecessary angiogram as the patients were mixed up which resulted in another person not having the procedure. It had been followed up and nobody had come to any harm because of the mix up and the correct person had since been given an appointment for their procedure.

249/21 Deviations NICE Guidance

None to discuss

250/21 Register of External Agency Visits

Jennifer Moverley referred to the report distributed which was taken as read. Jennifer highlighted that within the report there was a recommendation to pull one of the visits from the Royal College for the surgery review which Jennifer wanted to retract and for it to remain open a little longer until it was embedded and to be closed at a later date.

251/21 CQC update Report

Jennifer Moverley referred to the report distributed which was taken as read. The format of the report had changed to align with Committees.

Over the past month there were 14 actions completed and uploaded to the CQC. Jennifer noted that since August actions were only changed to blue at the stage of final approval and once, they had been uploaded to CQC to give show the real time progress. 76% of the actions were now either green or blue.

There were 95 actions aligned to the Quality and Safety Committee.

- The one red action was for Community nurse staffing which had a clear update and work was ongoing.
- Eight amber actions; included Community and Therapy continence service, EoL linked to care delivered in accordance with national guidance and linking into national guidance and Medical Records which were being re-audited. Paediatrics linked to the display and safety information; they were looking to buy some screens. Surgery had new equipment checklists in place.

The quarterly review of all closed actions continued and would be reflected in the next report.

Ellie Monkhouse asked why seven days services had been aligned to the Workforce Committee as Ellie thought it linked to here. Jennifer was happy to change that in the next report and Michael Whitworth was happy to discuss with Mike Proctor to ensure it sat in the right place. Kate Wood thought Ellie made a good challenge but explained that rationale behind that; one of the blockages to committing to seven day services was around the workforce element which was why Kate had suggested it was aligned to the Workforce Committee rather than here as the blockage was with the workforce.

Action: Michael Whitworth and Mike Proctor to discuss and decide outside of the meeting

Peter Reading agreed with Ellie that the reason for it coming to this Committee was about the quality but the difficulty in being able to do it was workforce and therefore Workforce Committee owned the issue.

Peter Reading raised an issue that had been raised with him twice in one week. It was known that CQC were very interested in the Paediatric work and the service provided and wondered what provision would be able to put in on a 24/7 basis as he had heard from A&E twice this week to say they were struggling with the children's service element and getting it covered. It was a question which Peter appreciated would be difficult to answer. Ellie did not entirely share Peter's view as there had been extensive work done around peak activity times in the department and had extended

our RCNs in those times and there had been no suggestion that the peak times had changed. There was a process in place already and for out of hours there was quite a rapid response from our Paediatricians attending the department. Ultimately they were trying to service two A&E departments. The other side of the argument was that they could end up with two RCNs not having any Paediatric patients and the mitigation being taken to CQC at the moment was that. Peter clarified that this was the view expressed to him on two separate evenings by the shift leads that they were full and were not getting the back-up they needed. Needed to be sighted on the fact that the A&E department were not getting the support from clinicians due to the wards being full and the clinicians not being released. The clinician at SGH was concerned about safety which was escalated to the site manager at the time and some discharges were made.

Michael was not sure whether this was a matter for this Committee to get involved in. Kate Wood added that there were processes in place, there would always be occasions where the departments were full but ultimately they needed to work together, Kate knew pathways were constantly being looked at to ensure things were running as well as possible and ultimately it was about providing assurance of safety. Ellie thought there was something about triangulating what Peter had said with what was going on in the department as this was not something that had been picked up so far. Ellie asked for the opportunity to triangulate this and include it into a report for the next meeting. Peter agreed there needed to be some simple arrangement in place to ensure the things in place were working.

Action: Ellie Monkhouse to provide a report for the November meeting.

Highlight reports

252/21 Mortality Improvement Group (MIG)

Kate Wood referred to the highlight report which was taken as read.
Kate summarised the key points and noted that the engagement at the meetings was fantastic and the discussions were palpable. The report summarised some of the queries and questions raised.

- There was still more work to be done,from an assurance perspective there had been some really good progress made with Respect and they were almost there with some of the changes made in the Palliative care provision.
- The Medicine team were looking to put a proposal together for SJRs to close off the historic ones, however there were some that would not be closed off, but that decision would be made later.

Jan Haxby added that as Kate had said the EoL Steering Group had done a lot of work to develop the clinical model and the governance arrangements for EoL. The CCG were putting together a dashboard to monitor the process not just in the hospital setting, recently Mike Proctor had asked if that could be shared once completed and Jan would be happy to do that once it was completed. There was also an Unexpected Mortality Group that looked at the SHMI and mortality across Lincolnshire. Jan was due to meet with Kishore Sasapu to look at deaths outside of hospital and how they could be aligned.

Maneesh Singh asked if the out of hospital SHMI was purely down to EoL care or were there other factors that affected it. Jan replied that there were different thoughts; there was a view that the out of hospital SHMI was a bad thing, however the fact they were admitted to hospital in the first place was the issue and they were looking at how to stop those admissions in the first place. Jan was meeting with NHSE/I to understand some of the admissions to hospital and out of hospital deaths. There were different streams of work to look at for this, there were some stats to support that N E Lincs were one of the best in the country for allowing people to die out of hospital so Jan felt the data contradicted itself.
Maneesh added that things such as VTE prophylaxis were more likely to occur outside of hospital as well as secondary Covid symptoms that increased the risks of heart attack and strokes and thought that our out of hospital was not just linked to EoL patients and was much wider.

Kate thought they were all good points raised by Maneesh, but Kate reminded everybody that the out of hospital SHMI issue had been evident for over 10 years, so it was not linked to Covid. Jan was right there were many factors involved in this but there were many knowns; advanced care planning and respect were consistent things that had been highlighted over the years and could not be ignored which was why Jan was ensuring provision was looked at all the time as there would always be more things to consider.

253/21 Quality Governance Group (QGG)

A highlight report was not provided this month due to timing of the meeting.

254/21 Patient Safety Champions

Angie Legge referred to the highlight report distributed which was taken as read.

The patient safety training was not yet available, but Angie was able to take an action plan responding to patient safety objectives to the meeting this time.

Items for Information

255/21 Quality Governance Group (QGG) minutes

Fiona Osborne asked about the Neonatal action plan there were some external actions (item 7.7)

Action: Kate Wood to pick up outside of the meeting and get back to Fiona Osborne.

256/21 Clinical Harm

Kate Wood referred to the risk and clinical harm oversight and assurance update distributed which was taken as read. Kishore Sasapu was still in Theatres therefore Kate gave the update on his behalf.

This was the bi-monthly report, the clinical harm aspect was looked at retrospectively and the risk stratification looked at the now. Kate drew members attention to slide seven and the 52 ww summary position and noted there was a number error there were three patients waiting over 104 weeks.

- A Gastro patient monitoring of liver/lung nodule still under validation
- A Urology patient transferred from HUTH who had been on their waiting list for a circumcision
- An Ophthalmology patient referred and listed for surgery who was discharged and appointed for squint correction.

Kate knew that this committee wanted assurance and felt the report provided that assurance. Abdi Abolfazi advised that patient had been booked in for surgery on 28th October.

With regards to 52wks they were now less than 450 and continued to reduce, considering that in February they had over a thousand good progress had been made. Kate added that the oversight was through this meeting and the numbers were there to show progress but highlighted there was a very good system in place to risk assess patients at point of referral and patients on our follow up waiting list, they were not creating an industry only when patients went overdue were they risk stratified otherwise it was a measured process and the patients were risk stratified when they came into clinic.

257/21 Mortality Improvement Group (MIG) minutes

258/21 Any Other Business

Maneesh Singh asked Peter Reading about the Oncology services in the Humber region, he had heard that one of the Oncologists in Hull had retired and that nobody had applied and wondered what was happening with that. Peter was not aware of another retirement but was knew the age profile of the Oncologists at Hull would lead to retirements and thought it would be appropriate at the CiC for HUTH to give an update.

259/21 Matters to Highlight to Trust Board or refer back to QGG

To refer to the Trust Board;

- General assurance items

To refer back to QGG

- Nothing to refer back

260/21 Meeting review

Fiona Osborne mentioned about the timeliness of papers, the papers had been distributed late this time which did not give much time to read through all the papers.

Rachel Stanton thanked members for letting her attend the meeting to shadow Jan Haxby and felt there had been a lot of very open and honest conversations.

Date and Time of the Next Meeting:

Friday 19 November 2021 at 9:30am - 11.30am (tbc) to be held virtually

The meeting closed at 11.26am

Attendance Record 2021/22

Name	Oct 2021	Nov 2021	Dec 2021	Jan 22	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022
Michael Proctor											
Michael Whitworth	✓										
Fiona Osborne	✓										
Maneesh Singh	✓										
Dr Kate Wood	✓										
Ellie Monkhouse	✓										
Dr Peter Reading	✓										
Angie Legge	✓										
Helen Harris											
Jan Haxby	✓										
Jennifer Moverley	✓										
Shaun Stacey											
Ian Reekie											
Diana Barnes	✓										

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NLG (21) 276

DATE OF MEETING	7 December 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 – ¼ Report for the period 1 July 2021 to 30 September 2021
BACKGROUND DOCUMENT (if any)	TCS 2016/2018 – Junior Doctors
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	This report goes to TMB and JDF.
EXECUTIVE SUMMARY	The note the quarterly report – for information Exception report data from 1 July 2021 to 30 September 2021 in line with the Doctors in Training contractual obligations. There was an increased in the number of exception reports this quarter up from 49 reports from previous quarter to 75 during this last reporting quarter. The majority of the reports were in connection with working hours. There was 1 report for missed educational opportunities.

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 Quarterly Report

Dr Liz Evans
Guardian of Safe Working
15 October 2021

Contents

1. Executive Summary

Exception reports for the quarter 1 July 2021 to 30 September 2021 saw a marked increase from 44 to 75 exception reports in this quarter.

The majority of the exception reports submitted were in connection with working hours, with a very small number also submitted around educational opportunities and work patterns for which the Director of Post Graduate Medical Education continues to oversee and discuss within the relevant Divisions/Directorates.

There is still on-going work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared.

Once refresher training has been carried out on the allocate system for exception reporting and Educational Supervisors reminded of their responsibilities the time spent by the Guardian of Safe Working in relation outstanding exception reports should reduce.

Exception Reports

Current numbers of Doctors in Training within NLaG is as follows:

Number of Training Posts (WTE)	268
Number of Doctors/Dentists in Training (WTE)	203.28
Number of Less than full time (LTFT) Trainees (Headcount)	21
Number of Training post vacancies (WTE)	30.82
Number of Trainees by Site (Head Count)	
SGH	120
DPOW	112
Goole	0

Source Recruitment

During the period of this quarterly report (July 2021 to September 2021) there have been a total of 75 exception reports submitted through the allocate exception report system.

This showed an increase of 31 exception reports from the last quarter (April 2021 to June 2021).

Of the 75 exception reports submitted, 67 of these were linked to hours. This showed an increase of 32 reports from the previous quarter.

The exception reports for this quarter relating to hours had been agreed by the Guardian of Safe Working (GoSW) for either payment or time off in lieu (TOIL).

These exception reports have now been closed on the system as they have been actioned appropriately.

The below table is a breakdown of the exception reports over the last quarter (July 2021 – September 2021)

Information for GoSW board report for 01/07/21 - 30/09/21

Exception Reports (ER) over past quarter	
Reference period of report	01/07/21 - 30/09/21
Total number of exception reports received	75
Number relating to immediate patient safety issues	3
Number relating to hours of working	67
Number relating to pattern of work	2
Number relating to educational opportunities	1
Number relating to service support available to the doctor	5

*Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an immediate safety concerns (ISC). ISC is not an exception by itself.

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	38
Total number of overtime payments	23
Total number of work schedule reviews	0
Total number of reports resulting in no action	5
Total number of organisation changes	1
Compensation	0
Unresolved	8
Total number of resolutions	**67**
Total resolved exceptions	**69**

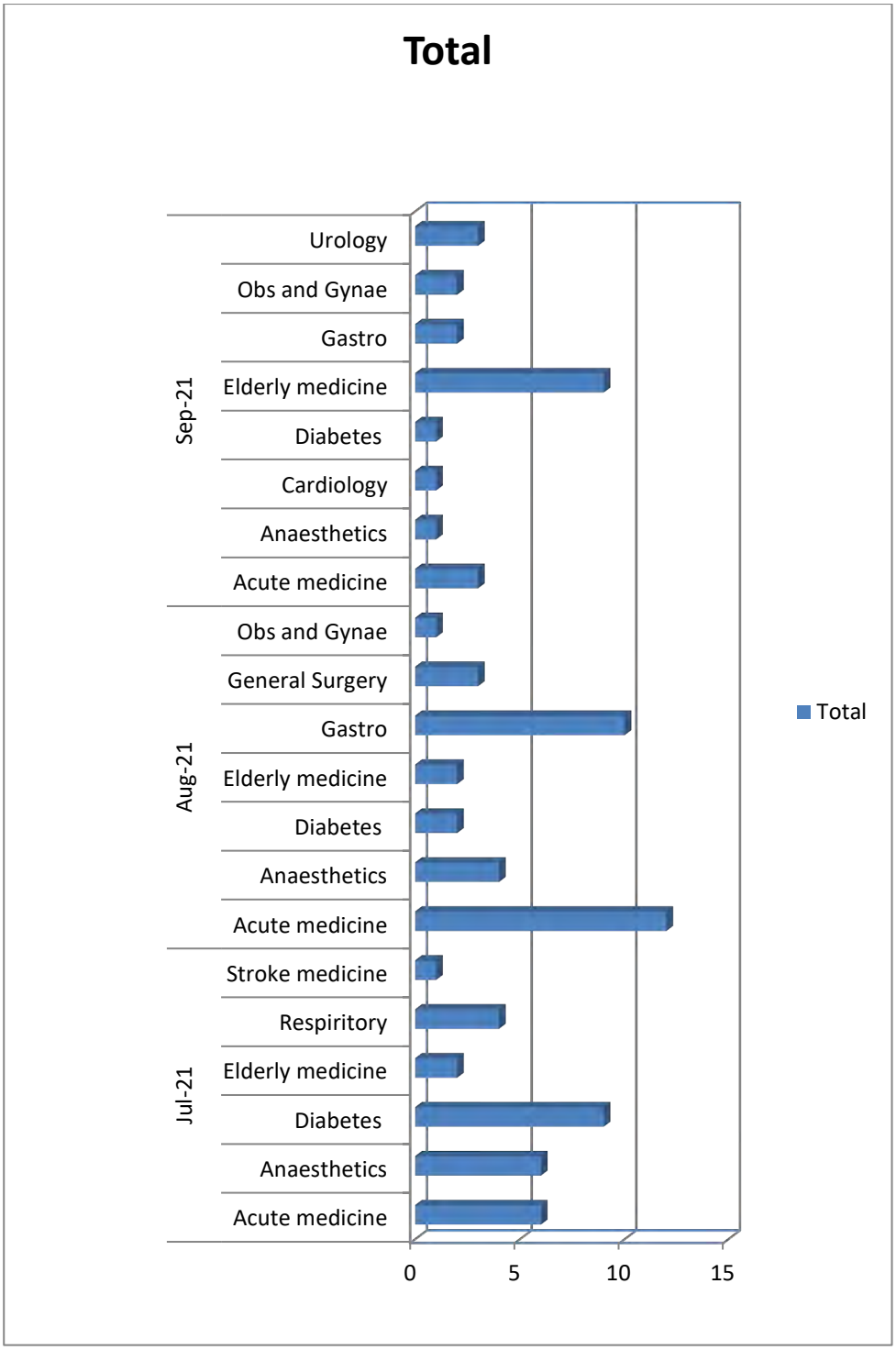
"Note:

* Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.

* Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.

* Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded."

Row Labels	Sum of Total number of exceptions submitted
Jul-21	**28**
Acute medicine	6
Anaesthetics	6
Diabetes	9
Elderly medicine	2
Respiritory	4
Stroke medicine	1
Aug-21	**34**
Acute medicine	12
Anaesthetics	4
Diabetes	2
Elderly medicine	2
Gastro	10
General Surgery	3
Obs and Gynae	1
Sep-21	**22**
Acute medicine	3
Anaesthetics	1
Cardiology	1
Diabetes	1
Elderly medicine	9
Gastro	2
Obs and Gynae	2
Urology	3
Grand Total	84



2. Immediate Safety Concerns

During this quarter there were 3 initial exception reports that flagged and immediate safety concerns.

Within the system, an exception report relating to hours of work, the work pattern, education opportunities and service support has the option for the doctor of specifying if they feel it is an immediate safety concern. An immediate safety concern is not an exception field on its own.

Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and progressed appropriately.

Of the 3 immediate safety concerns reported during quarter 2, the following reasons had been identified, investigated and solutions sought.

1). I am the only junior doctor covering ward (respiratory) today, looking after several sick patients and a number with COVID. This is unsafe level of staffing and I am unable to provide the level of patient care that would be minimum to be safe. This is unfair on both the patients any myself. – Resolved immediately by sending additional; staff to the ward once this was highlighted.

2). When I arrived at work I was the only junior doctor covering 24 patients, including unwell and COVID patients. Not only is this an infection control risk, switching between red and green patients, but it was unsafe level of staffing. This caused significant distress to myself and to the nursing team. The other doctor was only an FY1 and undertook an FY1 led review of half of the patients, which again is unacceptable and should not be happening as he does not have a full GMC license – Resolved Situation highlighted to both clinical lead and DCD.

3). Both F1s and our IMT3 registrar had to stay behind after work to cope with the large number of jobs generated. There isn't enough of us on the ward to cope with the workload. There isn't enough time to rest afterwards as I also have the PSA exam to study for after hours. This is making it very tiring and unsafe for the patients too. – Resolved, time given back to the doctor

3. Work Schedule Reviews

During this quarter there were no work schedule reviews required.

4. Trend in Exception Reporting

This quarter showed, as the previous ¼ report had, exception reports relating to educational opportunities were again due to service delivery, for example doctors have reported the inability to attend clinics either due to the clinic being converted to telephone consultations or the doctor required on the Ward due to service commitments.

5. Fines Levied against Departments this quarter

During this quarter there were one fine levied against General Surgery at Scunthorpe General Hospital because the rota co-ordinator had requested a doctor continue working following a night shift which was unacceptable and a breach of the Working Time Directorate. The Guardian of Safe Working provided further education and information to the rota co-ordinators and Directorates to ensure they are reminded of the legal requirements set under the Working Time Directive.

6. Communication and Engagement

Work continues to look at the communication and engagement with our Doctors in Training.

The Guardian of Safe Working/Junior Doctors Forum has been up and running now for 6 months, has formal terms of reference, agenda and notes. There is a lack of presence from Junior Doctors and work to improve this has taken place.
The GoSW has highlighted the forum at the August intake; steps have been taken to promote this widely through Trust communication channels.

In addition a GoSW information leaflet is about to be launched and a formal newsletter has been circulated throughout the Trust.

The September meeting did have an increase in attendance which was encouraging and work continues to increase this attendance with representation from all 3 sites within the Trust.

7. Support for the Guardian Role

The dedicated administrative resource for the Guardian of Safe Working which sits within the Medical Director's Office and is working well..

The Trust's Guardian of Safe Working, Dr Liz Evans, Specialty Doctor in Anaesthetics at DPOW commenced in this role back in June 2021.

8. Key Issues and Summary

Exception reporting during this quarter demonstrated a large increase in comparison with the previous quarters which can be attributed to increased communication and engagement.

Continued engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to resolve most issues as and when they arise.

Further training requirements for the Educational Supervisors has been identified and it is planned this will take place during 2021/2022.

Dr Liz Evans - Guardian of Safe Working

Date: 6 October 2021

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NLG(21)277

DATE OF MEETING	07 November 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 28 September 2021
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Workforce Committee on 28 September 2021
EXECUTIVE SUMMARY	Minutes of the Workforce Committee meeting held on 28 September 2021 and approved at its meeting on 30 November 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)	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. 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 for 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
		✓			

NHS
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Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday 28 September 2021 at 2.00 pm via Microsoft Teams

Present:

Michael Whitworth	Non-Executive Director (Chair)
Christine Brereton	Director of People
Paul Bunyan	Associate Director of Workforce
Alison Dubbins	Associate Director of Leadership, Culture and OD
Linda Jackson	Vice Chair
Claire Low	Deputy Director of People
Fiona Osborne	Associate Non-Executive Director
Robert Pickersgill	Governor, Membership Office
Michael Proctor	Non-Executive Director and Deputy Chair

In Attendance:

Jenny Hinchliffe	Deputy Chief Nurse
Kishore Sasapu	Deputy Medical Director
Simon Dunn	Senior HR Consultant, Humber Acute Services Programme (agenda item 7)
Claire Hansen	Programme Director, Humber Acute Services Programme (agenda item 7)
Ivan McConnell	Programme Director, Humber Acute Services Programme (agenda item 7)
Jennifer Moverley	Head of Compliance and Assurance (agenda item 9)
Helen Harris	Director of Corporate Governance (agenda item 15)
Wendy Stokes	Executive Personal Assistant to Director of People *(taking minutes)*

1 Apologies for absence:

Abolfazl Abdi, Stuart Hall, Helen Harris, Ellie Monkhouse, Peter Reading, Maneesh Singh, Shaun Stacey and Kate Wood

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, 27 July 2021:

The minutes from the previous meeting held on Tuesday, 27 July 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 90 – Invite a BAME staff representative to join the Workforce Committee
To be discussed at part of the TOR and it was agreed to remove the item from the action log after discussion.

Action 91 – To provide an organisational structure chart with names once the restructure has been finalised
Christine Brereton reported that the HR team are still going through the consultation to align job roles and responsibilities. Recruitment is currently taking place and the final organisational structure will not be available until the New Year. It was agreed to keep this item on the action log.

Action 92 – Ensure future FTSU Reports reflect how FTSU complaints are linked into exiting processes where relevant
At the last meeting it was made clear that if an incident/complaint was raised with Liz Houchin as the FTSU Guardian she was signposting people to the right place. Some cases had become formal incidents/complaints and it was about understanding that link to make sure things went into the proper processes. Liz Houchin had presented her report at the last meeting and the Board could be assured by adding an extra column further assurance would be given. It was agreed to keep this item on the action log.

Action 93 – Table the Disciplinary Policy at a future meeting when finalised for Trust Board oversight
Christine Brereton reported the draft format of the disciplinary policy was now available, but work was still ongoing with the trade unions to finalise as it needed to embed a just and learning approach. This would be discussed at the Workforce Committee when available.

6 People Strategy Deep Dive – Culture including HWB:

Alison Dubbins presented the culture deep dive presentation that was available on SharePoint.

Questions:
Kishore Sasapu stated that H&WB is talked about a lot and he can see that on the front line sickness rates are quite high with various flash points and he asked what feeds into your group to say that you need to focus on this group of people, who leads that support and is there already a system in place. Alison Dubbins reported that currently this is on an individual level, if anyone needs support, they go through their line manager and they pinpoint them to the various options available and that might include a referral to occupational health. In the last 12 to 18 months the trust has been reacting to the pandemic and what could be put in place at that time. Good things have been put in place which have helped but they are not sustainable longer term. Staff are fatigued and the purpose moving forward of the H&WB Steering Group is to put a more sustainable plan in place for the future. The trust has had confirmation it has been successful in joining the

H&WB NHSE/I HNA pilot wave 2 starting on 06 October. This will help with a self-assessment of where the trust is now and what it needs to focus on.

Mike Proctor asked regarding the annual review of the committee, he wasn't sure what things report into the Workforce Committee, H&WB Steering Group and Culture Task and Finish Working Group. He asked could they report into the Workforce Committee on a regular basis to give updates. Alison Dubbins proposed that the Working Group is accountable to the Transformation Board and that goes through to the Workforce Committee. They are currently working on a dashboard that will be presented at Workforce Committee and Trust Management Board on a regular basis.

The Chair commented that the deep dive presentation was succinct and grouping things together in themes highlights what is happening and how that is monitored. It was very disappointing that managers and clinicians feel that the term 'Wobble Rooms' could be construed as something that puts people off using them. Alison Dubbins responded that had already been recognised and didn't go down well because that was a national initiative but unfortunately it can stigmatise that the trust wants people to say they are not coping. It is more of a retreat space or down time space rather than suggesting people are not coping.

Culture and Engagement was presented to the executive team and is planned to go to Trust Board in November. This is about bringing everything together in one place. It has always been difficult to measure and if you look at the model hospital which was part of the model employer, they are developing KPI measurements around that and trusts will start to be measured on this.

Fiona Osborne asked about coaching and mentoring and whether that was an internal network or was it teaching line managers to do that. Alison Dubbins confirmed it was multifaceted, the trust has an expansive network of coaches and mentors and the intention would be to get the OD function team to look at the quality of that to see if it is being offered for the right reason and at the right time. The aim is to develop a bureau of accredited mentoring with appropriate supervision. Firstly, coaches need to be validated and that information refreshed to develop a coaching model of mentoring and coaching and differentiate between poor line management with lack of confidence. The trust must also embed and sustain line manager coaching in daily practice because collective and compassionate leadership should be a daily practice. The trust is obligated as part of managing staff performance to also monitor their H&WB and to bring that and ED&I to coach for career development and succession planning and to widen and deepen the understanding of that.

Robert Pickersgill asked if the leadership academy model is going to be figured in.
Christine Brereton confirmed it is in the plan and has been signed off by the Board to scope ideas for a leadership model by December of this year. The next deep dive will be on leadership, there are already some medical and nursing programmes in place.

Alison Dubbins stated that the trust knows it is data poor in OD interventions and HRBPs will be spending time doing coaching and mentoring and looking at that. One metric is to improve the engagement score because a 0.12% improvement equates to a 0.9% saving in agency fees. There are external drivers for change measured against culture, ED&I and leadership. From NSF data the trust knows what it knows from the 2019 and 2020 staff data. It is about how the trust builds that appetite to change using the NHSE/I tool kit. The aim of the Transformation Board through engagement, which is a participation sport, is to get it right and invest in the next 3 years collaboratively with the workforce. The first phase is to scope and discover what the trust already knows and what it can improve on and much of that work will be through coaching and mentoring.

The Chair confirmed that the deep dive gives assurance that the trust has a process.

7 HASR Review Update:

It was agreed to circulate the HASR presentation after today's meeting and the following summary was given:

- Programme 1 – internal clinical plan includes ten fragile and vulnerable services
- Looking at combining with HUTH in a joint way with joint clinical leadership teams and joint managerial teams with joint job descriptions for leadership roles
- Need to think about building leadership capability and using clinical models moving forward
- All base line work planned to be in place by December and that will transform into operational management
- Committees in Common and a Joint Development Board chaired by HUTH and Lee Bond from NLaG includes executives from both trusts

Programmes 2 and 3 are looking at core hospital services including urgent & emergency care, maternity, neonatal care & paediatrics and planned care & diagnostics. The pre-consultation business case to be completed by December and submitted to HSE/I. That will be signed off by the CCG Board and reported directly through ICS. This gives approval to consult and build pathways in more detail for sustainable clinical services for the future. This will shift activity and look at future skills locally led through Simon Dunn and the ICS, HR and OD colleagues. It will look at what can be done locally around partner working and career pathways to address workforce shortages. It is a big change programme and about organisations working in a different way with colleagues to operate across boundaries. A lot of work is underway and the programme is calling on people to support, engage, criticise and challenge. There are challenges with primary care and academic colleagues and the programme welcomes their support. The Staff Survey will build on that and continue with engagement which will form part of how to evaluate the options. This has worked well with the junior doctors' forum in HUTH asking trainees what they want, which is different to what consultants want, and that needs to be recognised and built on. The driver for this is the workforce challenge and that needs to be front and centre.

8 Workforce Performance Report – Trust and Directorate:

8.1 Vacancy Position

Medical, nursing and HCA rates are stable with recruitment ongoing in all areas. Travel difficulties are delaying new oversees employees from starting in post. The highest number of leavers are health professionals with some leaving to take up other career opportunities.

A total of 73 newly qualified nurses have been sourced with 20 commencing in October.

Medical vacancies are outside of target largely due to an increase in establishment in April 2021. There was an 80.10% fill rate for the August rotation and travel difficulties are causing some issues with delaying start dates.

8.2 Turnover

As a result of Covid pressures more people are making career choices sooner than they would have done and a high proportion of employees are leaving the trust, and some are retiring altogether.

8.3 Sickness Absence

Within normal variation and no significant change. Following the last Covid wave and sickness peak in November 2020 sickness had been in decline. The last couple of months had seen a slight increase but still within the control limits. Most days lost are due to anxiety and depression and as part of health and wellbeing some clinical support work is ongoing with ITU frontline staff.

8.4 Mandatory/Statutory Training Completion

Nothing discussed

8.5 PADR Completion

Nothing discussed

Questions:
Fiona Osborne asked with winter pressures on the horizon and the current mental health challenges how does the trust manage the peak of that. Paul Bunyan stated that if they know all the circumstances they will know when the peak is coming and can manage that period. They are already working with operations and nursing looking at how to take additional shifts on. The trust has just removed incentives and it is about how it balances H&WB and that is part of the resilience plans that the Operations directorate are developing.

Kishore Sasapu stated sickness doesn't give the full picture, in addition to that and more importantly are risk assessments for front line staff. That data is probably needed to give the real picture on a day to day basis. Nico Batinica joined the People directorate in August and the directorate is looking at targets and whether current percentages are realistic. Claire Low reported that some work on risk assessments is being done to bring in litigation around the new guidelines and allow some staff to come back to work. The People directorate is working with Bill Parkinson and the risk assessments should be completed by the end of the week.

The Chair stated that he would add sickness in the highlight to Board. This is a potential issue that will peak in November and the committee questioned whether the actions being taken are enough. Christine Brereton reported that the biggest challenge is workforce and that is part of winter planning. There is an acceptance that the trust will not have the workforce in the way it would want, and it needs to mitigate that in the best way it can. The trust is looking at incentivisation in a different way and workforce is also an area of special focus for the H2 plan.

Kishore Sasapu commented that mandatory training is slightly in discordance with what the trust is telling the CQC and he asked how the two can be tied together. The Chair replied that this is not new to the committee, there are hot spot areas and work is being done in those areas including specialist teams which will get better with quality data going to PRIMs. A piece of work has been commissioned to review mandatory and statutory training to find out if expectations are realistic, whether it is national guidance and is it necessary. NSE/I said CQC will manage against your own manager targets and a lot of work has been done to improve on those. Alison Dubbins added that early findings for phase 1 have been done and phase 2 starts in November. Training events on ESR for 2020-2021 are down by 28%

compared to 2019. There is no capacity to do training and best practice requirements and the trust is trying to mitigate that by streamlining mandatory and statutory training to a minimum to see if that boosts compliance. Extra energy is being used through HRBPs and the Education and Training team to be as match fit as the trust can be before CQC visit.

9 Update on CQC Action Plan:

Jennifer Moverley stated that she will attend Workforce Committee meetings and present the CQC progress report next month. There were 144 CQC actions from the last inspection two years ago with 74% being rated green or blue as being signed off. There has been commitment from divisions and in the last month 11 were signed off. There are eight red actions including mandatory training and statutory training. Work is ongoing and the CQC are due to visit the trust in the next couple of weeks. The trust is looking at staff groups in real time to reduce the administrative burden. There has not been a great deal of progress due to Covid and a reduction in the number of courses available and it is hoped that the strategies will help to increase that. Kishore Sasapu highlighted that the progress to date is commendable and he re-iterated that each division is looking at that.

10 Employee Relations Cases:

There has been a total of 192 formal cases in the two-year period April 2019 to April 2021. The predominant number has been disciplinaries. Paul Bunyan is looking to make the report more sophisticated going forward. FTSU gave some correlation for dignity at work and grievance cases but in future there will be more cross referencing with the E&DI agenda.

10.1 Discipline

The Just and Learning Culture and the Baroness Dido Harding letter should be at the front of what you do in disciplinary cases. Some people have taken their own life in relation to suspension and the length of time the process took. On average completion time for casework is 19 weeks and that is too high. Out of all the formal cases, over half had no case to answer or employees were given a first written warning. It is recognised that the more punitive the cases are the higher the detriment over time. The trust is looking at informal resolutions and that can be understood more by working with people to understand what went wrong and how it can be done differently either individually or team based. The recommendations are to reduce the number of formal cases and the amount of suspensions and give a better oversight of cases with a greater use of technology to inform what is going on.

10.2 MHPS

This is the process for investigation of doctors excluded and will form part of future process as this is being integrated into the offering.

The Chair felt the report was good and he agreed that the Just and Learning Culture will improve the way cases are managed and this will also impact on culture.

Robert Pickersgill asked if there was any correlation between the sickness data on page 8 and the disciplinary versus FTSU data on page 6 in relation to the peak in sickness. Paul Bunyan replied the peak is about capacity and how to make managers aware and about visually understanding trends in their staff group and whether it is avoidable or not. In

future you will see the presentation of data split by trends and the development of workforce metrics.

10.3 Grievance

Nothing discussed

10.4 Occupational Health Uptake

Nothing discussed

10.5 Bullying and Harassment

Nothing discussed

11 Workforce Policy and Procedures:

Claire Low, Paul Bunyan and Nico Batinica in partnership with Staff Side colleagues are going through the outstanding controlled documents to decide which are to be prioritised and to prepare an action plan with dates going forward. Another piece of work is reviewing all the controlled documents and to challenge with Helen Harris' support whether they are controlled documents because some are guidelines and procedures. A plan should be in place by the next committee meeting and that will be presented in terms of an update.

12 Medical Education Report:

Mr Silas Gimba is a consultant obstetrician and gynaecologist and has been at the trust since 2001 and for the past two years he has been in Postgraduate Medical Education. The report gives the performance of trainees and trainers in this trust. The trust performance is not where it needs to be and has been worsening for the last few years despite all the efforts that have been put in. The trust benchmarks lower against its neighbouring trusts and compared to trusts nationwide all departments are extreme outliers although there are pockets of good performance. Obstetrics and gynaecology is better in York and the Humber and the whole of England. There are some underperforming departments and in the last two years there has been a lot of change and the impact of that will come in time.

The Chair asked if the plan is the best possible to succeed. Mr Silas Gimba stated there are three areas that will help:

- Review the establishment out of hours, the biggest reason is workload at night and not being supported enough. The model for duty is very old and availability of consultants is an issue.
- The model has success in obstetrics and gynaecology, there is 1:1 time with consultant and trainee. Usually consultants do not have enough time in their workplans, but that time needs to be protected even if it is only for one hour per week.
- There are vacancy gaps and consultant gaps

Kishore Sasapu stated he and Kate Wood are supporting the discussions and working with Silas Gimba to focus on training. There should be three orthopaedic higher surgical trainees on each site and the trust gets one so that skews the figures. The other 5 are vacancies and there are also no locums so that must be considered. The Deanery places higher surgical and higher medical trainees and NLaG gets an allocation of around 30% to 40% whereas neighbouring trusts

get almost 90%. During Covid time was lost for elective work and orthopaedic work suffered the most and as a result some trainees have moved to the independent sector

The Chair felt the passion and he asked what the committee can do to help make the situation better. Christine Brereton suggested that she met with Silas Gimba and Kate Wood to discuss this further. The Chair welcomed that and asked for an update at the next Committee meeting.
Action: Christine Brereton

Fiona Osborne asked about the lack of funding as mentioned in the closing remarks on page 24. Silas Gimba stated that Health Education England (HEE) has allocated £60,000 for Covid-19 training recovery plans. One trainee can take up to between £4,000 and £5,000 and there will be a shortage in the next 5 to 6 years' time particularly in surgery.

The Chair felt there had been a good discussion and all present approved the report.

13 Trust Board Highlight Report including any BAF considerations:

The Chair confirmed the following to be included in the highlight report:

- Sickness levels
- Medical Education Report
- The deep dive into culture and health and wellbeing gave assurance to the committee

14 Annual Review of Workforce Committee Performance:

No comments made

15 Any Other Urgent Business:

Terms of Reference:
Helen Harris apologised for the lateness of the TOR being available. Peter Reading and Linda Jackson had asked Helen Harris to review the TOR particularly around quoracy and being on the correct template. Since then each Chair and Executive Director had been sent the TOR and feedback received had been incorporated. The main content had not changed significantly; the yellow highlighted sections are the new text and anything scored through in red has been crossed out as it is duplication.

Section 4.2.2
Christine Brereton stated that the Health and Wellbeing Group and the Equality and Diversity Working Group feed into this committee and are scheduled on the workplan. Deep dives are also on the workplan which bring out thorough discussions at meetings. The Chair confirmed he was in agreement with Christine Brereton.

Alison Dubbins agreed with Christine Brereton and asked is there not a role for governance boards who work collaboratively for medicine and nursing that would feed into this group from a strategic perspective. The Chair replied that there is still some work to do to look at governance and that is a longer-term action over the next four to six months. There also needs to be some dialogue with the Quality and Safety Committee.

Christine Brereton added that finance around nursing costs is picked up by the resource centre and bank is a prime example where this committee should look at the impact on the workforce although the finer details still need to be picked up in the smaller committees.

Section 6.1.1
The committee agreed the voting membership should include all Non-Executive Directors and Associate Non-Executive Directors

Section 6.3.1
The committee agreed Chief Nurse, BAME Staff Representative, Chair of Staff Side

Section 7.6
Helen Harris highlighted the changes in yellow

The committee asked can all the references to 'Non-Executive Directors' be changed to 'Non-Executive Directors or Associate Non-Executive Directors'.

Section 7.5.1
The committee asked should that be two Executive Directors and one must be the Director of People. Christine Brereton stated that Peter Reading is happy with that as Kate Wood is a regular attender at meetings. Kishore Sasapu stated that discussions around workforce usually include nursing and medicine. The Chair confirmed he was happy to go with Peter Reading's suggestion and if that needs changing in the future, he would be happy to do that.

Section 6.3.4
The Chair welcomed Robert Pickersgill's attendance at meetings and was happy to invite more staff governors.

The Chair confirmed there were no specific sub committees at this point.

16 FLU:

Vaccinations have commenced using the peer vaccination model. Guidance has been received to confirm that trusts can co-administer the Covid booster and Flu vaccinations using the hub model environment probably from the end of September/early October. This will then be part of the internal reporting programme and details will come to this committee.

17 Date, time and venue of next meeting:

Tuesday, 30 November 2021 at 2.00 pm held virtually via Microsoft Teams

The meeting closed at 16:48 hours

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)278

DATE OF MEETING	7 December 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Simon Parkes, Chair of ARG Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	Audit, Risk & Governance Committee Minutes from 22 July & 27 August 2021
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	ARG Committee –21 October 2021
EXECUTIVE SUMMARY	Minutes of the Audit, Risk & Governance Committee held on 22 July and the Extra-ordinary meeting held on 27 August and approved at its meeting on 21 October 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 July 2021** via MS Teams

PRESENT:	Andrew Smith	Chair of ARG Committee / Non-Executive Director
	Michael Whitworth	Non-Executive Director
	Gill Ponder	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)
	Mark Surridge	External Audit – Director (Mazars)
	Liz Stones	Governor Observer
	Graham Jaques	Head of EPRR and Operational Flow (For item 10.1)
	Bill Parkinson	Head of Safety and Statutory Compliance (For items 10.2;10.3;10.4 and 13.1)
	Sue Meakin	Data Protection Office (For item 11.3)
	Ivan Pannell	Head of Procurement (For items 11.4;11.5 and 11.6)
	Angie Legge	Associate Director – Quality Governance (For item 11.9)
	Shauna McMahon	Chief Information Officer (For item 13.2)
	Steve Mattern	Associate Director IT Infrastructure (For item 13.2)
	Tonya Frederickson	Cyber Security Lead (For item 13.2)
	Anne Barker	Finance Directorate Administration Manager / PA to CFO

Item 1 07/21 **Apologies for Absence:**

Apologies for absence were noted from Mike Norman, Mazars.

Item 2 07/21 **Declarations of Interests**

There were no declarations of interest made.

Item 3 07/21 **Minutes and Trust Board Highlight Report of the previous meeting held on 3 June 2021**

- The minutes of the public meeting held on 3 June 2021 were reviewed and agreed as an accurate record.
- The Highlight report from the meeting held on 3 June 2021 was noted.

Item 4 07/21 **Matters Arising / Review of Action Log**

The action log was reviewed as follows:

7.1 (16.06. 20) – A&E 4 Hour Wait Performance – Tom Watson confirmed that Internal Audit undertook this piece of work. Action closed.
6.4 (03.06.21) – A&E 4 Hour Wait Performance – Andrew Smith confirmed that the item had been referred to and discussed at the Finance & Performance Committee. Action closed.

6.1 (21.01.21) – Cyber Security – Included on the ARGC Agenda (22.07.21). Action closed.
8 (21.01.21) – Losses and Compensation Report – Lee Bond confirmed that he had now spoken with the Chief Pharmacist and advised that there had been routine expiration of drugs, which he felt were minimal values given the volume of drugs passing through pharmacy. The other incident involved drugs being left out of the fridge, which was more careless but given the totality was £2.5k and not a material issue. Lee Bond stated that he was impressed that Pharmacy staff were on top of such losses to this level. Action closed.
7.4 (22.04.21) – Waiting List Management - consideration to be included on the Internal Audit Plan 2021/22. Lee Bond advised that following discussions with both Sally Stevenson and Tom Watson it had been agreed to undertake this piece of work using carry forward days from 2020/21, etc. Action closed.

Following review and updates the Action Log was noted. All action log items closed, none outstanding.

Item 5 External Audit (Mazars)
07/21

5.1 Progress Report

Mark Surridge gave a verbal update to the Committee and referred to the change to the Value for Money (VFM) process which was now in place and therefore Mazars were moving towards completing the VFM commentary to be included within their Annual Auditors Report.

Mark Surridge confirmed that the themes included within their commentary were not unexpected for NLAG i.e. financial sustainability of system; special measures and workforce which were all a continuation from the previous year. Mark Surridge advised that a recommendation was required to be made by Mazars but they had been struggling with this, however they had come up with a solution and a conversationwas being had with NHSE/I. Lee Bond acknowledged the difficult position for the External Auditors on the VFM commentary given it was outside of their usual scope due to the system based approach, and noted that the NHSE/I conversation would be key, adding that they need closure in order to lay the Trusts accounts before Parliament.

Mark Surridge confirmed that their final report was expected to be completed in August to fully close down the audit. Helen Harris highlighted the timings of the Trust's AGM was a concern, noting that Parliament only returns from summer recess on 6 September 2021 and the scheduled Trust AGM was scheduled for 13 September 2021, advising that the Trust's Annual Report and Accounts had to be laid before Parliament before it could be received by the AGM. Mark Surridge also noted the ARG Committee would need to receive their VFM commentary and Annual Auditors Report and suggested that an extra-ordinary ARG Committee would need to take place, which was agreed to be arranged. It was agreed to include this issue in the Highlight report to the Trust Board.

Action: Sally Stevenson / Andrew Smith

5.2 Annual Review of External Audit Performance

Andrew Smith commented that it was a very concise and well constructed paper. Lee Bond advised that all the performance measures contained within the tender document had been achieved and there were no concerns on External Audit's performance, stating that he would have spoken to Mark Surridge in advance if there had been any concerns.

Mark Surridge advised that they also run their own annual survey with their clients which goes into more detail, and added that this would be sent to Andrew Smith and Lee Bond for them to complete and return in due course.

Andrew Smith stated that the work with Mazars had gone very smoothly and was delivered professionally and accommodated any additional requests. He thanked Mark Surridge and colleagues in the External Audit team for their work over the last year.

Item 6 07/21 **Internal Audit (Audit Yorkshire)**

6.1 Internal Audit Progress Report

Tom Watson presented the report which was taken as read and highlighted the salient points. There were two reports outstanding from the 2020/21 plan i.e. IT Business Continuity which had now been finalised with limited assurance and the summary was included within the report. The second report i.e. Fraud Prevention Notice – Mortality, was an advisory report and was currently in draft form. The recommendations included within the Mortality report had been agreed with the Medical Director and Tom Watson advised that he would be meeting with Dr Kate Wood and Shaun Stacey to finalise the report.

Andrew Smith referred to the two limited assurances given to IT Business Continuity and Data Security & Protection Toolkit (Stage 2) and noted the progress being made by the Chief Information Officer and her team. Andrew Smith also referred to the BAF, noting that it showed a sensible approach to the risk ratings assigned to these areas. However it was agreed that it would be highlighted to the Trust Board, to show support from the Committee, and that it recognised the progress being made but that the journey was not over.

Action: Sally Stevenson / Andrew Smith

Andrew Smith highlighted a referral from the Q&S Committee following the limited assurance rating given for the Mental Health Act audit. Mike Proctor as Chair of Q&S had asked if Internal Audit could re-audit given the significant number of actions that had been progressed since the initial audit. Tom Watson confirmed that good progress was being made and they were within the timeframes assigned for the recommendations. Tom Watson added that Internal Audit would normally follow-up the recommendations through their usual automated follow-up process, however he suggested that they could be included as part of their Follow-Up Review in order to perform a more in-depth review of the implementation of the recommendations. This was agreed by the Committee. Tom Watson queried the timing of such work as the target dates for the completion of the recommendations had not passed, it was agreed to perform the more in-depth follow-up shortly after the deadlines for implementation had expired and then report back to the Committee

.

Action: Tom Watson

Tom Watson highlighted the changes requested to the 2021/22 plan as follows:

- An urgent request to review revised Payroll control arrangements following a payroll error.
- National Cost Collection request to be deferred to Q2 to align it more closely to the Trust's submission deadline. This was agreed.
- Clinical Harm/Risk Stratification request to be deferred to Q4.
- HR Data Quality request to be deferred to 2022/23.
- Waiting List Management – request to be added to the plan.

Lee Bond advised that he had discussed with Tom Watson following the request from Christine Brereton to defer the HR Data Quality Audit which was a reasonable decision as it was not a high risk.

Lee Bond explained that he had requested the urgent payroll review following a near miss involving an input error which could have resulted in paying a member of staff a significant amount of money. The input error had been identified in time and the payment was not actually made to the member of staff concerned, however the BACS file had been submitted to the Bank and the payment had to be recalled. Additional controls had now been put in place and Internal Audit had been asked to provide the necessary assurance that it could not happen again. Lee Bond stated the controls in place at the bank were also disappointing and this was being addressed separately by Nicola Parker with the account manager. Lee bond thanked Internal Audit for doing the review so quickly, informing the Committee that he was happy with the report and recommendations made, and adding that it provided assurance to the Committee.

Gill Ponder raised her concerns regarding the request to defer the Clinical Harm Risk Stratification to Q4 and stated that whilst she understood the pressures in the divisions she was concerned about patient safety and the need to ensure that no one was coming to harm. Gill Ponder also noted that waiting lists are already long and could be longer with Covid still prevalent and worried that risk stratification was the mechanism to ensure correct prioritisation of patients for treatment, and if it was not doing well then we shouldn't wait to Q4 to find out. She asked if deferring the audit to Q4 could increase the risk to patients coming to harm as a result. Andrew Smith agreed with these comments.

Lee Bond suggested it should be a question to the Chief Operating Officer and the Medical Director and agreed to raise the Committee's concern and send an email to them, copying in Mike Proctor and Tom Watson.

Action: Lee Bond

Tom Watson explained the reason given for the deferral was a change in the process and policy to be implemented and embedded.

Tom Watson asked the Committee for a decision on the HR Data Quality review deferral. Andrew Smith asked Helen Harris whether it would impact on the Trust's IPR, and she confirmed that it would not. Lee Bond added that he understood some HR numbers would be coming into the IPR, so they would be able to see about the veracity of them.

Following the discussion it was agreed to the changes to the Audit Plan subject to clarification of the Clinical Harm Risk Stratification audit.

6.2 Internal Audit Recommendations Follow-Up – Status Report

Tom Watson presented the report and highlighted that the Trust had made reasonable progress since the last meeting, including some long standing recommendations. Gill Ponder noted some of the outstanding recommendations from 2017/18 and suggested that given the passage of time these could have expired or no longer be valid. She also questioned how there could be a high grade recommendation still outstanding from last year and medium ones from 17/18, adding that something must be going wrong if these were still outstanding. Andrew Smith and Lee Bond agreed.

Andrew Smith added that culturally it was not good having Internal Audit recommendations going overdue and that officers should be held to account as they are in other organisation. It was suggested to highlight this to the Board, noting general progress but to push the message that if recommendations were not actioned they become increased risks. It was suggested that this was discussed by the Executive Team in the first instance before the Board meeting and Lee Bond agreed to action.

Action: Lee Bond

Helen Kemp-Taylor thanked the ARG Committee for their support with this ongoing issue.

6.3 Insight Technical Updates Report

Andrew Smith commented that the report was always interesting and as useful as ever and asked Tom Watson if there was anything in particular that he wanted to highlight.

Tom Watson stated that there were just a couple he wished to draw out, referring to the workbook on Better Mental Care in Acute settings and Risk Strategy for Estates.

The report was noted.

10.10am Lee Bond temporarily left the meeting.

Item 7 07/2 Counter Fraud

7.1 LCFS Progress Report

Andrew Smith noted this and the LCFS Annual Report were incredibly well drafted and detailed reports as usual and invited Nicki Foley to highlight any specific issues to note. Nicki Foley highlighted as follows:

- Cabinet Office – New Government Functional Standard GovS 013: Counter Fraud. Issued in January 2021 and became effective on 1 April 2021. The annual self-assessment against these new standards was made on the previous year's work when the new standards were not yet in place. The NHSCFA have recognised however that 2021/22 will be a transitional year and the May 2021 self-assessment would be used as a baseline position only. The outcome of self-assessed compliance against the requirements of the standards resulted in two red ratings, namely in relation to the Fraud Risk Assessment, this is in place but does not meet the required new methodology and secondly the adoption of new Outcome-based Metrics which are yet to be developed. The overall RAG rating for the Trust however was 'Green'.
- Post-Event Assurance Exercise (PEA) – This exercise is intended to provide assurance to key stakeholders on spending activity relating to the Covid-19 pandemic. The data is to be reviewed includes PO against Non-PO data, and testing of Procurement Policy Notices which includes directly awarded contracts supplier relief payments and contract cancellations relating to the pandemic. The LCFS is working with colleagues in Finance and Procurement to prepare the Trust's submission, which is is due by 23 August 2021. The NHSCFA will report the national results although there is currently no timeframe for this.

- Fraud Awareness Survey issued to all staff – the latest survey was issue and a good response rate of 752 staff (11%) was achieved. The full findings and benchmarking data from the five collaborative organisations is being compiled and will be reported to the next ARG Committee meeting in October 2021. In the interim, highlights from the survey included 94% of respondents said there was no reason to prevent them reporting a suspicion of fraud and 94% thought the Trust takes allegations of fraud, bribery and corruption seriously.
- Trust Corporate Induction – Fraud Awareness Video Presentation – Out of 400 new starters there were only 77 who viewed the video. The LCFS anticipated the response to be low however as it is a non-mandatory training item.
- New fraud referrals – Six new referrals received since the last Committee meeting.

Gill Ponder commented on the LCFS induction video which she had watched when she commenced recently with the Trust, and stated that she struggled to understand why this was not mandatory for new starters given it was such an important topic. Nicki Foley concurred and stated that the video contained fraud awareness basics that the Trust need staff to understand, highlighting a recent conversation with management for example that staff do not always understand the rules around working whilst off sick even though awareness material has been circulated. However, Nicki Foley advised that this was the stance had taken to fraud awareness training. Gill Ponder stated that this would be a unique opportunity with new starters and it not being mandatory was, she felt, an opportunity lost. Andrew Smith agreed and asked if the Committee members wanted to challenge the Executives on this stance. Michael Whitworth was also in agreement saying that he fully supported it, as it raised awareness for staff and also improved fraud prevention. Helen Harris stated that she would take this to the Executive Team; Michael Whitworth also agreed to liaise with Christine Brereton / Workforce Committee regarding this.

Action: Helen Harris / Michael Whitworth

Andrew Smith referred to the two red items in the self-assessment and asked about timescales for moving these to green ratings. Nicki Foley explained that these were currently being worked on and expected to be finalised towards the end of the financial year. The NHSCFA are expecting compliance, wherever possible, by the next standards self-assessment submission expected to be in May 2022.

Andrew Smith asked if there was anything in the amber ratings that the Committee should be made aware of. Nicki Foley highlighted the new Counter Fraud Champion role, as there was currently limited central direction on expectations from the Champion. Nicki Foley stated that the other amber item was regarding recording outcomes, such as proactive exercises or values of fraud prevented, which had not been possible on the old case management system (FIRST). However now that a new national system (CLUE) was in place which recorded that information it should result in a green rating next time.

Following the review and discussion the report was noted.

7.2 LCFS Annual Report 2020/21

Nicki Foley presented the report and explained that the report was a summary of the previous year's counter fraud work, and that the Committee had therefore seen most of the contents apart from the graph of fraud activity (page 10) which identified the time spent by the LCFS and CFP team Support Officer on various aspects of their work. Nicki Foley advised that the report goes to the Trust Board as a private agenda item for information only.

Andrew Smith commented that the report summarises the LCFS work very well, and was another excellent report. The Committee were happy to approve it to be presented to Trust Board.

Item 8 07/21 **Board Assurance Framework and Strategic Risk Register**

8.1 Review of BAF and Strategic Risk Register

Helen Harris presented the report and explained that it was the first report in the new format and highlighted the headlines to note:

- Q&S received their section of the BAF the previous week with other Sub-Committees the following week i.e. Workforce Committee and Finance & Performance Committee. Due to timing of the ARG Committee, Strategic Objective 3 had not been updated but would be completed in time for the F&P Committee. The updated BAF would be presented to the Trust Board on 3 August 2021.
- A full review had been undertaken of the BAF and Helen Harris had met with all Executive Directors. Helen Harris stated that this approach brought to light for the Executives an understanding of their controls and actions and brought into a strategic focus. Helen Harris hoped that the ARG Committee were assured that progress had been made.
- Helen Harris highlighted that she had tried to provide an overarching report in the first few pages of the report and asked if the Committee were content with the approach taken, satisfied with the formatting and if there were any concerns on the risk ratings.

Andrew Smith congratulated Helen Harris on moving the BAF forwarded, which was very positive, and stated that if it continues to get embedded would be significant value to the Trust. Andrew Smith asked however, why the Trust was still sitting with risk scores of 20 i.e. Chief Information Officer work, acknowledging that the issues were recognised and realistic efforts were being made to address them. Andrew Smith also noted however the scoring within Estates & Facilities with long term scores of 20 and questioned if this meant that all the work undertaken by the Estates team to address the inherent risks was ineffective given that the scores were still sitting at 20.

Gill Ponder noted that Estates & Facilities risks sits within the Finance & Performance Committee and those risks would be reviewed by the Committee. She highlighted a recent site visit she had undertaken at DPOW the previous week and noted there were still significant issues where funding was not available to rectify; some service stopping issues and some historical. Gill Ponder commented that whilst there had been significant amounts of money invested and work being carried out would reduce risks, she doubted it would reduce to risk appetite levels.

Helen Harris highlighted that work was being undertaken on risk management which sits within the Medical Director's remit. The expectation was that the Chairs of F&P and Q&S would challenge those risk scores, in addition to a risk scoring review at the Executive Team to ensure consistency of scoring.

Gill Ponder stated that she would hope to see the initial risk score, current score and working towards the risk appetite. She also referred to the Gantt chart which appeared to be moving in the wrong direction because of Business Continuity and IG and the Board should be aware of why this was happening and the plan to deal with it. Gill Ponder stated that she would like to see a focus on those moving away from their intended risk score.

Andrew Smith acknowledged that F&P would provide the necessary challenge about the risk scores of 20 in Estates & Facilities as well as other high scores. The Trust Board need to know that things are in place to reduce them. He suggested a minor cross referral to F&P to review the high scores, which Gill Ponder agreed would be done as a matter of course.

Following the review the report and actions were noted.

Item 10 07/21 **Management Reports for Assurance – Items for Approval**

10.1 Annual Emergency Preparedness, Resilience and Business Continuity Report

Graham Jaques joined the meeting to present the paper which was taken as read, and highlighted two items to note. The core standards were slightly different from the previous year and the Trust had to show progress against those standards. Two post-Covid reviews were undertaken with all stakeholders and incorporated lessons learnt. Standard 59 (Decontamination capability and availability), was partially compliant in respect of chemical incidents due to the inability of doing face to face training. Some on-line training was available and they also now had lots of practical training days at both sites in place to take place towards the end of 2021, along with a live exercise planned for October/November.

Graham Jaques highlighted the need for organisations to bolster and expand their EPRR teams and not rely on one individual as identified from national lessons learnt from the first wave of the Covid pandemic. A service model was currently being considered by the Chief Operating Officer to secure permanency of the secondment, and to increase the current two half-time posts to two full-time posts, and they were waiting for agreement on how this would be funded. Graham Jaques added that if there was a third wave of the pandemic, they could be unstable.

Andrew Smith stated that the report read quite positively which Graham Jaques confirmed and added that maintaining the level of compliance and managing through a pandemic is exceptional but it took increased resources in the team to achieve that. The concern was more about the future and explained that the current staffing arrangement was due to finish in June but had been extended for three months whilst a more permanent solution was agreed. Andrew Smith advised that NEDs do not get involved in normal funding discussions, but added that if it became a significant risk issue to re-escalate the matter as necessary.

Andrew Smith stated that it was an excellent report with substantial assurance and thanked Graham Jaques for attending.

At this point Gill Ponder referred to the loss of patient cash of £540 and how this could possibly happen and asked if this had been investigated. Graham Jaques confirmed that the Local Security Management Specialist was involved and a full investigation had taken place including the police. Sally Stevenson advised that this issue also featured in the Losses & Compensation Report scheduled later in the meeting and she had asked for further details in anticipation of questions from the ARG Committee. Sally Stevenson outlined the events to the Committee that led to the loss of the patient's money.

Following the review and discussion the report was noted and Graham Jaques left the meeting.

10.2 Annual Fire Report 2020/21

Bill Parkinson presented the report, saying that it was positive and highlighted the funding which had allowed for the replacement of the Trust fire alarm systems, commencing with DPOW. The number of unwanted fire signals had reduced at both sites and a meeting had been held with the maintenance providers to determine if there was more life in the system, although noted the Grimsby system was much older and obsolete.

A business case was being produced by Estates & Facilities to seek funding to implement an accredited fire door inspection scheme. This would ensure fire doors were regularly inspected and repairs / replacement undertaken when necessary.

Bill Parkinson explained that the report was there for approval in advance of sending to the Trust Board; the ARG Committee confirmed approval of the annual report for submission to the Trust Board.

10.3 LSMS Annual Report 2020/21

Bill Parkinson presented the report and highlighted that there had unfortunately been an increase in violence and aggression towards Trust staff. However, an increase in training for security staff had been undertaken. A joint working agreement between the Trust and the Yorkshire and Humberside Crown Prosecution Service and Humberside Police had also been agreed with a six-point promise agreed between NLAG and Humberside Police which was now due to be released late 2021.

Bill Parkinson explained that there are 400 active lone worker devices and spot checks on the system were now in place to determine whether devices were being turned on and actively used.

Bill Parkinson also referred to the detailed LSMS workplan, and informed the Committee that they were feeding in the new national security management standards. Audits would now take place twice a year rather than once and the next one would be completed by the end of the year.

Andrew Smith commented that it was a good report, and as there were no questions raised the Committee approved the annual report for submission to the Trust Board.

10.55am – Lee Bond returned to the meeting.

10.4 Health, Safety and Fire Group Terms of Reference

Bill Parkinson presented the updated TOR which had only minor changes made to reflect the corporate reporting structure and the Chair of the Committee to be the Director of Estates & Facilities.

Gill Ponder noted the TOR referenced escalation of issues to the ARG Committee and/or the F&P Committee and said this re-opens up the debate of what goes where and suggested the reporting line should be clearer. Bill Parkinson explained that this had been reviewed as this feeds in from a number of groups and had tried to simplify and would continue to try and streamline. Gill Ponder stated that this was the responsibility of NEDs or the Trust Board to decide what goes to which committee and this illustrates the overlaps and asked if it would be appropriate to ask that question. Andrew Smith stated that they had been challenging things previously in this regard in an attempt to streamline and had clarified for other overlapping items.

Andrew Smith posed the question to Helen Harris as to whether we look again at what goes to each committee or leave to osmosis. Helen Harris agreed to take the action and review with Jug Johal and Bill Parkinson as well as reviewing both Committees' TOR.

Action: Helen Harris

Following the discussion the TOR as presented were approved.

Gill Ponder then raised a question as to where Health and Safety sat within an organisation, as this had been a particular concern in other Trusts also. Gill Ponder stated that having Health and Safety sitting with Estates and Facilities tends to drive a particular focus on buildings, etc. and it can sometimes lose the people focus. Gill Ponder added that the legal requirement of organisations that staff have appropriate training and supervision, and management undertake their responsibilities, should be viewed through a people lens.

Bill Parkinson informed the Committee that it used to sit within the Governance Directorate and that although it is a concern they do try to keep the people focus as they are Health and Safety professionals ultimately. Bill Parkinson explained that a compliance section is in place within the team that does look across the Trust as a whole and his remit covers the whole Trust so would always try to take an independent view. Manager training courses were held to ensure awareness of responsibilities.

Lee Bond stated that the Trust's Health and Safety team reside in Estates and Facilities as a home only. He reiterated what Bill Parkinson had said about them being professionals who look after the whole Trust, not just an Estates and Facilities focus which may be the case in others Trust in Gill Ponders experience. He asked if what Bill Parkinson had explained was sufficient assurance.

Gill Ponder added that when reading the report it does not articulate how the Trust gets the appropriate assurance that line managers were receiving training and providing supervision of staff in health and safety issues and whilst acknowledged that it probably does happen it is not clear.

Bill Parkinson highlighted that there was good working relationships with staff side, unions and managers across the Trust and he was continually looking at the training plans to provide both formal and informal training. There are logistic problems with an organisation this size but if there was a particular issue it would get highlighted quickly and there is a good escalation process in place. Bill Parkinson added that he couldn't say they had got it 100% right, and that there would be gaps, but they try to cover as much as possible.

Gill Ponder agreed that she was assured with the responses heard but in future would like a clear line in written reports provided to the Committee that the team were sighted on a particular issue or things were happening.

Item 11 Management Reports for Assurance
07/21

11.1 Clinical Audit Annual Workplan 2020/21

Jeremy Daws arrived at the meeting and presented the report and highlighted issues of note to the Committee. Lee Bond posed the question of the requirement for CQINs this year and Jeremy Daws responded that they were not sure yet, they were watching the national picture. The commencement of the CQUINs programme had therefore not yet been confirmed, and was not included in any detail in the clinical audit annual workplan presented. These would be added retrospectively and until then the implications to the workloads of the team was unknown. If CQINs work is not required this will mean that resource can go into the rest of the plan. Given this risk it was proposed that a further progress update would be provided to the Committee in October 2021.

Action: Jeremy Daws

Lee Bond noted that out of the 147 audits identified in the provisional programme 84 were mandatory and asked out of the remaining who decides what the priorities are. Jeremy Daws explained that some audits were considered mandatory and local topics were decided by the Divisions. There were 84 from the national programme and other local “must dos” based on CQC issues, SI’s, etc.in order to support Divisions with their priorities and obligations.

Lee Bond also noted that there was a significant amount of time in terms of job plans but no clear indication of size of resource required and this could be considered in future reports. Jeremy Daws explained that the team were set up for hands on support and facilitate as much as possible to reduce workload on clinicians.

Andrew Smith asked that the national v local debate be taken outside of the meeting and brought back to the Committee when/if changes to the clinical audit workplan were required.

Following the review the report was noted and Jeremy Daws was thanked for attending before leaving the meeting.

11.2 Quarterly Document Control Report

Helen Harris presented this item in the absence of Alison Hurley and asked the Committee if there were any questions.

Gill Ponder reiterated previous comments that there were some very old, out of date documents still. Helen Harris highlighted that they were looking at what is and isn’t a controlled document adding that there were a number of overdue patient leaflets and work was underway on what was still appropriate. Helen Harris stated that it was much improved from where it was.

Andrew Smith acknowledged that the report was improved from the position three months ago but the Committee would keep the pressure on to reduce the out of date documents.

Following the review the report was noted.

The next item was taken out of sequence

Item 9 07/21 **Losses and Compensations Report**

Lee Bond presented the report and drew the Committee's attention specifically to the overseas visitors' write-offs, adding that it was pleasing to see that the Home Office had been made aware of some of the debts owed in case any of these patients attempted to travel back to the UK.

The question was posed as to whether these were elective or emergency admissions. Lee Bond noted that if they were elective patients then payment should be secured upfront and would be asking the Finance Team to ensure that the Private Patients & Overseas Visitors team were ensuring this happened.

Following the review the report was noted.

The next item returned to the order of the Agenda

11.4 Waiving of Standing Orders Report

Ivan Pannell presented the report which included 21 waivers recorded i.e. seven non-compliant with SFIs; ten against standardisation; one against insufficient suppliers; and three against maintenance agreements. Ivan Pannell highlighted that it had been a much quieter quarter and there were no contentious issues to draw to the Committee's attention.

There were no questions and the report was noted.

11.5 Invoices with Purchase Orders

Ivan Pannell presented the report and highlighted that the report included the first quarter and therefore difficult to identify any trends. The report also included comparator information from the full year 2020/21.

Ivan Pannell noted that a significant amount of capital work was being undertaken across the Trust which affects the figures. There was nothing standing out that was different from other quarters so the position was fairly static. Ivan Pannell did note that there was no deterioration being seen but neither was any improvement so it was a status quo at the moment.

There were no questions and the report was noted.

11.6 Contract Progress Update

Ivan Pannell presented the report which outlined the number of contracts due to expire or had already expired; with a static position on the number of lines included in the contract database.

Ivan Pannell highlighted that a contract was now in place for car parking and security services which commenced on 1st July 2021. The retender exercise commenced around July 2020 and demonstrates the significant amount of time required to retender a contract of this size.

There were a number of highest risk/most urgent contracts requiring input and oversight from the Strategic Procurement Team and these were included within the report and the mitigation in place until re-tendering could take place.

In additional to tendering work through the contract database the team had also been heavily involved in supporting one-off procurement activities linked to the investment in the Trust's Estate and elective recovery work. Ivan Pannell added that there was lots on the to do list.

Andrew Smith commented that it seemed to be a case of holding their own but with a fair way to go and asked Ivan Pannell if that was a fair summary of the position. Ivan Pannell confirmed this was a fair assessment and stated that they were acutely aware of further improvements needing to be made. Andrew Smith acknowledged that there seemed to be a huge scope for improvement and asked what the risks were, what still remains to be done and whether this was a resource issue. Ivan Pannell confirmed that it was partly a resource issue but there were a couple of ideas to help the position over the next 3 to 6 months, but there was still no full time oversight of the contracts.

Andrew Smith stated that the report was a valuable piece of assurance on the position.

Lee Bond thanked Ivan Pannell for the report and ongoing work and referred to the pre-pandemic published national procurement statistics and asked what good performance looked like for purchase order compliance; noting that 88% at this Trust was close. Ivan Pannell could not recall without checking, but thought NLAG were in the 3rd quartile which confirmed there was room for improvement.

The reports presented were noted and Ivan Pannell was thanked for attending and he left the meeting.

11.7 Salary Overpayments report.

Sally Stevenson presented the report and highlighted a slight increase of circa £5k in the value of overpayments in Q1 but was hoping that these can be kept to a minimum this year. The details of the highest value overpayments and recovery status were included within the report as usual.

Lee Bond referred to one of the overpayments (no.5) on page 3 of the report and queried if this was a manager or payroll department error. Sally Stevenson explained that the employee in question had contacted the Payroll Team to highlight the error which was due to different allowances paid dependent on which rota they are on, but was not immediately certain who was responsible for the error.

Lee Bond raised the question of what/who overpayments were attributable to, and Sally Stevenson advised that this detail was analysed in the report. Lee Bond highlighted that 40% of errors appeared to be Payroll errors; and 60% were managers not providing change forms, so still some work to do. Sally Stevenson also stated that there were also on going resource issues within the Payroll team which had not helped either. Lee Bond commented that he would discuss further with Sally Stevenson outside of the meeting.

Following the review the report was noted.

11.8 Hospitality and Sponsorship Declarations inc Update on New Electronic Conflicts of Interest Declaration System

Helen Harris presented the report and highlighted that she had attended two Consultant meetings and shared the importance of declaring interests; this had resulted in the receipt of additional Declarations of Interest forms which was very positive work and will improve even further. Helen Harris also advised that the new electronic system pilot was due to close at the end of July 2021 and following a review anticipated a roll out across the organisation.

Andrew Smith commented that once fully implemented would need to be prepared to deal with more declarations being made and whatever it shows up. Helen Harris highlighted that the Internal Audit review scheduled for this area had been planned for the following year in order to have a review of the new system and controls.

Following the update the report was noted.

The next item was taken out of sequence

Item 12 07/21 Action Logs & Highlight Reports from other Board Sub-Committees

The following action logs and highlight reports were provided for information and noted.

12.1 Finance & Performance Committee
12.2 Quality & Safety Committee
12.3 Workforce Committee
12.4 Health Tree Foundation Committee

Item 13 07/21 Private Agenda Items

There were two items discussed and minuted under private agenda items.

Item 14 07/21 Any Other Business

14.1 Any Other Urgent Business

There were no other urgent issues raised.

The two remaining items from Item 11 were discussed.

Item 11 07/21 Management Reports for Assurance

11.9 Risk Management Strategy Development Plan Update

Angie Legge attended the meeting to provide a verbal update to the Committee and highlighted as follows:

- Confirm and Challenge meetings continued and now had one Executive attending.
- TOR work to ensure groups included risk identification and escalation in the responsibilities complete; other than any new groups commencing.
- Risk Training commenced and assurance would start going to Confirm and Challenge in September 2021.
- Improvements seen in all Divisions and working through some of the corporate areas.
- Some difficulties noted with managers and ownership in Divisions.

- Risk Management system was due to be changed from DATIX to Ulysses which had better functionality, particularly in terms of the risk register. The new system would enable each action to be included separately with target data and progress of each action and therefore a better management tool.
- NHSE/I had joined the Risk Clinics with Divisions and a draft plan was being prepared; this would be aligned with other national work, as the National Patient Safety Strategy objectives and advice from the National Patient Safety Team was to assess culture first.
- Work from the National Patient Safety Team with Strategy Development to understand risks on culture which would inform how to take forward the risk strategy.
- Recent confirm and challenge meetings had been reduced due to the current operational pressures.
- Discussions would be held with Mike Simpson and Nicola Parker regarding the equipment process to prevent the inappropriate use of the risk register for equipment. Requests for equipment would be based on risk requirements.

Andrew Smith commented that this was clearly a journey and he would brief his successor on his thinking on this issue.

Following the update Angie Legge was thanked and she left the meeting

11.3 IG Steering Group Highlight Report inc Annual IG Toolkit Return

Sue Meakin presented the paper and advised that the Trust submitted the Data Security & Protection Toolkit in June 2021 with the assessment of "Standards not met" and eight gaps were identified. A plan to address the gaps was approved by NHS Digital. The plan and actions would be monitored by the IG Steering Group and Digital Services SMT and would need to be completed by the end of December 2021. There were a number of other actions not linked to the improvement plan that would also be monitored by the groups. Sue Meakin also advised that a new DSP Toolkit came out the previous day.

Andrew Smith commented that this was a clear paper and there were no questions from the Committee.

Sue Meakin further advised that the 2021/22 Toolkit would require a baseline submission in February 2022 with the final submission in June 2022, which falls outside the annual reporting schedule.

There were no open cases with the ICO. The last one reviewed by the ICO was closed as they were satisfied with the Trust's actions.

The current compliance rate for staff undertaking Data Security and Protection training was 95%, although noted, this had currently reduced to 87%, due to the Trust being in Opal 4, and the team would continue working with staff to bring that compliance rate back up.

Andrew Smith noted themes around Cyber and Data Security matters which shows positive progress but with still a way to go. Andrew Smith proposed highlighting to the Trust Board the journey and the risk but intended this to be in a supportive way to the CIO and her team.

Following the review the report was noted.

Item 15 07/21 **Matters for Escalation to the Trust Board**

The following items were agreed to be highlighted to the Trust Board:

- Audited Annual Accounts 2020/21 – VFM Conclusion, including the need for Extraordinary ARG Committee meeting;
- Internal Audit Limited Assurance Reports and Cyber Security Arrangements Update;
- Outstanding Internal Audit Recommendations.

Item 16 07/21 **Matters to Highlight to other Trust Board Assurance Committees**

None.

Item 17 07/21 **Review of ARG Committee Workplan**

The ARG Committee workplan was reviewed and noted. Andrew Smith asked Helen Harris if this satisfied her needs and she confirmed that it did.

Item 18 07/21 **Review of the Meeting**

It was noted that it was a positive meeting and finished slightly early despite the weighty agenda.

Helen Harris, on behalf of the Committee, thanked Andrew Smith for his time as Chair of the ARG Committee and wished him the very best for the future.

Andrew Smith thanked the Committee and noted his personal disappointment at leaving after a relatively short period at the Trust, as he would have liked to have stayed longer.

The meeting closed at 12.18pm.

Item 19 07/21 **Date and Time of the next meeting**

Thursday, 21 October 2021 – 9.30am-12.30pm – via Teams Meeting

MINUTES

MEETING: Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee – Extraordinary Meeting**

DATE: **27 August 2021** via MS Teams

PRESENT:	Michael Whitworth	Vice Chair of ARG Committee / Non-Executive Director
	Gill Ponder	Non-Executive Director
IN ATTENDANCE:	Lee Bond	Chief Financial Officer
	Peter Reading	Chief Executive
	Helen Harris	Director of Corporate Services
	Mark Surridge	External Audit – Director (Mazars)
	Mike Norman	External Audit – Auditor (Mazars)
	Tom Watson	Internal Audit Manager (Audit Yorkshire)
	Sally Stevenson	Assistant Director of Finance – Compliance & Counter Fraud
	Rob Pickersgill	Deputy Lead Governor
	Anne Sprason	Finance Administration Manager / PA to CFO (Minutes)

Peter Reading thanked Mazars for responding to the need for this meeting so quickly and getting their work concluded, in order to prevent the Annual Members Meeting date having to be changed. Mark Surridge commented that the National Audit Office (NAO) changes had not made things easy this year.

Item 1 08/21 **Apologies for Absence:**

Apologies received from Andrew Smith

Item 2 08/21 **Declarations of Interests**

There were no declarations of interest made.

Item 3 08/21 **External Audit (Mazars)**

3.1 2020/21 VFM Progress Report

Mark Surridge presented the report and explained that the VFM Progress Report was embedded within the Auditor's Annual Report at item 3.2 on the agenda. This was a belt and braces approach due to changes in the Code of Audit Practice which states that where there is a significant weakness it should be reported separately before issuing the Annual Auditor's Report.

Mark Surridge therefore proposed focusing on the full report at item 3.2.

3.2 Auditor's Annual Report Year Ended 31 March 2021

Mark Surridge presented the report which required the Audit, Risk & Governance Committee to receive the report in order for the External Auditors to issue the Audit Certificate for inclusion in the Trust's Annual Report. It would also be shared with Trust Governors and included on the Trust's website.

Mark Surridge explained the broad sweeping assessments undertaken on financial governance and economy, efficiency and effectiveness in its use of resources and suggested that positive assessments came through within the report.

The Trust however continues to be in Special Measures and the report showed that in the last 12 months the Trust had attempted to address the matters but was impacted by Covid-19 as well as system issues around finances, which would require a top down solution from a number of organisations including the Department of Health. Mark Surridge highlighted that the requirements of the Trust were not outlined within the report as the Trust were aware of what would be required.

Mark Surridge explained that the two recommendations relating to these two significant weaknesses contained within the audit report would be included within the Audit Certificate, and this was largely completed pending a final quality check on the wording but the substance of the Audit Certificate would not change. Once the Audit Certificate was signed by the External Auditor it would allow the Trust to publish their Annual Accounts and Report.

Mark Surridge shared his screen to allow the ARG Committee members to have sight of the draft Audit Certificate which stated that the audit of NLAG was completed. Mark Surridge informed the Committee that the signed Audit Certificate would be issued to the Trust either later that day or over the weekend.

Michael Whitworth explained that the purpose of the extraordinary meeting was for review and assurance and invited questions from the Committee members.

Gill Ponder stated that she had read the report as a relatively new NED to the Trust and was left with a sense that the report was not as positive as she would have expected and felt it came across negatively. She acknowledged that the Trust was still in Special Measures but a significant amount of work had been undertaken around quality and finance. Gill Ponder suggested that if a member of the public read the report, without any background knowledge, they may wonder why the audit was required and that last year's report could have been used as there was nothing new to report. Gill Ponder concluded therefore, that in her opinion the report was not reflective of the improvements being made.

Gill Ponder also highlighted two minor details i.e. some of the Committees listed within the report were not the correct names of Committees within NLAG; and within the footer on each page of the report it referred to audit fees but these did not feature.

Mark Surridge confirmed that the report would have a final quality check, noting Gill Ponder's comments about Committee names and the erroneous audit fee reference.

Mark Surridge explained that the report included both Special Measures and financial sustainability and agreed that on first read it could feel negative with the set language that had to be used e.g. adequate. Mark Surridge further explained the difficulties with both Covid-19 and not having clarity over the NHS financial regime. He explained that when Mazars report to the Governors at their Annual Members Meeting, he would want to reiterate the positives that the Trust was moving forward as well as reference to the uncertainty of the current environment nationally.

Michael Whitworth acknowledged Mark Surridge's comments and understood the Trust's position and the system changes. He referred to the financial standing arrangements and the approach to planning (page 19) and stated that he would like assurance that the approach and financial planning was sound. Michael Whitworth added that whilst the financial regime was uncertain it was unclear if this was just this Trust or all Trusts, noting that the report did not include a comment or opinion specifically on this.

Lee Bond highlighted that if a member of the public reviewed the Trust's annual accounts over the last two or three years they would see that there was a £40m-£50m deficit, off-set by centrally funded income so it would not make great reading; that is what the public would see and what the Auditors have reported.

Lee Bond referred to the comments on planning and explained that the Trust were not informed of anything other than the income for the first six months and had to keep the cost base within that. Lee Bond stated that they were factual statements in the report, and was a fair assessment unfortunately, adding that it was a sterile report but did what it said on the tin.

Mark Surridge stated that he could say that the Trust had complied with all planning guidance to date, but it was simply not know what was happening after the first 6 months.

Peter Reading agreed with Lee Bond's comment adding that it was understood what the External Auditors were required to do. Peter Reading stated that as the Accountable Officer for the Trust he recalled the helpful explanations provided by the Auditors last year with members. He added that he could come up with any number of reasons for the position the Trust was in but the numbers were what they were. Peter Reading stated that he was prepared to accept the report as the Auditors have a role to play and unfortunately that included some negative comments included within the report. He added that maybe the conversation next year would be different if the Trust exited Special Measures.

Michael Whitworth acknowledged that the Trust was in a negative position however the comments were constructive.

Rob Pickersgill commented that, from a Governors perspective, he felt Gill Ponder was right in a way and his impression was that this was a "fence sitting" exercise and whilst he understood from what he had heard he was unsure that other governors would understand. Rob Pickersgill had three areas for clarification i.e. Committee structure and NEDs challenge and was looking for measurable things to substantiate the comments; and the SOF (Single Oversight Framework) scoring.

Mark Surridge explained that they only reflect on the SOF scoring; it was an outcome measure and not a defining feature of where the Trust was going, but still important.

Mark Surridge added that in terms of whether NEDs challenge effectively, this was not within the Auditors responsibility but was for Governors to determine. Mark Surridge explained further however that through the AGS (Annual Governance Statement) the Auditors witness and review the functioning of committees as well as reviewing Trust Board minutes which gave a benchmark of how the Trust was structurally set up and was similar to most other Trusts; it was deemed adequate for the Auditor's purposes.

Rob Pickersgill stated that even during Covid-19 there was some good achievements both operationally and in KPIs and the Trust were ahead of others within the sector, but that work was not detailed within the report. Mark Surridge explained that the report did not require that level of detail whereas the Trust's Annual Report would highlight key successes across the organisation.

Lee Bond agreed with Mark Surridge that this was the VFM part of the report and therefore not the right place to be highlighting organisational successes.

Michael Whitworth commented that it was a helpful discussion and an insightful report in light of the requirements of reporting to the public and Governors. He added that whilst comments from Lee Bond and Mark Surridge were relevant the nuances from the discussion should have a wider discussion.

Michael Whitworth asked Peter Reading, as Accountable Officer, if any further clarification was required.

Peter Reading confirmed that, other than the minor adjustments required as discussed, he was content with the report. Michael Whitworth agreed that following reading, reviewing and the questions raised, it was very sound. Michael Whitworth asked Gill Ponder if she was okay with the report.

Gill Ponder stated that following the discussion, it was not much different from any other Trust in financial special measures, adding that the Auditors have reported within the required framework and the explanations were factual, if not reserved.

Lee Bond added that the Auditors Annual Report and their Audit Certificate needed to be received in order to present the final accounts to the Governors. It was noted that the Trust's Annual Report and Accounts would first need to be laid before Parliament.

Helen Harris asked Mark Surridge if the Audit Certificate could be provided later that day in order to get it to Parliament. Mark Surridge advised that the Audit Certificate was currently being completed and therefore could be accommodated.

Item 4 08/21 **Any Other Business**

4.1 Any other urgent business

There was no other urgent business raised.

Item 5 08/21 **Matters for Escalation to the Trust Board**

It was agreed the highlight report to the Trust Board would reflect the discussions and that the Committee received and endorsed the report from the External Auditors, who would in turn be issuing their Audit Certificate.

Item 6 08/21 **Matters to Highlight to other Trust Board Assurance Committees**

There were no issues raised to highlight to other Trust Board Assurance Committees

The meeting closed at 9.07am

Item 7 08/21 **Date and Time of the next full meeting**

Thursday, 21 October 2021 – 9.30am-12.30pm – via Teams Meeting

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)279

DATE OF MEETING	7 December 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Neil Gammon, Independent Chair of HTF Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	Health Tree Foundation Trustees' Committee – Minutes from 15 July, 16 September & 5 October 2021
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	HTF Committee – 16 September & 4 November 2021
EXECUTIVE SUMMARY	Minutes of the Health Tree Foundation Trustees' Committee held on 15 July and approved at its meeting on the 16 September 2021. Minutes of the meeting held on 16 September and Extraordinary meeting on 5 October and approved at its meeting on 4 November 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)	N/A				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **15 July 2021 – Via Teams Meeting**

Present:	Neil Gammon	Independent Chair of HTF
	Peter Reading	Chief Executive
	Gill Ponder	Non-Executive Director
	Dr Kate Wood	Medical Director
	Jug Johal	Director of Estates & Facilities
	Paul Marchant	Chief Financial Accountant
	Victoria Winterton	Head of Smile Health
	Clare Woodard	HTF Charity Manager
	Brian Shipley	Deputy Director of Finance
	Mel Sharp	Deputy Chief Nurse
In attendance:	Lucy Skipworth	Community Champion, DPOW
	Simon Leonard	Communications Assistant
	Sarah Fox	Consultant Radiographic Practitioner, Breast Imaging (For item 6.1)
	Anne Barker	Finance Admin Manager (For the Minutes)

Item 1 07/21 **Apologies for Absence**

Apologies for absence were received from: Linda Jackson; Lee Bond (Brian Shipley Deputising); Ellie Monkhouse (Mel Sharp Deputising); Adrian Beddow (Simon Leonard representing); and Ian Reekie.

It was noted that Gill Ponder would be slightly late to the meeting.

Welcomes – Neil Gammon welcomed Lucy Skipworth to the meeting and invited her to introduce herself to the Committee. Lucy Skipworth explained that she had been with the Trust for the past two months and had found everyone kind and welcoming and was looking forward to forthcoming fund raising events over the summer. She highlighted that she had previously worked within the recruitment sector and had previously undertaken fund raising on behalf of HTF on a personal level.

Neil Gammon also welcomed Brian Shipley, Mel Sharp and Simon Leonard to the meeting.

Item 2 07/21 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declarations of Interests". None were raised.

Item 3 07/21 **Minutes of last meeting held on 13 May 2021**

The minutes of the meeting held on 13 May 2021 were reviewed for accuracy and completion of actions.

- Patient Self-checking Screens – Clare Woodard advised that she had taken an action to speak with the Chief Nurse's Office. This was still to be addressed and it was agreed to add the task to the action log.

Action: Clare Woodard

- C1 returning to Cardiology Ward – Dr Kate Wood advised that ward C1 (Glover) had now been reinstated as a Cardiology Ward and would remain for that purpose as per its legacy funding. The reason for the change of use was the immediate safety of patients due to ongoing Covid issues which was needed at that time.

Following review the minutes from the last meeting were agreed as an accurate record.

Peter Reading joined the meeting.

Item 5 07/21 **Review of Action Log**

The action log was reviewed as follows:

3 (16 01 21) – Annual Statement of value added by the handyperson. Clare Woodard advised that a new handyman had recently commenced at DPOW and subsequently resigned. The resignation from SGH had also been received. It was agreed to close this action as it would be another 12 months before any meaningful performance information could be obtained.

11 (16 01 21) – Fusion Biopsy Machine – The preferred machine had been identified but needed formal sign-off from the Digital Strategy Group. An update would be provided at the next meeting.

Action: Clare Woodard

7 (08 03 21) – Office accommodation for HTF. Discussions had been held between Estates and Facilities and the Patient Experience Team. The latter understand the need for them to move out of the current DPOW HTF accommodation. Jug Johal advised that the Estates team are currently identifying accommodation for the Patient Experience Team, possibly within Medicine at DPOW.

7 (08 03 21) – Recruitment of Project Officer has resulted in ten applications. Ellie Rodger and Clare Woodard would be shortlisting the following week.

10 (08 03 21) – Preservation of war memorial at SGH as a result of ED works. Preservation of the stones was part of the planning conditions and costs included. Item closed.

6 (13 05 21) – Patient Feedback Stations. Clare Woodard highlighted that the units needed to be compatible with the Family & Friends system and that the two systems must be properly integrated. It was agreed to keep this item open until further information could be obtained.

10 – (13 05 21) - £10k, Stage 3 grant funding. Discussed outside of the Committee. Item closed.

Following review the action log was noted.

Item 6 07/21 **Items for Discussion / Approval**

6.1 Wish Ref 152/21 Breast Imaging Ultrasound Machine

Sarah Fox attended the meeting to present the request for funding for a Breast Imaging Ultrasound Machine. Neil Gammon welcomed Sarah to the meeting and invited her to highlight any additional information for the Committee, over and above the paper submitted.

Sarah Fox highlighted that this is new technology on the market and, if purchased, would enhance patient and staff experience. The current piece of equipment was purchased six years ago, by the then charitable funds, and has already exceeded its recommended lifespan. The new equipment would be more accurate in targeting specific tumour sites as the software enhances the needles for better accuracy and increasing chances of cancer diagnostics. It would also enable detection of smaller cancers ensuring timely treatment and patient management, with better diagnosis of smaller tumours for removal before spreading anywhere else.

Sarah Fox also advised that the probes are lighter and more ergonomically designed for both patients and staff. Therefore the purchase of this equipment would improve the experience for everyone involved.

Dr Kate Wood stated that the paper and the presentation were very clear in the benefits and therefore was happy to support the request.

Dr Kate Wood had to leave the meeting at this point but had given comments for other items to Mel Sharp to present. She anticipated returning to the meeting.

Jug Johal also supported the focus on patient and staff benefits included in the report. He queried the fate of the old equipment and whether the Committee would consider using it elsewhere, in either another organisation or third world country.

Victoria Winterton noted that the original equipment was purchased by charitable funds and therefore HTF could have a say in its disposal. Neil Gammon asked Victoria Winterton and Clare Woodard to pursue and update at the next meeting.

Action: Victoria Winterton / Clare Woodard

Gill Ponder had joined the meeting and fully supported the request.

Peter Reading strongly supported the request for the new equipment but queried the quoracy of the Committee for approval.

Paul Marchant reviewed the TOR and advised that a minimum of four Trustees and two Executives need to be in attendance to be quorate. It was noted that whilst Kate Wood had left the meeting, she had been here for the presentation of this item and was fully supportive. It was also noted that whilst Neil Gammon was not a Non-Executive Director, his presence counted towards quoracy.

Mel Sharp commented that when she had read the paper initially she was not fully assured but on hearing how well Sarah Fox had articulated the benefits she was fully supportive.

Following the review and discussion, approval was given for the purchase of the equipment. Neil Gammon thanked Sarah Fox for the excellent presentation and she left the meeting.

6.2 Wish 164/21 RITA Machines

Neil Gammon noted that the Committee was still quorate as Mel Sharp had comments from Dr Kate Wood.

Clare Woodard presented the request and explained that over the last two years a number of requests had been received for additional RITA machines, which were used for reminiscences and memory activities. Those already purchased had been a great benefit on the ward, so it was decided by HTF that, rather than react to individual wards requesting RITA machines, they would look where the needs were across all wards. It had been identified that seven areas would benefit from having the machines. It was also noted that by buying in bulk, negotiation could be undertaken with the manufacturer on the price.

Mel Sharp highlighted that the machines are used on the wards for much more than just for dementia patients and shared three stories with the Committee on how they had helped patients and staff. Mel Sharp also confirmed that Dr Kate Wood is fully supportive of the purchase of additional machines.

Gill Ponder was pleased to hear that the machines had given benefit to a broader range of patients which confirmed they were not under-utilised and therefore was fully supportive of the purchase.

Neil Gammon queried the funding source and Clare Woodard confirmed that given the bulk ordering it would come out of the Big Thank You appeal initially. She had spoken with the individual fund guardians to explain that the costs would then come out of their particular funds.

Following the discussion, approval was given for the purchase of seven RITA machines.

6.3 Trustee Development Opportunity “Making the Best of the Board” – The Governance Wheel

Neil Gammon explained that Clare Woodard had recently attended a presentation called “Making the Best of your Board” with the National Council of Voluntary Organisations (NCVO) Governance Wheel demonstrated as an assessment tool. The idea behind the Governance Wheel is to demonstrate maturity of the charity and its board i.e. Trustees. Neil Gammon highlighted that in discussion with Dr Kate Wood she had agreed this was a sensible way forward. It was suggested by Neil Gammon, that some time would be set aside, later in the year, to assess where the Trustees were in terms of the wheel which would help to understand and develop the Trustee’s role, leadership of the charity and the integrity of the organisation. It would also reinvigorate the involvement of the Trustees with their charity.

Clare Woodard explained that initial thoughts were to issue a brief survey to the Committee for their thoughts on the current position on the wheel. This would be followed up for possibly a half-day to identify any gaps or areas for improvement.

The Committee agreed to this approach and Neil Gammon asked Clare Woodard to devise and issue the survey and bring back to the Committee in September with a more substantial proposal on how to capture that half-day.

Action: Clare Woodard

Item 7 07/21 Updates from Health Tree Foundation

7.1 HTF Update Report

Neil Gammon observed the incremental improvement in the report and commended the Trustees to read the report as it was full of information and ideas.

Clare Woodard presented the report and highlighted areas to note including:

Section 5 – A&E Fundraising Campaign – Following approval at the last meeting of the several wishes, the team joined up with the communication team to engage staff and the public and to put together an ambitious but realistic fund raising campaign. A campaign logo for each site had been developed along with a communications plan for the appeal including a news release and social media content. A target had been set of £35k for each site, with both charity champions involved in the fund raising on their own site.

There has already been lots of interest from both staff and public and the team were also reaching out to local businesses. This would create an opportunity to reinvigorate, post the pandemic slowdown, what the charity stands for and people would be able to see what their fund raising is doing for the hospitals. There had also been interest from local radio and newspapers.

Victoria Winterton commented that being involved, and thus an integral part, since the beginning of the ED project had really helped and shows what a long way the HTF have come having that engagement.

Gill Ponder noted that given the positive start to the campaign there would seem to be a real prospect to exceed the target and asked if there was a strategy to deal with that. Clare Woodard explained that when the appeal was put together a fund zone was created so once the target was reached they would be able to add to that fund zone for any future wishes for A&E.

Neil Gammon commented that Trustees should also give their thoughts on the use of funds if the target is exceeded, but agreed that a “plan B” should be ready to cater for an excess of funds.

Clare Woodard agreed that it was a fantastic opportunity to be involved at the beginning of the project and then included in the design team meetings. She noted that a lot of the décor in the childrens’ area also gave an opportunity for HTF brand awareness.

Section 6 – Current Appeals Update. Clare Woodard highlighted the recent opening of the MRI unit and noted that as the appeal commenced before Covid with good uptake they were not able to fund raise throughout the pandemic. The appeal was now closed and the equipment now in situ, however, if there were any additional donations these would go into the Radiology fund zone.

Therapy Garden at Goole – Clare Woodard explained this was an ongoing appeal with the staff very engaged. The garden was also being used as part of staff wellbeing. Due to the lack of a ‘Sparkle’ officer it had not been possible to commission a landscaper at the present time.

Jug Johal observed that given that the technology in the MRI unit had been funded by HTF there was very little branding and asked if an opportunity had been missed. Clare Woodard agreed to look at increasing the branding in the unit.

Action: Clare Woodard

Gill Ponder queried how the staff thank you draw had been received and if it achieved what was expected. Clare Woodward agreed to discuss with Christine Brereton and to have a review at the next meeting.

Action: Clare Woodard

Mel Sharp commented that during the Covid pandemic the HTF remained visible and put patients and staff first, which was noted and agreed by Trustees.

Neil Gammon asked about the community partnership grant of £624k and whether the money had been accounted for separately. Paul Marchant confirmed and also noted that agreement had been received to charge overheads which would all be identified separately.

Item 8 07/21 **Sparkle Update**

Clare Woodard reported that there had been ten applicants for the project officer post and Ellie Rodger and Clare Woodard would be shortlisting the week after next.

Victoria Winterton highlighted that given the issues with the handymen posts she suggested exploring the way forward outside of the meeting, given the problems over time with recruitment and retention. It was agreed that Victoria Winterton, Clare Woodard and an Estates representative discuss how to move forward.

Action: Victoria Winterton / Clare Woodard

Item 9 07/21 Finance

9.1 Finance Report June 2021

Paul Marchant presented the finance report and highlighted the key points to note as follows:

- Income for the first quarter was £82k which is £97k less than the plan of £179k; the planned figure includes legacy income of £55k. Income has shown a steady increase from £12k in April, to £25k in May and £45k in June which is reflective of activity now taking place on fund raising.
- Notification has been received of two legacies but there is currently no indication of their value; with one expected from America.
- Expenditure of £106k is £359k less than the plan of £465k. The plan assumed delivery of the mannequins (£100k) but these were not received until July. However, expenditure is forecast to increase following the wishes approved today (Breast Ultrasound machine £75k and RITA machines £35k).
- Revaluation of investments at 30th June resulted in an increased value of £117k.
- Fund balances are £1,336k after commitments of £674k
- The Covid fund balance is £30k.
- Income is already looking positive for July

Neil Gammon asked Clare Woodard about the successful grant bid of £10k and she explained that an application for children's development for specialist chairs of £5k had been requested. The grant received was for £10k therefore two chairs could be purchased, bought specifically for DPOW.

Neil Gammon also queried the work on legacies and Clare Woodard briefly explained that she would be interviewing people who have identified themselves to leave a legacy to explain how a legacy could make a difference. Information would also be issued to local solicitors.

Following the discussion the finance report was noted.

9.2 Draft Annual Accounts 2020/21 and Going Concern

The Going Concern Concept is a new requirement for Charities in 20/21 due to a change in the Charities Accounting Standard. The Charity is now required to give an assessment that it is a going concern.

The going concern assessment report explained that the Covid-19 pandemic has had an impact on the charity's fundraising income although this has been offset by grant income from the NHS Charities Together national appeal. As a grant making charity with few on-going commitments, this will have little impact on the charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts. The report highlighted the level of reserves (£1,917k), reserves policy and cash balances (£336k) at 31st March 2021.

Gill Ponder commented that all the evidence heard today of the health of the funding raising campaigns and current finances is ample evidence for this group to support the concept of a going concern.

Following review the draft annual accounts were noted and the going concern assessment report was approved.

Item 10 07/21 **Any Other Business**

There was no other business raised.

Item 11 07/21 **Matters for Escalation to the Trust Board**

The following items were agreed to be included within the Highlight Report to the Trust Board:

- The decision formally creating a new appeal for the EDs at both DPOW and SGH.
- Actions on the existing appeals
- The two wishes agreed i.e. Breast Imaging Ultrasound Machine; and Seven additional RITA machines

Neil Gammon thanked the Committee for attending and the meeting closed at 2.20pm. Neil Gammon asked Mel Sharp to inform Dr Kate Wood that the meeting had ended.

Item 12 07/21 **Date and Time of the next meeting**

Thursday, 16 September 2021 – 1.00pm-4.00pm – Via Teams Meeting

Attendance Record:

Name	May 2021	July 2021	Sept 2021	Nov 2021	January 2022	March 2022
Neil Gammon	✓	✓				
Peter Reading	✓	✓				
Terry Moran	-	-				
Linda Jackson	✓	Apols				
Gill Ponder	✓	✓				
Mike Proctor	apols	Apols				
Lee Bond	✓	Apols (Rep)				
Jug Johal	✓	✓				
Kate Wood	✓	✓				
Ellie Monkhouse	✓	Apols (Rep)				
Christine Brereton	✓	-				
Paul Marchant	✓	✓				
Andy Barber	apols	-				
Victoria Winterton	✓	✓				
Clare Woodard	✓	✓				
Adrian Beddow	✓	Apols (Rep)				
Ian Reekie (Governor)	Apols (Rep)	Apols				
Total	**13**	**8**				

MINUTES

MEETING:	Northern Lincolnshire & Goole NHS Foundation Trust **Health Tree Foundation Trustees' Committee**	
Date:	**16 September 2021 – Via Teams Meeting**	
Present:	Neil Gammon	Independent Chair of HTF
	Mike Proctor	Non-Executive Director
	Peter Reading	Chief Executive
	Christine Brereton	Director of People
	Dr Kate Wood	Medical Director
	Maneesh Singh	Associate Non-Executive Director
	Jug Johal	Director of Estates & Facilities
	Paul Marchant	Chief Financial Accountant
	Victoria Winterton	Head of Smile Health
	Clare Woodard	HTF Charity Manager
	Adrian Beddow	Associate Director of Communications & Engagement
	Mel Sharp	Deputy Chief Nurse
In attendance:	Simon Leonard	Communications Assistant
	Vicky Marshall	Group Manager Surgery - Trustwide
	Anne Sprason	Finance Admin Manager (For the Minutes)

Item 1 09/21 **Apologies for Absence**

Apologies for absence were received from: Gill Ponder; Ellie Monkhouse (Mel Sharp deputising); Lee Bond; Andy Barber; and Ian Reekie.

It was noted that Mike Proctor, NED, would be late joining the meeting; Dr Kate Wood would have to leave at 1.30pm to attend another meeting; and Simon Leonard would be joining the meeting at 2.00pm.

Item 2 09/21 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declarations of Interests". None were raised.

Item 3 09/21 **Minutes of last meeting held on 15 July 2021**

The minutes of the meeting held on 15 July 2021 were reviewed for accuracy and completion of actions. Following review the minutes from the last meeting were agreed as an accurate record.

Item 5 09/21 **Review of Action Log**

The action log was reviewed as follows:

7 (08 03 21) – Office space for HTF. Clare Woodard advised that work was in progress to establish the location of an office on the DPOW site for the HTF team. She had met with Mike Simpson who had advised that a space audit was being undertaken and he would keep Clare Woodard informed.

7 (08 03 21) – Dedicated Estates Support for HTF. Clare Woodard advised that Lauren Henry would be commencing as the new HTF Project Co-ordinator and the Sparkle projects could once again be taken forward.
7 (15 07 21) – Patient Self Check-in Screens. Clare Woodard advised that she had spoken with Jo Loughborough and Mel Sharp and had received feedback. There were concerns about how people would use these appropriately and it had been suggested that the trust should trial these items first before HTF commit to fund.

6 (13 05 21) – Patient Feedback Stations. Clare Woodard advised that this was currently on hold. She had spoken with Jo Loughborough and Mel Sharp who had received a presentation about the ECC kiosks and there were some concerns around having two data sets.

Following review the action log was noted.

Item 6 09/21 **Items for Discussion / Approval**

6.2 Trustee Development Opportunity "Making the Best of the Board" Survey

Neil Gammon introduced the item highlighting that this was raised at the last meeting as a result of a training event attended by Clare Woodard. Neil Gammon suggested that the development opportunity would be good for new Trustees as well as serving as a refresher for those longer serving Trustees.

Clare Woodard presented the paper and highlighted that, if agreed, a brief survey would be sent out in September to get an understanding of the knowledge, skills and expertise of the Trustees. This would be followed with the findings presented to the Committee in November, to identify any gaps and decide whether there was a requirement for further development. Dependent on the results it was suggested that a half day development session could be arranged in the new year to explore any issues in more detail.

The Committee agreed that this was a good idea and should be taken forward.

Action: Clare Woodard

6.1 Wish Ref 077/20 Fusion Biopsy Machine – Final Costings

This item was due to be discussed at 1.30pm when Vicky Marshall would be in attendance. As Dr Kate Wood needed to leave the meeting, Neil Gammon sought her thoughts on the paper. Neil Gammon reminded the Committee that the original request for the Fusion Biopsy Machine was submitted in March 2020 and the Urology team subsequently trialled a machine, with money ring fenced at that time.

Dr Kate Wood confirmed that she fully supported the request when first brought to the Committee and was still in support.

6.1 (cont'd) Wish Ref 077/20 Fusion Biopsy Machine – final costings

Vicky Marshall joined the meeting and explained that fusion biopsy machines from two separate companies had been trialled. Following training on the machines it was felt that DK1 gave the best quality for the type of procedures required. The checklist as part of the HTF process had been completed. It was a low maintenance piece of equipment and therefore had been signed-off. Following the full process now completed it had been brought back to the Committee for final sign-off to purchase.

Neil Gammon enquired about the NICE standard of care recommendations. Vicky Marshall explained that this particular machine was not provided by other hospitals in the region. There had therefore been regional interest, particularly as the equipment was being based at Goole and would be a potential contribution from NLAG to system working.

Peter Reading raised the following questions: were there any revenue consequences and whether they were covered; the training requirements; and patient flows and asked if this would mean that York patients would be travelling to this Trust site.

Vicky Marshall explained that the revenue costs were minimal and already signed-off in surgery. In terms of training, this was undertaken as part of the trial with each machine. Once the machine had been purchased, they would bring back the trainers for an afternoon refresher course. Vicky Marshall also explained that pathways were being drawn up and a positive Urology Area Network meeting had been held, with a view to offering access to Hull and York for their individual patients' requirements. A full information sheet had been drawn up and would be submitted to Urology Network once signed off by Dr Kate Wood and Ellie Monkhouse, so confirming that NLAG would be looking to offer the service to Hull and York patients.

Peter Reading suggested this may need virtual approval.

Maneesh Singh was welcomed to the committee and Neil Gammon asked if there were any views on ratifying ex committee.

Kate Wood explained that the reason for the machine to be located at Goole was because this particular service was not provided at Grimsby. There was concern that the money had been provided by the Cleethorpes Cancer Support Group and Clare Woodard and Victoria Winterton were asked to speak to the group to explain that whilst the equipment would be located at another site it would benefit Grimsby patients.

Action: Clare Woodard; Victoria Winterton

Mell Sharp agreed to speak with Ellie Monkhouse to confirm her approval but advised that they had spoken briefly, and she was happy that there were clear patient benefits as well as helping reduce the risk of sepsis and the use of antibiotics.

Maneesh Singh fully supported the purchase of the Fusion Biopsy machine.

Vicky Marshall thanked everyone for their support, particularly the help received by HTF, and she left the meeting.

6.3 Future Strategic Funding Plan

Clare Woodard presented the item which was to agree a strategic and realistic HTF funding plan to support the Trust's priorities for the next financial year and beyond.

Clare Woodard reminded the Committee that she had been included in the ED initial project planning stage, which had proved extremely helpful in coordinating fundraising requirements of the project with all concerned. She explained that adopting a similar approach for future projects would be most beneficial. Clare Woodard was asking to be advised about forthcoming capital projects so that HTF could be involved at the inception of the programme. She explained that she had met with Lynsey Chessman and Matt Clements to ensure she was on the right committees to understand future potential charitable funding requirements.

She highlighted that she currently sits on the Equipment Group; Patient Experience; weekly business planning and had asked to attend a marketplace event.

Jug Johal asked if it would be helpful if Clare Woodard was involved in the business planning process, rather than wait until schemes were agreed, noting there were 93 BLM schemes and no doubt schemes within those where support could be offered. Clare Woodard readily agreed to this suggestion. Jug Johal undertook to confirm who was leading on business planning this year.

Action: Jug Johal

6.4 Dates and Format for 2022 HTF Meetings

Neil Gammon highlighted that currently HTF was held every two months, which he suggested was appropriate, but would like to keep the meetings down to 2 hours duration in future. The dates of the meetings for 2022 were currently being determined and would be circulated once finalised.

Item 7 09/21 **Updates from Health Tree Foundation**

7.1 HTF Update Report

Clare Woodard presented the report and highlighted that since July the fundraising efforts had increased with the A&E campaign underway and a recent NL GPs vs hospital doctor's afternoon cricket match. Planned events included a Halloween Drive-in cinema; 2 sky dives as well as Christmas happenings.

Clare Woodard referred to the KPI information (Appendix 1) and highlighted the recent staff survey that had been sent out to gain information on people's knowledge and opinion of the charity. Good results had been received so far with 128 responses and Clare Woodard thanked Adrian Beddow for help with distribution of the survey. Out of the responses received so far, 95% knew what the HTF did and 92% had seen an increase in branding and awareness of the charity.

Clare Woodard drew the Committee's attention to the enthusiastic and positive reports from the charity champions with a lot of work going on in terms of fund raising appeals, comms, events over the summer, the cricket match, Grimsby 10k, and open garden events.

Clare Woodard highlighted the patient gifts for Christmas and whilst this had been haphazard in the past it was proposed to provide a branded blanket with the HTF logo which would mean everyone was treated equally and the Trustees were asked to support this approach, which they did.

The 2021 Annual Report was currently being finalised and once the auditors had completed their work the accounts would be signed off by the CEO and Chief Financial Accountant. The Trustees were asked for their agreement for the Chair of the Committee to approve the final report narrative on their behalf in order to file the accounts with the Charities Commission as soon as possible. This was agreed.

Clare Woodard highlighted a recent charity football match arranged by the son of a patient who sadly died of Covid on SGH ICU with over £20k being raised. Following the event, Neil Gammon had telephoned the son to personally thank him for the support and it was understood that a similar event would be held the following year. Clare Woodard explained that a personal phone call, or perhaps letter or email, was something that she would like to see more of and Maneesh Singh agreed that he would be happy to oblige.

Item 8 09/21 **Sparkle Programme**

8.1 Sparkle Update

Clare Woodard advised that a new Sparkle Officer had now been appointed and the Sparkle projects would be reinvigorated. An update on the projects would be provided at the next meeting.

Action: Clare Woodard

Neil Gammon explained that the lack of a Sparkle Officer, and thus Sparkle activity, had drastically reduced the ability for the Charity Manager and her team to publicise the work that HTF do as well as their not being able to provide the physical benefits to patients and staff.

Item 9 09/21 **Finance**

9.1 Finance Report August 2021

Paul Marchant presented the report and highlighted the key points, including:

- Income for the first 5 months was £166k which is £140k behind the plan; there was no single reason but an accumulation of being without a DPOW fund champion earlier in the year; no office presence on the DPOW site and not being able to go ahead with Sparkle projects. A re-forecast would be provided next month once 6-months of actual income had been received.
- Expenditure for the 5 months was £327k which was £289k less than expected. Some of this is due to the timing of capital expenditure and it is expected that the planned full year expenditure of £1,260k will still be achieved.
- Fund balances showed £1.3m of uncommitted funds including £27k in the Covid fund after accounting for BAME and staff wellbeing funding.
- The Trustwide Big Thank You had a balance of £86k and plans were being worked up to spend more of that.
- The value of the legacy from America, that had been highlighted at the last meeting, was still unknown although it was understood that property was to be sold.
- Cash balances were £190k.

Peter Reading had a question for Trustees, noting that if £1.2m was spent this year and there were still fund balances of £1.3m, was there a responsibility to spend a large part of that balance? He was unsure of the minimum balance required but asked if the aim should be to spend more and seek more schemes to do just that.

Neil Gammon agreed that the onus on Trustees was to spend donated money but that must always be in an appropriate way and in line with the objects of the charity. There are a significant number of current wishes and planned spend looks to be on track compared with the two previous years. He suggested that it is more about the big-ticket items, which is what Clare Woodard was highlighting earlier, in terms of her involvement at the initial stages of capital schemes. Neil Gammon also suggested that item 6.2 (Trustees Development Opportunity) could help to find ways of spending more money.

Paul Marchant explained that the reserves policy states that there should be 6-months of general expenditure, so fund balances could go to £700k.

Neil Gammon asked Victoria Winterton if we were an outlier or do other charities suffer from similar problems in spending money appropriately. Victoria Winterton stated that three years ago HTF had £3m, so spend has been increased and HTF were ahead of many other charities in this regard. The number of wishes was really high so HTF is in a strong position but could be stronger, which is why Clare Woodard had brought the paper on strategic funding plans, the idea being that the more that is spent the more will be raised.

Simon Leonard joined the meeting.

Mel Sharp commented that there would always be the need for more equipment, acknowledging that it would have to be appropriate for charitable funding. If we look at the Sparkle projects this increases staff morale, and it was agreed that we cannot underestimate the impact of Sparkle activity.

Neil Gammon noted that donor stewardship was really important and would welcome more instances of Trustees being involved. It was also agreed that Clare Woodard being involved right at the beginning of schemes would help to focus on spending.

Jug Johal asked if was worth considering the AAU and SDEC schemes that would be commencing straight after the A&E scheme which would be right outside HTF offices and would be a major scheme when refurbished.

Following the discussion, the finance report was noted.

9.2 Audit Strategy Memorandum NLAG NHS FT Charitable Funds

Paul Marchant explained that the report sets out the approach taken by the auditors to the audit of the charity accounts. The audit was almost completed and it was expected that the final accounts would be brought to the November HTF meeting.

The report was noted.

9.3 CCLA Investment Update

Paul Marchant presented the report which was a summary of the fund position as at 9 September 2021; noting there had been a £96k increase since the last report. The investments were on target and above the benchmark. Trustees agreed attendance by CCLA early next year to give a full update.

The report was noted.

Item 10 09/21 **Any Other Business**

Christine Brereton had earlier in the year put forward a wish to support the Trust in thanking staff members for their superb sustained response to the pandemic with the opportunity for all staff to be entered in a prize draw funded by HTF. As part of that bid it had been suggested that a similar request would be submitted for the flu campaign and offer incentives to staff to encourage them to take up the flu jab. There were two things being considered, a “Get a jab, Give a jab” campaign which would see for every jab given a donation would be provided to fund a flu jab for a child in a third world country via the Charity UNICEF. The other idea was to offer staff entry into a prize draw again.

Neil Gammon suggested that £10k could be used from the NHS Charities Together Stage 3 grant. This grant was based on Trust head count and targeted specifically at staff wellbeing. Moreover, such funds were not raised by HTF fundraisers.

Neil Gammon stated that whilst it was a totally admirable sentiment to have flu vaccinations funded for a poorer country that was not what local people and businesses donated their money for. Indeed, it was questionable whether this met the objects of the HTF charity.

Christine Brereton confirmed that she was seeking funding from HTF for the staff prize draw only, as the "Get a jab, Give a jab" funding would be from the Trust.

Peter Reading suggested that having staff vaccinated against flu would benefit patients. Higher vaccination rates would increase that patient benefit.

Jug Johal was in agreement as he thought the wider benefit would be quite appealing to staff. Mel Sharp also supported and agreed indirectly protect staff – protect patients. Maneesh Singh asked if historically there was low uptake of the flu jab, which Christine Brereton confirmed, however the Covid booster may encourage more flu jabs this time around.

Peter Reading reminded the Committee that last year the incentive was to offer a £5.00 food voucher which a lot of people had donated to local food banks.

Maneesh Singh asked if the charity supported funding for both direct and indirect patient benefit. Neil Gammon replied that HTF has provided funds in a variety of ways that spanned the full spectrum of direct and indirect support. Many arguments were finely balanced and HTF did look to the NHS Charities Together umbrella NHS charity, for precedent to help with debate and decision making. He added that particularly when Trustee opinion was divided, the cases were rigorously debated, as evidenced in the Trustee Meeting minutes.

Neil Gammon asked that a 'wish' be submitted to the HTF and once received, if this request could be considered by the Trustees ex-committee, rather than having to wait until the November meeting for a decision. Trustees agreed and he stated that the relevant paper work would be issued to trustees for their comments, via Clare Woodard, once the 'wish' had been received through the Circle of Wishes.

Action: Neil Gammon

Item 11 09/21 **Matters for Escalation to the Trust Board**

It was agreed that the following item would be included within the Highlight Report to the Trust Board:

- Final Sign-off of the Fusion Biopsy machine

At this point the members of SMILE left the meeting in order for the following item to be discussed in private.

Item 12 09/21 **PRIVATE ITEM – HTF Contractual Arrangements**

Neil Gammon gave a brief update by way of background and explained that the current Smile contract had been in place for almost 7-years. It was originally extended and then renewed and was due to expire on 31 March 2022. He therefore wished to raise the topic early and seek advice from procurement on whether a full tender should be undertaken to test the market. He noted that sound procurement practice pointed to tendering the current activity.

Mike Proctor joined the meeting.

He noted that the HTF team are employed by The Smile Foundation so wondered if it was best to continue with an external provider or bring the work back in-house. It should also be noted that there is wider Smile expertise to draw on and they have a presence across the ICS and broad national network links.

Peter Reading commented that the Trust ought to go out to tender acknowledging that there was no dissatisfaction with Smile but if there were better providers out there we have a responsibility to spend money wisely. Maneesh Singh agreed.

Adrian Beddow asked who had ownership of the brand, which Neil Gammon confirmed was with the Trust. Any new provider would take over the HTF and either populate it by members of their own staff or they may TUPE the existing HTF team members across.

Peter Reading stated that the decision should be taken by the Trust Board as a whole and it was suggested a short options paper should be provided.

Action: Neil Gammon

It was also agreed that Neil Gammon would inform Clare Woodard and Victoria Winterton that the discussion would be held at Trust Board for a final decision, but the recommendation from the Committee was that after 7-years that it would likely be a retendering exercise.

Action: Neil Gammon

Christine Brereton was asked to check if TUPE would apply if the contract was lost by Smile.

Action: Christine Brereton

Item 13 09/21 **Date and Time of the next meeting**

Thursday, 4 November 2021 – 1.00pm-4.00pm – Via Teams Meeting

Attendance Record:

Name	May 2021	July 2021	Sept 2021	Nov 2021	January 2022	March 2022
Neil Gammon	✓	✓	✓			
Peter Reading	✓	✓	✓			
Terry Moran	-					
Linda Jackson	✓	Apols	-			
Gill Ponder	✓	✓	Apols			
Mike Proctor	apols	Apols	-			
Maneesh Singh			✓			
Lee Bond	✓	Apols (Rep)	Apols			
Jug Johal	✓	✓	✓			
Kate Wood	✓	✓	✓			
Ellie Monkhouse	✓	Apols (Rep)	Apols (R)			
Christine Brereton	✓	-	✓			
Paul Marchant	✓	✓	✓			
Andy Barber	apols	-	Apols			
Victoria Winterton	✓	✓	✓			
Clare Woodard	✓	✓	✓			
Adrian Beddow	✓	Apols (Rep)	✓			
Ian Reekie (Governor)	Apols (Rep)	Apols	Apols			
Total	**13**	**8**	**9**			

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Extra-Ordinary Meeting of Health Tree Foundation Trustees' Committee

Date: **5 October 2021 – The Sands Stadium, Glanford Park**

Present:		
	Neil Gammon	Independent Chair of HTF
	Peter Reading	Chief Executive
	Gill Ponder	Non-Executive Director
	Maneesh Singh	Non-Executive Director
	Dr Kate Wood	Medical Director
	Ellie Monkhouse	Chief Nurse
	Christine Brereton	Director of People
	Mike Proctor	Non- Executive Director
	Ade Beddow	Associate Director of Comms and Engagement
	Clare Woodard	HTF Charity Manager

Item 1 10/21 **Apologies for Absence**

Apologies for absence were received from: Jug Johal, Paul Marchant

Item 2 10/21 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declarations of Interests". None were raised.

Item 3 10/21 3.1 Wish Ref 267/21 HTF Contribution towards Peer Vaccinator Gifts and a Staff Prize Draw as part of NLaG 2021 Flu Campaign Incentive

Neil Gammon reminded the committee of the history of the request. It was originally brought up at the HTF committee meeting on 16 September 2021 by Christine Brereton under AOB. It was agreed at the meeting that once a formal request had been received by HTF via the circle of wishes, it would be dealt with on an ex committee basis. Papers were circulated to Trustees, however it was then suggested that this matter could be discussed face to face following the October Trust Board meeting as HTF Trustees would be together in the room.

Christine Brereton was invited to present the paper to the meeting.

The key points of the request are as follows:-

The Trust has started the rollout of the 2021 flu campaign and are trying to encourage greater staff uptake of the vaccine than in previous years, in accordance with NHSE policy.

Christine Brereton made it clear that "The Get a Jab Give a Jab" campaign is not included in this wish and HTF will not be asked to fund a donation to Unicef.

The wish therefore consists of two parts:-

Part 1 £2000 of shopping vouchers for peer vaccinators, to encourage them to vaccinate as many staff as possible as well as a thank you for them helping the campaign.

Part 2: £10,000 towards prizes. Those staff members who have taken the flu jab, will be automatically entered into a prize draw.

At this point Neil Gammon reminded Trustees of items 2.6 and 2.7 in the HTF Terms of Reference Document:-

2.6 The members of the Trustees' Committee shall act independently of the Trust Board when making decisions about expenditure.

2.7 The Trustees Committee must ensure that the expenditure decisions are granted only to further the charity's purposes for the public benefit and for no other purpose.

He then reminded the committee that NHS Charites Together awarded £143k to Health Tree Foundation to be used for the recovery and staff wellbeing for NLAG staff.

The role of the HTF in this Stage 3 grant is to act as a conduit between NHS Charities Together and the Trust.

To date the NHS CT Stage 3 grant has been used as follows:-

Income	143,300
Expenditure to date	
24 Month Band 7 HWB Post	96,000
Insights Training and licences	13,300
Staff Big Thank you Draw Summer 2020	10,000
Drawn down so far	**119,300**
Balance	**24,000**

Neil Gammon commented that as there is money still available, there are different ways to proceed with this request. First trustees are asked to consider if this should come from HTF funds and if so should it come from the NHS CT Stage 3 remaining balance.

Kate Wood asked if this wish could be considered against the Stage 3 grant as it seems there is still money available under this heading.

Christine Brereton understood that all Stage 3 grant funds had been spent and would be delighted if there were still funds available for this request. Neil Gammon commented that it could be there may be plans for the outstanding balance but as yet this had not been drawn down through the circle of wishes so at present there is £24,000 still available. He suggested that Christine Brereton's team may need to reassess the priorities.

Kate Wood said that the wish sits within the grant guidelines and that there is clear patient benefit whether it is funded through HTF funds or not.

Christine Brereton advised that her team is currently looking at putting some support in place for trauma and PTSD support for staff, so she feels this may be what the remaining grant is allocated for but not yet drawn down. She would need to clarify this so asked Trustees to consider using other HTF funds in case this money was no longer available.

Maneesh Singh stated he understood the sentiment to maximise staff vaccination but it makes an assumption that the vaccine is efficacious and would indeed reduce flu and secondly he worries about the ethics of giving a reward for a medical treatment, which what some drug companies have got into trouble for and thirdly people who donate to HTF want to see a proven patient benefit. It does not sit quite right that HTF should be funding things for staff with an indirect patient benefit.

Neil Gammon said that as Trustees we are asked to consider three questions when deliberating a wish.

1) Is this something over and above what the NHS should provide?
2) Is there a clear and measurable patient benefit?
3) Would you be happy to tell someone where their donation has been spent?

Gill Ponder commented that she was one of the people originally in favour of the staff Covid-19 thank your prize draw which HTF funded in the summer, again from NHS Charities Together Stage 3 Grant Funding. She was concerned that it is too soon after the last prize draw, that we would potentially be raising the expectation that we will do this every year and about offering a reward for something that is personal responsibility. Why would we incentivise the flu jab and not the covid jab? Gill Ponder stated that sickness absence levels are high at the moment and it is not down to flu so why should we offer this incentive?

She also expressed concerns about the proposal to give shopping vouchers to peer vaccinators and feels this may encourage some vaccinators to try and get their numbers up and others potentially feeling bullied or coerced into taking the vaccination.

Peter Reading commented that the imperative to get staff vaccinated comes from the government and is based on national public health in order to protect patients. The moral aspect to give people an incentive is a well-trodden path in the NHS. NLAG has done this in the past by giving £5 food voucher for those taking the flu jab. Regarding the effectiveness of the vaccine, he commented that he did not know if giving people the chance in a draw will overcome any resistance, but in HUTH, where staff are offered an extra day's annual leave, their uptake is much higher.

Regarding the rewards for peer vaccinators, Peter Reading said that he did not think this was a good idea to come from charitable funds and was unsure why it had been suggested because in previous years NLAG has given gold, silver and bronze awards to peer vaccinators including an IPad.

Peter Reading said that in terms of where the money would come from, it would be easier to come from the Stage 3 grant however he would not like to see it replace any plans to support the trauma issues.

Mike Proctor said that he has always opposed incentivising vaccinations as he feels it is a duty of care that staff should undertake. He stated that if NLAG Board want to give this incentive they should but it certainly should not come out of the charity.

Kate Wood commented that having worked at the Trust for a long time there are things that give people a little bit more hope and optimism and this would be a way of giving staff something.

Ellie Monkhouse stated that this is absolutely about patient and staff safety. She said we need to give our staff some incentives as we are working in a different NHS culture post pandemic and historically our people are reluctant to take up the flu jab.

Ellie Monkhouse thinks it will help by offering incentives to peer vaccinators as they are going above and beyond.

Gill Ponder said that peer vaccinators should be paid if they are doing extra work. She commented that there was already really good take up of the flu jab in the first few clinics which have been held so should we just wait and see what happens without offering incentives.

Christine Brereton said that on the first day in the vaccine hub 65% of people who had their covid booster had their flu vaccine at the same time during one clinic. We, however, still have ground to make up and there is evidence that incentives do make a difference and they are widely used.

Maneesh Singh stated that if the Trust feel that incentives will help boost the numbers then they should make money available from their own budgets. He was adamant he would not be able to tell someone comfortably where their donation had been spent if this wish was approved.

Peter Reading asked Trustees if the exec team should take the question of rewarding peer vaccinators outside the meeting and consider funding it themselves.

Neil Gammon suggested that as everyone was there as trustees that a decision should be made at this meeting. He stated that HTF fundraised money should not be used for this wish or the peer vaccinators, however he would be in favour of using the stage 3 money noting that the priorities from Christine Brereton's team may need to be revisited.

He asked for a show of hands and asked the following questions-

Should HTF Core Funds be used to fund this wish?

In Favour

- Kate Wood
- Ellie Monkhouse

Not In Favour

- Maneesh Singh
- Mike Proctor
- Gill Ponder
- Neil Gammon

Abstained

- Peter Reading

Encourage the take up of the vaccine and take £10,000 funding from the NHS CT Stage 3 grant residue

In Favour

- Kate Wood
- Ellie Monkhouse
- Neil Gammon
- Gill Ponder

- Peter Reading

Not In Favour

- Maneesh Singh
- Mike Proctor

Who is in favour of using NHS CT Stage 3 Grant for Peer Vaccinators

In Favour

- Kate Wood
- Ellie Monkhouse

Not In Favour

- Neil Gammon
- Gill Ponder
- Maneesh Singh
- Mike Proctor

Abstained

- Peter Reading

It was therefore agreed that £10,000 would be made available from the HTF NHS CT Stage 3 grant for a prize draw for those having their flu jab.

Peter Reading stated that he would examine funding an incentive for peer vaccinators from CEO budget.

Meeting Closed

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NLG(21)280

DATE OF MEETING	7/12/21
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Adrian Beddow, Associate Director of Communications
CONTACT OFFICER	Charlotte 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 the 6 week period 1 Oct – 12 Nov and is a round up of the team's activity in relation to each of the team's objectives.

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**
		✓			

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Communications Team update

December 2021

Kindness • Courage • Respect

December update 2021 – covering 1 Oct to 12 Nov

Key campaigns

Two key campaigns the team are currently supporting are the National Staff Survey and the Flu campaign.

Staff survey stats:
5000+ reach on Facebook
26 Hub/staff Facebook posts
6 Ask Peters
2 Monday Messages
Hub Hot Topic
Screensaver

Flu stats:
53.35% of staff have had the flu vaccination at the time of writing
Since September 1:
4,424 Hub page hits (a 1.6% increase on the total hits last year's campaign page received from September 1 to January 31)
48 Facebook posts (total reach of 61,998).These generated 513 link clicks to either the booking system, form to report having your jab elsewhere or the Hub pages.
2 polls asking for feedback from staff via the staff Facebook page.

Team Objectives

Improve Trust reputation through external communications and patient experience

Improve staff morale and engagement

Celebrate staff achievements

Plan and deliver communications relating to service and capital investment

CQC preparation

Support the delivery of the Trust priorities

December update 2021 – covering 1 Oct to 12 Nov

Other Projects we are supporting include:

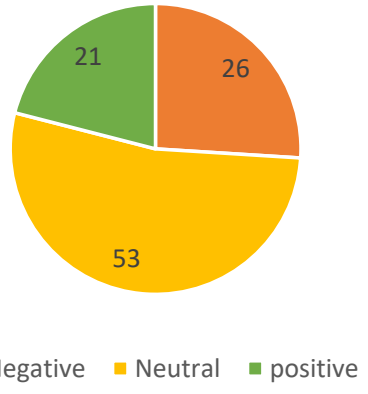
- **Community store equipment return appeal:** 24,500 reach on social media and 1,500+ engagements on 3 social media posts. News release covered by GI media, Goole times and BBC Radio Humberside and was clicked on 629 times on our website.
- **Fraud awareness:** Press release issued leading to an interview on Viking FM with Nicki Foley plus internal comms
- **Speak Up month:** A campaign ran throughout the month focusing on why staff should speak up, how they speak up and what happens when they do. Including real NLaG case studies and stats.
- **EPR survey**
- **Health Tree Foundation:** We are launching the Christmas A&E appeal which encourages people to give a festive fiver to fund enhancements to improve patient experience, we have promoted blanket donations for inpatients and secured positive media coverage on the RITA machines
- **Promotion of awareness weeks and months** including disability awareness month, World Antibiotic Awareness Week, Development Language Disorder Awareness Day, Breast Cancer Awareness Month and many more
- **Veteran Aware**: Since being given Veteran Aware accreditation in September, we have made a conscious effort to share information about the support available to veterans that we and the wider NHS is able to provide – both to our own ex-military staff and to those in our communities. We have created a dedicated page on the external website, which has had 37 unique views since October 1 and will be replicating this on the Hub. This has been further supported by content on our internal and external social media channels, giving information about the challenges Veterans face around Bonfire Night and Remembrance Day. The combined reach of these 12 posts has been 11,969 and have received 95 positive reactions.

Improving reputation through external communications

Media coverage

There were 89 stories about the Trust in the media during this period.
The majority of the articles (53%) were classed as neutral in tone. 21% were positive and 26% negative.
The team works hard to balance negative stories when we are contacted in advance of publication.
Coronavirus continues to be the top theme on media coverage, with 23 stories on this.
8 articles covered patient complaints.

Tone of coverage



National media coverage of note

Our maternity services were praised by a woman whose baby was born weighing less than a bag of sugar – this made it into the Sun, The Mirror and more

Media enquiries

88% of media enquiries were dealt with within timescale
Top theme for media enquiries was winter pressures
The top request type was interview request

Improving reputation through external communications

Social media

We currently have 16,593 followers:
11,696 on the Trust's Facebook page
4,897 followers on Twitter

Twitter: @NHSNLaG
Facebook.com/NHSNLaG

Website

The external website is being revamped with the New version (meeting accessibility requirements) due to launch in December
Stats:
202,499 page views
Staff guidance page: 12,668 page views
Top news release on the website was 'grab a jab'

55,392 Reach on facebook

16,593 followers on our corporate accounts

64,000 Tweet impressions in October

Top Facebook post – 15k reach

Top Tweet – 2,221 impressions

Improving staff morale and engagement

Ask Peter .
135 Ask Peter's were received in this period (up from 104 last year) Hot topics included vaccinations, parking issues, winter incentives and pension scheme arrears.

We have started a new 'You said, we did' feature to demonstrate actions taken as a result of Ask Peter questions.

Senior Leadership Briefing
77 senior leaders attended the October SLC briefing and 81 went to the November one.
Updates included:
- Humber Acute Services
- Finances
- Divisional Management changes
- Capital funding
- Covid boosters and flu vaccinations

Staff closed Facebook group stats
3,001 active members
691 posts
4,163 comments
11,682 reactions

81
Senior leaders attended the last SLC briefing

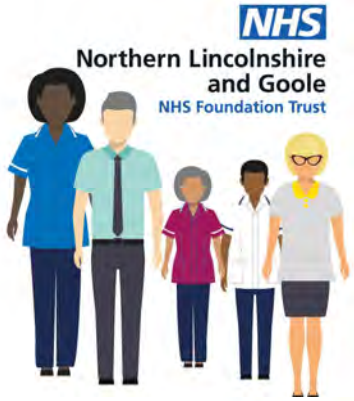
135
Ask Peter questions raised

4,163
Comments on the staff Facebook group

Improving staff morale and engagement

Wednesday Weekly News
We are unable to track how many people read this, but we are able to access link clicks.

Key stats on vaccinations and testing in this period:
Ordering lateral flow test (3 editions) 974 clicks
Tiger vaccination booking (2 editions) 696 clicks
Reporting lateral flow test (2 editions) 210 clicks



Monday Message
Topics have included:
Winter incentives
15 steps
Winter pressures
Trust priorities
Emergency care and inpatient survey results

Celebrating staff

Thumbs up Friday
We shared 30 #ThumbsUpFriday posts in this period. The Medicine division has received the most

#ThankYouTuesday
We shared more than 30 thank you's for staff – these Are generated either from other staff or from patients

NLaG people
AHP day – 16 staff profiles shared on social media celebrating our allied health professionals

Working with divisions

Currently this financial year Family services and the Chief Nurse division have generated the most press releases

30 #Thumbs UpFriday posts

30+ #ThankYou Tuesday's received

16 staff profiles shared for AHP day

Supporting the Trust's priorities

- Pandemic response – we continue with COVID-19 updates to all staff when needed
- Workforce and leadership – we continue to support the recruitment team with job adverts and reviewed 29 in this period
- Quality and Safety
    - End of Life: Contributed an article to the North Lincs CCG stakeholder newsletter

Launch of the Bluebell pilot on four wards across Grimsby and Scunthorpe

- Strategic service development and improvement
    - Humber Acute Services – we continue with fortnightly newsletter to all staff. A Chief Executive's question time event was also held recently.
- Estates, equipment and capital investment – see next slide
- Digital
- Finances
- The NHS Green agenda - we've been encouraging staff to dispose of their clinical waste in the correct bags and plan to cover the planting of NHS forest trees on our sites
- Partnership and system working – we have supported the Humber Acute Services Children & Young People – What Matters to You? survey on both internal and external channels

CQC preparation

We have created an inspection guide for staff, a welcome pack for inspectors, created a Hub page and have written a Monday Message on the forthcoming inspection.

Communications relating to service and capital investment

Building Our Future update

Between October 1 and Nov 22 we:

- Shared 39 external social media posts.
- Responded to 3 direct questions from the public
- Had 4,760 visitors to the website pages giving updates on our capital works (including the latest parking information)

Internally, over the same period we:

- Had 288 visitors to our internal Hub pages
- Shared 17 staff facebook group posts
- Sent out 10 all staff emails
- Answered 4 Ask Peter queries
- Provided four direct staff briefings

592,720
Combined campaign reach so far

The combined reach of the campaign to date is well in excess of 592,720. This figure does not include those who have viewed articles on the Hub or read all staff emails, as this data is not available to us.

When taking into account the circulation/ viewing figures of the media outlets who have shared our content, this takes our potential reach to over 15,015,075

Focus on employer brand

Use of LinkedIn

The team is starting to use LinkedIn more. The account was set up by and is owned by the Recruitment team, but the Communications team have access to post good news stories. In line with our People Strategy we're putting more focus on employer brand pieces i.e anything that promotes the Trust as a good place to work and shows we care about and celebrate the successes of our staff.

This has included sharing more posts about innovation, investment and staff wellbeing.

Our LinkedIn page currently has 3,479 followers (a rise of 23% between Oct 23 and Nov 22).

Top performing posts:
Demolition of SGH admin block due to start – preserving our heritage
Completion of the refurbishment of SGH theatre E
Time lapse footage of the DPOW ED build
Time lapse footage of the SGH demolition works
Investment in new stab vests for our security teams

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NLG(21)281

DATE OF MEETING	7 December 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Helen Harris, Director of Corporate Governance
CONTACT OFFICER	As above
SUBJECT	Timetable of Board & Sub-Committee Meetings
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The detailed timetable of the Trust Board, Council of Governors and all sub-committee meetings for 2022 is provided for information. The key changes made to the timetable are: * Key committees that need IPR data are in Week 3 and 4 * HUTH committees and Trust Board were considered to minimise any clashes * Committees not IPR sensitive, ie HTFC, RATS, AR&GC have been fitted in around the other committees * Standard executive committees have been avoided, ie TMB, PRIMS, Exec Team

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**
		✓			

Meeting Schedule - 2022 - Option 3 - Trust Board to remain on the same date

Notes

* Trust Board is on same date as current
* IPR fully mapped with Execs as per email to Board
* Key committees that need IPR data are in Week 3 and 4
* Considered HUTH committees and Trust Board and minimised any clashes
* Committees not IPR sensitive, ie HTFC, RATS, AR&GC have been fitted in around the rest
* Standard executive committees have been avoided, ie TMB, PRIMS, Exec Team

Month	Week 1	Week 2	Week 3	Week 4	Week 5
January	NO TRUST BOARD IN JANUARY	Health Tree Foundation Committee - NLAG Thur - 13.01.2022 - PM	Workforce Committee - NLAG Tue - 18.01.2022 - PM	Quality & Safety Committee - NLAG Tue 25.01.2022 - PM	
	Governor Assurance Group Thur - 06.01.2022		Council of Governors - NLAG Tue - 18.01.2022 - PM	Strategic Development Committee Wed - 26.01.2022 - AM	
			Finance & Performance Committee - NLAG Wed - 19.01.2022 - PM		
			PRIMS - NLAG - 20.01.2022		
February	Formal Trust Board - NLAG Tue - 01.02.2022		PRIMS - NLAG - 17.02.2022	Quality & Safety Committee - NLAG Tue - 22.02.2022 - PM	
			Finance & Performance Committee - NLAG Fri - 18.02.2022 - AM	RATS Committee - NLAG Wed - 23.02.2022 - PM	
				Audit, Risk & Governance Committee - NLAG Thur - 24.02.2022 - AM	
				Strategic Development Committee Thur - 24.02.2022 - PM	
March	Board Development - NLAG Tue - 01.03.2022	Governor Assurance Group Thur - 10.03.2022 - PM	Appointments & Remuneration Committee Wed - 16.03.2022 - PM	Quality & Safety Committee - NLAG Tue - 22.03.2022 - PM	Workforce Committee - NLAG Tue - 29.03.2022 - PM
	Health Tree Foundation Committee - NLAG Thur - 03.03.2022 - PM		PRIMS - NLAG - 17.03.2022	Finance & Performance Committee - NLAG Wed - 23.03.2022 - PM	Strategic Development Committee Wed - 30.03.2022 - AM

April	Formal Trust Board - NLAG Tue - 05.04.2022	Council of Governors - NLAG Wed - 13.04.2021 - PM	Finance & Performance Committee - NLAG Wed - 20.04.2022 - PM	Quality & Safety Committee - NLAG Tue - 26.04.2022 - PM	
			Audit, Risk & Governance Committee - NLAG Thur - 21.04.2022 - AM	Strategic Development Committee Wed - 27.04.2022 - AM	
			PRIMS - NLAG - 21.04.2022		
May	Board Development - NLAG Tue - 03.05.2022	RATS Committee - NLAG Tue - 10.05.2022 - PM	Strategic Development Committee Wed - 18.05.2022 - AM	Quality & Safety Committee - NLAG Tue - 24.05.2022 - PM	Workforce Committee - NLAG Tue - 31.05.2022 - PM
	Health Tree Foundation Committee - NLAG Thur - 05.05.2022 - PM	Governor Assurance Group Thur - 12.05.2022 - PM	PRIMS - NLAG - 19.05.2022	Finance & Performance Committee - NLAG Wed - 25.05.2022 - PM	
			Audit, Risk & Governance Committee - NLAG Thur - 19.05.2022 - AM		
June	Formal Trust Board - NLAG Tue - 07.06.2022	Council of Governors Annual Review Mon - 13.06.2021 - PM	Quality & Safety Committee - NLAG Tue - 21.06.2022 - PM		
		Appointments & Remuneration Committee Wed - 15.06.2022 - PM	Finance & Performance Committee - NLAG Wed - 22.06.2022 - PM		
		PRIMS - NLAG - 16.06.2022	Strategic Development Committee Thur - 23.06.2022 - AM		
		Audit, Risk & Governance Committee - NLAG Thur - 16.06.2022 - AM			
July	Board Development - NLAG Tue - 05.07.2022	Council of Governors - NLAG Mon - 11.07.2022 - PM	Workforce Committee - NLAG Tue - 19.07.2022 - PM	Quality & Safety Committee - NLAG Tue - 26.07.2022 - PM	
	Health Tree Foundation Committee - NLAG Thur - 07.07.2022 - AM		Finance & Performance Committee - NLAG Wed - 20.07.2022 - PM	Strategic Development Committee Wed - 27.07.2022 - AM	
	Governor Assurance Group Thur - 07.07.2022 - PM		PRIMS - NLAG - 21.07.2022	Audit, Risk & Governance Committee - NLAG Wed - 27.07.2022 - PM	
August	Formal Trust Board - NLAG Tue - 02.08.2022		RATS Committee - NLAG Tue - 16.08.2022 - PM	Strategic Development Committee 22.08.2022 - PM	
			PRIMS - NLAG - 18.08.2022	Quality & Safety Committee - NLAG Tue - 23.08.2022 - PM	
				Finance & Performance Committee - NLAG Wed - 24.08.2022 - PM	
September	Board Development - NLAG Tue - 06.09.2022		Workforce Committee - NLAG Tue - 20.09.2022 - PM	Quality & Safety Committee - NLAG Tue - 27.09.2022 - PM	
	Governor Assurance Group Thur - 08.09.2022 - AM		Finance & Performance Committee - NLAG Wed - 21.09.2022 - PM	Strategic Development Committee Wed - 28.09.2022 - AM	

	Health Tree Foundation Committee - NLAG Thur 08.09.2022 - PM		PRIMS - NLAG - 22.09.2022	Appointments & Remuneration Committee Wed - 28.09.2022 - PM	
				Council of Governors - Annual Members Meeting Thur - 29.09.2022 - PM	
October	Formal Trust Board - NLAG Tue - 04.10.2022	Council of Governors - NLAG Thur - 13.10.2022 - PM	Finance & Performance Committee - NLAG Wed - 19.10.2022 - PM	Quality & Safety Committee - NLAG Tue - 25.10.2022 - PM	
			PRIMS - NLAG - 20.10.2022	Strategic Development Committee Wed - 26.10.2022 - AM	
November	Board Development - NLAG Tue - 01.11.2022	Governor Assurance Group Thur - 10.11.2022 - PM	RATS Committee - NLAG Tue - 15.11.2022 - PM	Quality & Safety Committee - NLAG Tue - 22.11.2022 - PM	Workforce Committee - NLAG Tue - 29.11.2022 - PM
	Health Tree Foundation Committee - NLAG Thur - 03.11.2022 - PM		PRIMS - NLAG - 17.11.2022	Finance & Performance Committee - NLAG Wed - 23.11.2022 - PM	Strategic Development Committee Wed - 30.11.2022 - AM
				Audit, Risk & Governance Committee - NLAG Thur - 24.11.2022 - PM	
December	Formal Trust Board - NLAG Tue - 06.12.2022	Strategic Development Committee Thur - 15.12.2022 - PM	Quality & Safety Committee - NLAG Tue - 20.12.2022 - PM		
	Appointments & Remuneration Committee Wed - 07.12.2022 - PM		Finance & Performance Committee - NLAG Wed - 21.12.2022 - PM		
			PRIMS - NLAG - 22.12.2022		

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NLG(21)282

DATE OF MEETING	7 December 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)185).

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 – December 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.