NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC MEETING

Tuesday, 2 February 2021 – Via MS Teams – 9.00 am – 12.15 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 (To receive and consider the learning and further actions required from a patient experience story)	Note	09:00 hrs	Verbal
2.	**Business Items**			
2.1	**Chair's Opening Remarks** Terry Moran, Chair (To note the Chair's opening remarks)	Note	09:10 hrs	Verbal
2.2	**Apologies for Absence** Terry Moran, Chair (To note apologies for absence)	Note		Verbal
2.3	**Declarations of Interest** Terry Moran, Chair (To note any declarations of interest in any of the agenda items)	Note		Verbal
2.3.1	**Updated Register of Directors' Interests** Helen Harris, Trust Secretary (To note the updated Register of Directors' Interests as at February 2021)	Note		NLG(21)023 Attached
2.3.2	**Chair's Annual Declaration** Terry Moran, Chair (To note the updated Chair's Annual Declaration)	Note		NLG(21)024 Attached
2.4	**To approve the minutes of the previous Public meeting held on the 4 January 2021** Terry Moran, Chair (To approve or amend the minutes of the January 2021 meeting)	Approve		NLG(21)025 Attached
2.5	**Urgent Matters Arising** Terry Moran, Chair (To discuss any matters arising from the minutes that are not on the agenda)	Note		Verbal
2.6	**Trust Board Action Log** Terry Moran, Chair (To consider progress against agreed actions agreed at the previous meetings)	Note		NLG(21)026 Attached

2.7	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive (To receive a report on relevant national, regional and local developments to note)	Note		NLG(21)027 Attached
2.8	**COVID-19 Briefing including NLAG Phase 3 Response (Appendix 1)** Shaun Stacey, Chief Operating Officer (To note updates in respect of COVID-19)	Note		NLG(21)028 Attached
3.	**Board Assurance**			
3.1	**Board Assurance Framework - Deep Dive Strategic Objective – Handling Emergencies** Shaun Stacey, Chief Operating Officer & Executive Directors (To review and challenge the board assurance framework and agree the need for any changes and / or remedial actions)	Note	09:40 hrs	NLG(21)029 Attached
4.	**Quality & Safety**			
4.1	**Quality & Safety Committee Highlight Report and Board Challenge including the Patient Impacts Update** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee & Dr Kate Wood, Medical Director (To report issues from the Quality & Safety Committee requiring escalation by exception to the Trust Board for discussion and agreement of any required actions)	Note	10:00 hrs	NLG(21)031 Attached
4.2	**Annual Safeguarding Report** Lynn Benefer, Acting Head of Safeguarding (To approve the Annual Safeguarding Report)	Approve	10:10 hrs	NLG(21)032 Attached
4.3	**Ockenden Review** Jane Warner, Head of Midwifery (To note the report and provide assurance)	Note	10:20 hrs	NLG(21)033 Attached
4.4	**Care Quality Commission (CQC) Progress** Dr Kate Wood, Medical Director & Lucy Kent, Associate Director of Compliance & Assurance (To report to the board the current CQC progress)	Note	10:30 hrs	NLG(21)034 Attached
	BREAK (5 minutes)			
5.	**Finance & Performance**			
5.1	**Finance & Performance Committee Highlight Report & Board Challenge – January 2021** Neil Gammon, Non-Executive Director & Chair of the Finance & Performance Committee (To report issues from the Finance & Performance Committee requiring escalation by exception to the Trust Board for discussion and agreement of any required actions)	Note	10:40 hrs	NLG(21)035 Attached
5.2	**Estates Strategy** Jug Johal, Director of Estates & Facilities (To approve the Estates Strategy)	Approve	10:45 hrs	NLG(21)036 Attached

5.3	**Annual Accounts – Delegation of Authority** Lee Bond, Chief Financial Officer (To approve the Annual Accounts – Delegation of Authority)	Approve	11:00 hrs	NLG(21)038 Attached
5.4	**Finance 2020 / 21 – Month 09** Lee Bond, Chief Financial Officer (To receive the report of the reported financial position at Month 09 of the 2020/21 reporting period and agree any additional actions required)	Note	11:10 hrs	NLG(21)039 Attached
5.5	**Integrated Performance Report** Shaun Stacey, Chief Operating Officer & Helen Harris, Trust Secretary (To note the Integrated Performance Report. Key indicators – including assurance about the actions and improvements being taken to recover areas of exception to expected performance)	Note	11:15 hrs	NLG(21)040 Attached
6.	**Leadership, Organisational Development & Culture**			
6.1	**Self Assessment Review – Health Education Engalnd** Christine Brereton, Director of People (To approve the Self Assessment Review – Health Education Engalnd)	Approve	11:25 hrs	NLG(21)042 Attached
6.2	**Workforce Report (including Flu Assessment)** Christine Brereton, Director of People (To provide an update from the People Directorate including approval of the Flu Self Assessment)	Note / Approve	11:30 hrs	NLG(21)043 Attached
6.3	**Freedom to Speak Up Guardian Quarterly Report** Liz Houchin, Freedom to Speak Up Guardian (To note the quarterly report)	Note	11:40 hrs	NLG(21)045 Attached
7.	**Audit, Risk & Governance Committee**			
7.1	**Audit, Risk & Governance Committee Highlight Report & Board Challenge – January 2021** Andrew Smith, Non-Executive Director & Chair of the Audit, Risk & Governance Committee (To report issues from the Audit, Risk & Governance Committee requiring escalation by exception to the Trust Board for discussion and agreement of any required actions)	Note	11:45 hrs	NLG(21)046 Attached
7.2	**Annual Review of Audit, Risk & Governance Committee Terms of Reference** Andrew Smith, Non-Executive Director & Chair of the Audit, Risk & Governance Committee (To formally approve the Audit, Risk & Governance Committee Terms of Reference)	Approve	11:50 hrs	NLG(21)047 Attached

8.	**Clinical Ethics Committee**			
8.1	**Clinical Ethics Committee Highlight Report & Board Challenge** Dr Kate Wood, Medical Director (To report issues from the Clinical Ethics Committee requiring escalation by exception to the Trust Board for discussion and agreement of any required actions)	Note	11:55 hrs	Verbal
9.	**Health Tree Foundation Trustees' Committee**			
9.1	**Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – November 2020** Neil Gammon, Non-Executive Director & Chair of the Health Tree Foundation Trustees' Committee (To report issues from the Health Tree Foundation Trustees' Committee requiring escalation by exception to the Trust Board for discussion and agreement of any required actions)	Note	12:00 hrs	NLG(21)049 Attached
10.	**Other Items for Approval**			
10.1	**Annual Review of Non-Executive Director Statutory & Other Lead** Helen Harris, Trust Secretary (To approve the Annual Review of Non-Executive Director Statutory & Other Lead Roles)	Approve	12:05 hrs	NLG(21)050 Attached
11.	**Items for Information / To Note (please refer to Appendix A)** Terry Moran, Chair (To note items for information)	Note		
12.	**Any Other Urgent Business** Terry Moran, Chair (To discuss any other urgent items of business)	Note	12:10 hrs	Verbal
13.	**Board Performance and Reflection** Terry Moran, Chair (To consider the performance of the Trust Board, including asking): • Has the Board focussed on the appropriate agenda items? Are there any item(s) missing or not given enough attention? • Where appropriate, have relevant items been debated at the relevant Board assurance Sub-Committee prior to being submitted to the Trust Board? • Are Board members satisfied with the quality of papers: - Is the purpose and content clear? - Are papers clear on the Board action required?	Note		NLG(21)051 Attached

14.	**Date and Time of the Next Meeting:** Terry Moran, Chair (To note the date and time of the next meeting) **Trust Board Development Session** Tuesday, 2 March 2021 & Tuesday, 16 March, Times TBC By Video Conference **Formal Trust Board Meeting** Tuesday, 6 April 2021, Time TBC By Video Conference	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.

11.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
11.1	**Finance & Performance Committee Minutes – August & September 2020** Neil Gammon, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(21)052 Attached
	Audit, Risk & Governance Committee	
11.2	**Audit, Risk & Governance Committee Minutes – October 2020** Andrew Smith, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(21)053 Attached
11.3	**Self-Assessment Exercise – January 2021** Andrew Smith, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(21)054 Attached
	Health Tree Foundation Trustees' Committee	
11.4	**Health Tree Foundation Trustees' Committee Minutes – September 2021** Neil Gammon, Non-Executive Director & Chair of the Health Tree Foundation Trustees' Committee	NLG(21)055 Attached
	Other	
11.5	**Documents Signed Under Seal** Helen Harris, Trust Secretary	NLG(21)056 Attached
11.6	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(21)057 Attached

NLG(21)023

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	2 February 2021				
REPORT FOR	Trust Board of Directors – Public Meeting				
REPORT FROM	Helen Harris, Trust Secretary				
CONTACT OFFICER	Alison Hurley, Membership Manager & Assistant Trust Secretary				
SUBJECT	Updated Register of Directors' Interests				
BACKGROUND DOCUMENT (if any)	Trust Constitution (Paragraph 33)				
PURPOSE OF REPORT	For Assurance				
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A				
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The report provides the updated Register of Directors' Interests as at February 2021				
ACTION REQUIRED					
Approval	**Information**	**Discussion**	**Assurance**	**Review**	
LINK TO STRATEGIC OBJECTIVES					
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**	
TRUST PRIORITIES					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**
BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	11 - Risk of insufficient investment and development of the Trust's leadership (including clinical leadership) – capacity and capability.				
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: Note the report.				

Northern Lincolnshire and Goole NHS Foundation Trust

REGISTER OF DIRECTORS' INTERESTS
Updated as at January 2021 (v1)

NAME & POSITION	INTERESTS	DATE
Terry Moran, Chair	➢ Chair, Hull University Teaching Hospitals NHS Trust ➢ Chair, SLP College Charity ➢ Trustee, Cat Zero Charity	05.11.2020
Linda Jackson, Vice Chair	➢ Associate NED at Hull University Teaching Hospitals NHS Trust ➢ Both Sister and Sister-in-law works at DPoW (in Women's and Children division)	30.11.2020
Dr Peter Reading, Chief Executive	➢ Spouse of Dr Catherine Reading, Director, Catherine Reading Limited ➢ Company Secretary of spouses company, Catherine Reading Limited ➢ Director ex officio as Trust CEO of WebV Solutions Ltd ➢ Director ex officio as Trust CEO Together Plc	21.12.2020
Lee Bond, Interim Director of Finance	➢ Chief Finance Officer and Deputy Chief Executive Officer at Hull University Teaching Hospitals ➢ Trustee of WISHH Charity ➢ Vice President, Healthcare Financial Management Association (HFMA)	29.10.2020
Ellie Monkhouse, Chief Nurse	➢ Husband is foot and ankle Consultant Orthopedic Surgeon at Leeds Teaching Hospitals	16.11.2020
Shaun Stacey, Director of Operations	➢ None	04.11.2020
Dr Kate Wood, Medical Director	➢ Husband is Trust employee (Theatre Manager, DPoWH)	04.11.2020
Christine Brereton, Director of People (non-voting director)	➢ Partner is currently working in the Humber Coast and Vale as the Integrated Care System Finance Lead and working with the Trust's Chief Financial Officer	26.01.2021
Helen Harris, Trust Secretary	➢ Member of Patient Participation Group, central Surgery, Barton-upon-Humber (NLCCG)	04.11.2020
Jug Johal, Director of Estates & Facilities (non-voting director)	➢ Chairman, Asian Sports Foundation	05.11.2020

NAME & POSITION	INTERESTS	DATE
Ivan McConnell, Director Of Strategic Development (non-voting director)	➢ None	16.11.2020
Shauna McMahan, Chief Information Officer	➢ None	22.10.2020
Tony Bramley, Non-Executive Director	➢ None	04.11.2020
Neil Gammon, Non-Executive Director	➢ Governor of Grimsby Institute of Further & Higher Education (GIFHE)	04.11.2020
Stuart Hall, Associate Non-Executive Director	➢ Non –Executive/Vice Chair, Hull University Teaching Hospitals NHS Trust	16.11.2020
Michael Proctor, Non-Executive Director	➢ Non-Executive Chair of Conclusion (Health Care Consultancy).	21.01.2021
Andrew Smith, Associate Non-Executive Director	➢ 100% shareholder and sole Director of First Advisory Services Ltd my personal service company – no NHS involvement	10.11.2020
Michael Whitworth, Non-Executive Director	➢ Interim Chief Executive Officer of Barnet Federated GPs (part-time) ➢ Owner/Director of Michael Whitworth Consultancy Ltd – this has been inactive since the summer of 2019 and is currently inactive and in the process of being wound up ➢ I have been asked by NSHE/I to be a part-time advisor to the Finance Workstream of the Flu and COVID-19 Vaccination Programme. The expectation is that this role will be remunerated	16.10.2020
Ade Beddows, Associate Director of Communications	➢ None	17.11.2020

NLG(21)024

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	2 February 2021
REPORT FOR	Trust Board
REPORT FROM	Terry Moran, Trust Chair
CONTACT OFFICER	Helen Harris, Trust Secretary
SUBJECT	Fit and Proper Persons Test: Chair's Annual Declaration
BACKGROUND DOCUMENT (if any)	N/A
PURPOSE OF THE REPORT	The report provides the Chair's Annual Declaration in respect of compliance with the Fit & Proper Persons Test by those individuals who are board directors, board members and individuals who perform the functions equivalent to the functions of a board director and member.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	All existing board directors, board members and individuals who perform the functions equivalent to the functions of a board director and member (both permanent and interim), as defined within the Trust's Fit and Proper Persons Policy, meet the requirements of the Fit and Proper Persons Test.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Risk to strategic objective: 11) Risk of insufficient investment and development of the Trust's leadership (including clinical leadership) - capacity and capability
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report

Fit and Proper Persons Requirements: Chair's Annual Declaration

In line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust is required to ensure that all relevant individuals meet the requirements of the Fit and Proper Persons Test (Regulation 5).

Regulation 5 recognises that individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care. For the purpose of this regulation, these individuals are board directors, board members and individuals who perform the functions equivalent to the functions of a board director and member (whether existing, interim or permanent and irrespective of their voting rights).

Regulation 5 states that a provider must not appoint or have in place an individual as a director who:

- is not of good character;
- does not have the necessary qualifications, competence, skills and experience;
- is not physically and mentally fit (after adjustments) to perform their duties.

Regulation 5 also decrees that these individuals cannot have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or discharging any functions relating to any office or employment with a service provider.

These requirements play a major part in ensuring the accountability of leaders of NHS bodies and outline the requirements for robust recruitment & employment, appraisal and performance management processes for Board level appointments and for ensuring that there are appropriate checks that leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis.

As Chair of Northern Lincolnshire and Goole NHS Foundation Trust, I confirm that all existing board directors, board members and individuals who perform the functions equivalent to the functions of a board director and member (both permanent and interim), as defined within the Trust's Fit and Proper Persons Policy, meet the requirements of the Fit and Proper Persons Test. My declaration has been informed by:

- the annual Fit and Proper Persons Test self-declarations completed by all board directors, board members and individuals who perform the functions equivalent to the functions of a board director and member;
- the outcome of the 2019/20 annual appraisals of those individuals and the agreement of objectives and, where required, the agreement of personal development plans;
- monitoring of sickness absence;
- monitoring of mandatory training compliance;
- sample testing (100%) of files of the relevant individuals against the Trust's Fit and Proper Persons Policy; specifically the Fit and Proper Persons checks required on recruitment and those required on an ongoing basis, to ensure capture of the required information and assurances.

Terry Moran CB
Chair
January 2021

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 5 January 2021 at 9.00 am
Via Video Conference

For the purpose of transacting the business set out below:

Present:

Mr Terry Moran CB	Chair
Dr Peter Reading	Chief Executive
Mr Lee Bond	Chief Finance Officer
Dr Kate Wood	Medical Director
Mr Shaun Stacey	Chief Operating Officer
Mrs Linda Jackson	Vice Chair
Mr Anthony Bramley	Non-Executive Director
Mr Neil Gammon	Non-Executive Director
Mr Michael Proctor	Non-Executive Director
Mr Michael Whitworth	Non-Executive Director

In Attendance:

Mr Sakkaf Ahmed Aftab	Consultant Ophthalmologist
Mr Adrian Beddow	Associate Director of Communications
Mrs Christine Brereton	Director of People
Mrs Elaine Criddle	Deputy Improvement Director
Mr Stuart Hall	Associate Non-Executive Director
Mrs Helen Harris	Trust Secretary
Mrs Jenny Hinchliffe	Deputy Chief Nurse
Mrs Alison Hurley	Membership Manager & Assistant Trust Secretary
Mr Jug Johal	Director of Estates & Facilities
Ms Claire Low	Deputy Director of People
Mr Ivan McConnell	Director of Strategic Development
Mr James McHale	Strategic Relationship Manager – East Midlands and Yorkshire Wound Management
Mrs Shauna McMahon	Chief Information Officer
Mr Ian Reekie	Lead Governor
Mr Andrew Smith	Associate Non-Executive Director
Mrs Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Trust Secretary (note taker)

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

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

1. Business Items

1.1 Chair's Opening Remarks

Terry Moran welcomed Board members to the meeting and declared it open at 09.00 hours.

Terry Moran advised that due to the previous evening's announcement of a further lockdown a decision had been made to postpone today's Trust Board Development Session. Although the session was noted as being essential and very important it was felt the added pressure of the lockdown could lead to additional pressures on staff. It was confirmed the session would be rearranged as soon as practically possible.

Terry Moran welcomed the new Director of People, Christine Brereton to the Trust and explained the vast previous experience gained by Christine Brereton from working across the NHS in Acute and Ambulance Services.

Terry Moran advised the Trust were still operating under the revised governance arrangements due to COVID-19 and this would be in place until the end of January 2021, at this point it would be reviewed to formally agree whether normal governance arrangements should resume from February 2021. The decision would be formally ratified by the Trust Board at the meeting due to be held on the 2 February 2021.

During these difficult times Terry Moran wanted everyone to ensure that they carried on offering kindness and support to one another. However, if difficult conversations needed to take place this should still ensue whilst ensuring the Trust Vision and Values were upheld.

1.2 Apologies for Absence

Apologies for absence were received from Ellie Monkhouse who was represented by Jenny Hinchliffe, Deputy Chief Nurse.

1.3 Declarations of Interest

Terry Moran requested any declarations of interest in relation to the business to be transacted. No declarations of interests were declared at this point but it was agreed to add Christine Brereton to the register.

1.4 To approve the minutes of the Public Meeting held on Tuesday, 1 December 2020 – NLG(21)001

The minutes of the meeting held on the 1 December 2020 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendment had been made.

- Jug Johal referred to page two of the minutes and asked for an amendment to the final paragraph “difficulties with the supply of oxygen” to read “difficulties with the oxygen system capacity”.

1.5 Urgent Matters Arising

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

Neil Gammon referred to page seven of the minutes in terms of lessons learnt which related to the Trust’s November 2020 12 hour breaches and sought an update. Shaun Stacey advised a number of issues had been highlighted from those breaches which related to escalation and communication, and the way the system in Accident & Emergency (A&E) recorded accurate timings of each patient flow stage. This also related to some data issues around recording admissions onto wards. All issues were to be reviewed to prevent a repeat occurrence of the situation. All December breaches were currently being reviewed.

Stuart Hall referred to paragraph three on page eight of the minutes, which highlighted that General Practitioners (GPs) had been invited to take part in the validation process. A query was raised as to whether the current situation with vaccination rollout to GPs would impact on their ability to take part in the validation process. Shaun Stacey advised the programme being ran was “Connected to Health” which had been well received and was currently being piloted. Some funds had been received to implement the process which was now being rolled at a faster pace. This was in addition to the rollout of the vaccine programme and would continue alongside that at present.

Elaine Criddle advised a meeting had taken place on 4 January 2021 to consider the programme commencement, and had been attended by GPs and Jackie France – Head of Patient Administration, who was leading the project. This issue had been queried at the meeting and it was clarified that a number of retired GPs were

interested in the risk stratification work and not the vaccine programme, so it was hoped this would commence on 11 January 2021.

1.6 Trust Board Action Log – Public by exception NLG(21)002

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

1.7 COVID-19 Trust Board Decision Log: Use of Emergency Powers and Matters Deferred or Dealt with via a Different Route – NLG(21)003

Terry Moran referred to two items that were due for review in January 2021 and queried whether they needed to remain on the paper. One item was in respect of the Staffing Report and the second the Nursing Assurance Report. Claire Low advised the staffing report was still being addressed. Jenny Hinchliffe confirmed the details of the Nursing Assurance Report were included within the Patient Impacts Paper. It was agreed the Nursing Assurance Report could be removed from the Decision Log.

Action: Sarah Meggitt

1.8 Chief Executive's Briefing – NLG(21)004

Dr Peter Reading highlighted the importance of the issues and work Trust staff had been faced with. Sickness levels continued to fluctuate and had reduced slightly after the report had been shared, although they remained high. Staff were being thanked on a regular basis for the work they were doing and in such difficult circumstances.

On the morning of the meeting, the Trust had launched the COVID-19 vaccination programme at the Scunthorpe site and Dr Peter Reading had attended in person to offer support. This remarkable exercise had been very impressive and co-ordinated very efficiently. The region was currently at the bottom of the league table for COVID-19 positive cases after previously being one of the highest numbers. Trust inpatients had also declined but there was concern that Wave three may impact soon due to the Christmas period. Dr Peter Reading advised the Trust continued with "business as usual" in respect of operational areas, with elective and cancer patients continuing to be treated. This included the capital programme due to commence the critical work of the Digital Strategy and the Humber Acute Services Review (HASR). The quality agenda continued to be driven by Dr Kate Wood and Ellie Monkhouse; which included the response to the Ockenden Review and the Care Quality Commission (CQC).

Terry Moran thanked Dr Peter Reading and advised that Trust Board colleagues had met in December to consider the Ockenden Review which would be covered again within the meeting. Comments or questions were sought in respect of Dr Peter Reading's update. No comments were received.

2. Urgent Items for Discussion

2.1 COVID-19: planning and preparedness including key risks arising and decisions required by the Trust Board

Dr Peter Reading confirmed no additional updates were required as items were covered within the agenda items.

2.1.1 Highlight Report from the Ethics Committee – NLG(21)005

Dr Kate Wood thanked those people who had supported the Ethics Committee and asked Board members to note the report and the work completed to date. The Terms of Reference required approval in addition to agreement from the Board as to whether the committee should remain after the pandemic.

Tony Bramley referred to current governance arrangements in terms of the Audit, Risk & Governance Committee (AR&GC) having oversight of other sub-committees and whether the Ethics Committee should be included. Members of the Trust Board agreed to this proposal.

Mike Proctor highlighted that the Ethics Committee had met on a weekly basis but it had been agreed this was no longer required unless urgent issues required discussion and that the committee should continue after the pandemic to review any ethical issues that may arise. Neil Gammon suggested the committee should take place on an ad-hoc basis after the pandemic and be publicised within the Trust, which may attract staff with experience of ethical issues that could support the committee.

Dr Peter Reading suggested the Terms of Reference be reviewed and strengthened. Greater guidance was also required to determine what are difficult management decisions opposed to ethical issues, and the committee would need to be managed and governed similarly to other Trust Board committees.

Dr Kate Wood confirmed the committee had been very effective during the first wave of the pandemic but operational issues had taken over discussion during the second wave and it had been agreed to stand it down unless urgent issues arose.

It was noted that the Terms of Reference would state that if the committee had not met within three months a decision would be taken as to whether it remained relevant and if further meetings would be required.

ACTION: Dr Kate Wood

Terry Moran noted the highlight report and queried whether Board members wanted to speak against approval with the qualification of the proposal to review the Terms of Reference. It was agreed for the AR&GC to have oversight of the Ethics Committee Terms of Reference. No further comments were received.

2.2 Our patient impacts: quality & safety issues and progress against relevant priorities including the Trust's response to the CQC 'must dos', key risks arising and decisions required – NLG(21)006

Terry Moran highlighted that the quality of papers and focus on priorities had improved in standard during the revised governance arrangements. It was requested that when governance arrangements reverted back to normal, these benefits and lessons learned should be maintained.

Mike Proctor advised the paper was jointly owned by Dr Kate Wood and Ellie Monkhouse and provided an overview of the current risks in respect of the quality and safety issues in relation to patient care during the pandemic. It allowed the Quality and Safety Committee (Q&SC) to understand and challenge the mitigations in place to manage any risks.

Shaun Stacey advised the referral to treatment (RTT) and cancer performance positions had changed and was now at 70% for cancer, the RTT performance was 63%. The latest data received to the end of November showed the Trust had achieved 85% on overall performance.

The Trust had fallen behind on day cases and outpatient performance, although the wave three recovery position had been achieved and was 90% of its planned activity overall.

Linda Jackson referred to the lack of capacity within radiology to risk stratify patients on the diagnostic waiting list, and queried whether feedback had been received from the validation team in respect of this issue. The second query related to whether support was to be obtained from the Independent Sector in relation to the cancer surgery position as at 15 December, which was at 40% compared to the previous year position.

Shaun Stacey confirmed diagnostics remained a challenge due to the processes required; however, patients were still risk stratified at the start of their journey in addition to the clinical teams. The Trust was awaiting advice from the centre on how the improvements could be made with the risk approach to diagnostics.

Dr Kate Wood confirmed radiology patients were risk stratified at the start of their journey and as with the previous process patients were reviewed to ensure they had not come to harm. Those that did have delayed diagnosis were patients that had received an incidental diagnosis during other investigations. In respect of cancer patients, all waiting lists had been prioritised and those that were priority two had been allocated. All elective activity continued only at Goole District Hospital, St Hugh's and Grimsby hospital due to risks at the Scunthorpe hospital site. To ensure major cancer surgery continued, a hobs facility had been introduced at Goole along with St Hugh's Hospital. In terms of the Grimsby site, beds were now "ring fenced" to ensure elective surgery continued. The ICS contract had changed at the end of December 2020 and there were a number of lists available but not as many as previously available. Other organisations were also struggling to care for priority two patients.

Shaun Stacey referred to the 52 week patients and confirmed they had increased along with 40 week patients. The Trust currently had 185 patients waiting over 62 days to receive an outcome and diagnosis on their cancer treatment. There had also been four patients who had waited over 104 days for treatment. The re-establishment of the Goole site for elective treatment this week would benefit the Trust greatly.

Neil Gammon referred to the risk stratification of patients as greater assurance was required for the Board to feel confident. There also appeared to be no consistent uniformed approach within the specialties and queried whether patients on the waiting list had been written to by the 31 December 2020 deadline. Dr Kate Wood advised the Trust could not provide assurance on the risk stratification of the follow-up waiting lists, and confirmed this had not been provided previously. All patients who were on the inpatient waiting lists had been risk stratified, and this could be evidenced. Dr Kate Wood apologised if confusion had been caused with the information provided.

Shaun Stacey confirmed all patients on the waiting list had been written to by the deadline and the information received was being collated. The Trust did have a summary report on risk stratification for the inpatient and outpatient waiting list, and the report would be provided in future. It was confirmed that any patient who attended a new outpatient or follow up episode had a completed risk stratification as part of the process.

Terry Moran felt the concerns raised could be in relation to the current governance arrangements as Board members had not received information due to sub-committees being stood down. It highlighted the need to re-instate committees going forward to provide a greater level of assurance.

Andrew Smith agreed that the current level of information provided within reports did not provide enough assurance and more would be required in future. Dr Kate Wood noted the information provided was complex and recognised it required greater clarity. The Trust had spent several years interrogating the waiting lists to ensure transparency was evident on how long patients were waiting, and this remained an ongoing process. It was recognised that waiting list comparisons were not very effective as waiting lists were often constructed differently in other Trusts. It was agreed that Shaun Stacey, Dr Kate Wood and Ellie Monkhouse would work together to provide further assurance. It was noted the Trust was a major outlier in terms of ambulance handover and 12 hour breaches, however, the care of patients in Accident & Emergency (A&E) remained the primary priority.

ACTION: Dr Kate Wood, Ellie Monkhouse, Shaun Stacey

Dr Kate Wood clarified that in respect of assurance an email had been received. Key points from the CQC email were highlighted and it was agreed to circulate the email to Board members.

ACTION: Dr Kate Wood

Mike Proctor felt the Trust was currently missing assurance in terms of performance due to the F&PC not being held. In terms of how other organisations were performing, it was confirmed that information could be obtained through Public View on line.

Terry Moran wanted to note that the queries raised had been appropriate and the Executive Directors had answered them with openness. It was recognised normal governance may need to be stood back up in February 2021.

Terry Moran thanked everyone for the very important discussions, Non-Executive Director (NED) challenge and Executive Director updates on this item, and confirmed that the current governance arrangements would be reviewed as discussed earlier in the meeting.

2.2.1 Response to the Ockenden Report – NLG(21)008

Terry Moran highlighted the national request for the Trust to respond to a letter received in December 2020. There would be a need nationally to learn from the Ockenden maternity services report provided due to the concerns raised and actions that would be required.

Jenny Hinchliffe advised the Trust had met five out of the seven standards to date, and audit work was now underway to provide further assurance on those not met. Further information was required for submission by the 15 January 2021, and the response would also be discussed during the Q&SC. Improvements had been made in terms of the introduction of a monthly Maternity Transformation Board which would replace the original Maternity Steering Group meeting.

Dr Kate Wood advised Lucy Kent was supporting the process in respect of providing assurance and the monitoring of action plans that included evidencing risks and the associated mitigations.

Terry Moran queried with Dr Kate Wood and Jenny Hinchliffe if they had any further concerns with the service that should be noted at the meeting. Dr Kate Wood felt there was a need to show the evidence requirements within each area. Some of the issues within the report could not be completed locally which would mean a regional response, as some of the issues related to the management of complex pregnancies which were supported by, Sheffield Teaching Hospital NHS Foundation Trust and their guidance would be sought on this. Jenny Hinchliffe confirmed there was confidence in the requirements to be implemented and there were no concerns from a nursing perspective. Dr Peter Reading provided an overview of key requirements and how these would be addressed. The Trust had been selected in 2020 for an intensive support improvement programme which included support from Katie Chilton who already worked with the team.

Tony Bramley confirmed the Q&SC had deliberated the response and was assured that following appropriate challenge, the response was appropriate. Maternity Services had experienced difficulties in the past and the Trust had previously received assurance which may not have been robust, so this had also been discussed. Mike Proctor advised the Q&SC would review the next iteration and

there would also be a further meeting for the control and challenge team of the response. Terry Moran clarified Mike Proctor was the Non-Executive (NED) lead for the review.

Lee Bond queried whether there would be hidden financial consequences along with the submission of a business case. It was noted that the Maternity Incentive Scheme referred to the Clinical Negligence Scheme for Trusts (CNST) monies being utilised to improve patient safety but was unaware of a separate amount of funds for maternity training. Terry Moran agreed with Lee Bond's point on what funds would be required to put the required actions in place. Dr Kate Wood explained that once costs were available they would be shared with Lee Bond, and confirmed that an important issue raised was in respect of twice daily consultant ward rounds, which the Trust already had in place.

Terry Moran thanked colleagues for the work undertaken in providing the response by the required deadlines.

2.3 Our people impacts: resilience, safe staffing, absences, progress against relevant priorities, key risks arising and decisions required by the Trust Board – NLG(21)009

Claire Low explained the risk assessment tool had been utilised as a guide for which staff required the COVID-19 vaccinations as a priority. In total 92 vaccinations would be given to staff during the week. As the vaccinations were currently being provided at the Scunthorpe site, equipment had been ordered so this could also be rolled out at Grimsby.

Lateral flow tests continued to be undertaken by staff but some had not received the kits yet, and a targeted distribution would be established to capture those members of staff. The system was proving effective and some staff had tested positive along with a further positive confirmation from the Polymerase Chain Reaction (PCR) process. There may be further challenges in light of the lockdown restrictions announced due to staff struggling with childcare, and a greater need for staff to work at home.

Dr Peter Reading personally thanked the staff who had been involved in successfully rolling out the vaccination and lateral flow test programmes. An issue had been raised nationally due to when the second Pfizer vaccine should be given, and it was explained that the Trust was working to the current national guidance of a 12 week gap.

Lee Bond queried whether the increased budget establishment by 31 whole time equivalent (wte) posts which would equate to approximately £1.5 million, had been approved or whether it was incorrect. There were significant numbers of unregistered nurse vacancies referred to in the report, with a plan to achieve zero vacancies but a target date was not provided. In addition agile working was not due to be reviewed sooner than five months as a number of staff were already working at home due to the pandemic. Claire Low advised the establishment figures were provided by recruitment and sought advice from Jenny Hinchliffe as to whether this was a true reflection. Jenny Hinchliffe was unable to confirm this and agreed to

review the figures. Terry Moran requested this be discussed and confirmed outside of the meeting.

ACTION: Claire Low and Jenny Hinchliffe

Claire Low provided an update on the work with the Indeed employment organisation to address the Health Care Assistant (HCA) vacancy rates. Jenny Hinchliffe confirmed the aim was to achieve zero vacancies for HCA staff by the end of March 2021 in line with the additional support and funding received. Claire Low agreed that the Agile Working Policy required immediate review to support the current establishment of agile working arrangements. Christine Brereton concurred and advised the People Directorate had various priorities which required review and this would be included in such discussions.

Neil Gammon queried what the most up to date figure was for the flu vaccination uptake; Claire Low advised this was currently 71%.

Linda Jackson queried whether back office staff who may have been at home working through the pandemic would be offered a COVID-19 vaccination prior to front line staff due to their risk assessment score, and whether there was a directive to make this decision. Claire Low advised those who had scored six or above had been contacted to book an appointment for the vaccine. Those staff shielding may not always be the ones who had been identified as high risk so would not necessarily be offered the vaccine first. Terry Moran declared that due to his personal risk assessment score he had received an invite to book in for the vaccine, however, had declined the invite to allow a front line member of staff to receive the vaccine first. This had been a personal choice, and thanks were again given to the staff who had mobilised the vaccination programme so quickly.

2.3.1 Risk Assessments for Staff – NLG(21)010

Members received the Risk Assessment for Staff report. Claire Low advised the paper discussed the option of allowing staff who had scored six on their risk assessment to be allowed to continue working in an ‘at risk’ area by signing a waiver with consent from their manager.

The advice received from NHSE/I was that it was a Board decision as it was a localised arrangement. Dr Kate Wood queried how many risk assessments were now outstanding, and it was confirmed there were 186 from a Black, Asian and Minority Ethnicity (BAME) perspective. Dr Peter Reading advised this had been discussed in great detail at the Trust Management Board (TMB) meeting and that on an advisory basis they had sought the opinion of attendees via a show of hands. The majority had voted in favour of introducing a waiver, which included clinicians. Dr Peter Reading’s personal view was that this should not be agreed as the Trust had a legal and moral responsibility for the health and wellbeing of its staff. Legal advice should be followed and not overridden with a waiver. The legal advice offered had been that a discussion should be undertaken with staff at risk to redeploy them to other areas where possible.

Terry Moran referred to the sensitive nature of this issue in respect of the legal and

health and safety issues that would surround such a decision, as well as the personal wishes of staff.

Terry Moran advised that if a vote by Board members was required this would be undertaken.

Tony Bramley agreed with the proposal of not introducing the waiver due to the importance of keeping staff safe and confirmed the intention to vote against this approach was required. It was suggested that all staff should complete a risk assessment which should then be a mandatory matter for managers to address. Mike Proctor concurred.

Dr Kate Wood queried whether mandatory risk assessments would be a legal obligation or an organisational mandatory requirement, and whether vaccination would change risk assessments scores. Terry Moran sought advice from Claire Low and Christine Brereton but felt all staff should undertake appropriate risk assessments. Claire Low advised the organisation had a liability from an employer perspective under the Health and Safety Act. The Trust was also measured in terms of how many staff had undertaken the risk assessment. Christine Brereton advised there had been an issue as to whether staff had to comply with completing a risk assessment.

Dr Kate Wood queried what the organisation could do if an employee did not complete the assessment. Terry Moran requested this be reviewed further to establish confirmation as to whether this was a voluntary or legal requirement for staff to comply. Decisions of Board members were being noted in the chat box and the opinion was to not support the waiver but that risk assessments should be completed by all staff. Board members were asked if they had an alternative view and felt staff should be able to sign a waiver. No comments were received.

Christine Brereton felt individuals should be given support to actively redeploy them in any way possible.

Dr Kate Wood raised a concern in respect of risk assessments being mandatory, and whether managers would be held responsible. Terry Moran suggested this was an obligation of the employer for them to be completed, and clarity was required for how this was managed including whether it should be mandatory. Terry Moran referred to the need for other emergency services to also complete such risk assessments. Christine Brereton suggested that if individual risk assessments were unable to be completed then a generic assessment could be completed in certain areas and agreed to review this outside of the meeting so that assurance could be provided.

ACTION: Christine Brereton

Dr Peter Reading suggested the Trust Board needed to review these expectations in terms of risk assessments and whether they could be universally applied, which included whether managers should be expected to ensure every assessment was completed or to ensure every attempt should be made to complete it.

Shaun Stacey highlighted the need to identify and evidence why staff were not

completing the risk assessments. Claire Low confirmed a record was taken of staff who had declined to complete the risk assessment. It was highlighted that anecdotal information suggested some staff feared redeployment and was a reason for not completing it.

Terry Moran confirmed the waiver would not be supported, and the need for the Trust to establish the legal obligation and responsibilities around risk assessments not being undertaken. The Trust could then determine appropriate guidance on these responsibilities. Terry Moran did not feel this would normally be a Board decision.

The Trust Board were in agreement.

2.4 Our financial impacts: progress against relevant priorities, key risks arising and decisions required by the Trust Board – NLG(21)011

Lee Bond clarified that month nine would be reviewed in the next few weeks along with capital funding. A letter had been received prior to Christmas in respect of future financial readiness which referenced the financial framework for 2021/22 and indicated a move to traditional financial allocations to contracts. Some items were missing within the framework in respect of funds that would be available in terms of COVID-19 and the recovery of waiting lists funds.

Terry Moran referred to potential penalties for electives and whether this had been resolved. Lee Bond advised a letter had been received which had calculated the September position, and explained that in September the Integrated Care System had split into York and North Yorkshire; and Humber areas but no adjustment had been made in the Humber area.

Stuart Hall referred to the cost of the vaccination programme, and whether funds would be received for the loss of activity of staff redeployed to other roles. Lee Bond advised no funding would be received as staff had been redeployed to manage these requirements.

3. Urgent Items for Approval

3.1 Digital Strategy - NLG(21)012

Members reviewed the Digital Strategy. Shauna McMahon explained that Board approval was being sought and confirmed an update could be provided to individuals outside of the meeting if required.

Andrew Smith queried how much attention had been given to data security. Shauna McMahon advised a cyber security specialist had been recruited and the Trust continued to work through the standards. Details of cyber security would also be discussed at the AR&GC.

Stuart Hall queried if anything had been planned in respect of educational opportunities for staff to be knowledgeable in all areas and would the Trust receive additional funding for the predictive patient and activity analysis. Shaun McMahon

advised that the appendices included information around data collected in respect of digital skills. This area had scored high but required additional support in some areas of the community. In respect of predictive analysis, the Trust still needed to progress forward with this.

Tony Bramley queried where the oversight was for the delivery of the strategy and how the governance would be managed. Terry Moran suggested this should come to the Trust Board and requested the Executive Team review this to establish the appropriate scrutiny and oversight.

ACTION: Executive Team

Dr Peter Reading thanked and congratulated Shauna McMahon on the excellent work undertaken to date. The need to consider choices about such Trust strategies to allow the Trust Board to rank their priority was noted, along with the associated monitoring. Dr Peter Reading stated his view that the Digital Strategy should be rated as a high priority. There would be a need to come back to the Trust Board for an implementation plan on strategies for agreement. The Trust Board agreed to support the Digital Strategy.

4. Any Other Urgent Business

Terry Moran queried whether there was any other urgent business that needed to be raised. No items were raised.

Terry Moran advised this would be Tony Bramley's last meeting as a NED at the Trust and gave thanks for the work undertaken during this time. The support offered along with input into particular issues had been very strong and this would be missed. Tony Bramley thanked Terry Moran for the feedback and felt the Trust would move forward in a positive way, and confirmed the experience of the role had been enjoyable. Terry Moran advised the Trust were in the process of appointing a NED to replace Neil Gammon.

Terry Moran also thanked Claire Low for all the support provided during the time of acting up in the Director role. As Christine Brereton was now in post Claire Low would take up the Deputy Director role.

Terry Moran sought comments or questions in relation to the meeting from members of the public in attendance. Mr Aftab highlighted that issues may arise in respect of the second dose of the Pfizer vaccine. Mr Aftab referred to the earlier discussions and advised a meeting had taken place that morning in respect of COVID-19 risk assessments by Professor Chris Witty, however, an outcome of the meeting had not yet been received. The reason for highlighting this was to inform the Trust Board that further implications may arise from this. Terry Moran thanked Mr Aftab for raising these points with the Trust Board. Terry Moran advised further discussion at the Trust Board would be undertaken if required.

5. Date and Time of the next meeting

Formal Trust Board Meeting
Tuesday, 2 February 2021
Time: TBC
Via video conference

The Private Trust Board meeting was due to follow at 12.00 hours via video conference

Terry Moran closed the meeting at 11.58 hours.

NLG(21)026

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2020/2021

Kindness · Courage · Respect

ACTION LOG & TRACKER

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Board Public Meeting

2020/21

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
3.1	04.01.2021	Digital Strategy		Executive team to consider where the oversight should sit for the delivery of the Digital Strategy	Shauna McMahon	Feb-21	Update to be provided at the February 2021 Trust Board meeting.	On Track		
2.3.1	04.01.2021	Risk Assessments for Staff		Clarification to be provided as to whether a generic risk assessment would be sufficient in circumstances where an individual Risk Assessment was unable to be completed	Christine Brereton	Feb-21	Update to be provided at the February 2021 Trust Board meeting.	On Track		

Key:

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

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Public Meeting

2020

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

Key:

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

NLG(21)027

DATE	2 February 2021
REPORT FOR	Trust Board
REPORT FROM	Peter Reading, Chief Executive
CONTACT OFFICER	Peter Reading, Chief Executive
SUBJECT	Chief Executive's Briefing
BACKGROUND DOCUMENT (if any)	N/A
PURPOSE OF THE REPORT	To present a briefing from the Chief Executive and provide an overview on key matters.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The report details an overview of the following: • Pandemic impact (including impact on staff) • Reducing bureaucratic burden to release capacity (App 1) • EU Exit • Chief Midwifery Officer virtual visit • Humber Coast & Vale HCP developments • Building work and parking issues • Health Tree Foundation – national funding

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	• Achievement of the constitutional performance targets. • Risk of non-delivery of agreed quality and clinical improvements. • Adverse impact of external events on business continuity.
BOARD ACTION REQUIRED	The Trust Board is asked to note the report.

Chief Executive's Overview

Pandemic impact (including staff impact)

The number of Covid-positive inpatients remains higher than at the peak of Wave 1, but has been relatively stable for several weeks and is lower than half the peak level in Wave 2. Northern Lincolnshire and the East Riding of Yorkshire have been experiencing lower than national prevalence rates for Covid for several weeks, and these rates continue to decline.

The Trust began vaccinating its staff with the Pfizer vaccine on 5 January at SGH and for the last three weeks it has been vaccinating its staff and staff from partners in the local health and care system at both SGH and DPOW. To date, approximately 8,000 vaccinations have been administered. The Trust works strictly to national (Joint Committee on Vaccination and Immunisation) guidelines on which staff to vaccinate.

The Trust has been offering 'Mutual Aid' in the form of access to operating and/or bed capacity at its Goole site since mid-January, initially just to Hull and latterly to York hospitals. This is part of the national and local system of inter-hospital support to optimise the NHS's response to the pandemic and to the needs of high priority cancer and elective patients.

It is important again to recognise and praise the continued extraordinary efforts, commitment and dedication of our staff, and to acknowledge the stress and strain that continuing to serve our patients in the current context puts on them. The Board should once again than our staff for the burden they are carrying so stoically.

Reducing bureaucratic burden to release capacity (App 1)

At Appendix 1 is a letter to all CEOs from Amanda Pritchard, Chief Operating Officer of NHSE/I, advising the NHS how the burden of bureaucracy may be reduced in various ways to release capacity for pandemic response. The Board is invited to discuss possible implications for the way the Trust conducts its business over the coming months.

EU Exit

Following December agreement between the UK and the EU, there has been no observable adverse impact on the Trust of the final stage of EU Exit.

A Regional workshop is being convened of the Integrated Care System (ICS) EU Exit Leads from across the North East and Yorkshire to consider what the medium term impact of EU Exit might be for the NHS. I will be attending as the Humber Coast and Vale (HCV) EU Exit Lead.

Chief Midwifery Officer virtual visit

On 26 January, the Trust hosted a virtual visit from Jacqueline Dunkley-Bent, Chief Midwifery Officer (CMO) for NHSE/I, the Deputy CMO, the Regional CMO and our

Maternity Improvement Adviser, as part of the launch of the Maternity Intensive Support Programme which the Trust was invited to join last autumn. Jane Warner, Head of Midwifery, gave a presentation, which was received well by our 'visitors'.

Humber Coast & Vale Health and Care Partnership developments

The Trust is very actively involved in various initiatives across HCV to develop the infrastructure of the new ICS. This includes both the Acute and the Community Collaboratives, the North East Lincolnshire Health and Care Executive and the Humber Partnership Board.

Building work and parking issues

DPOW and SGH now have very substantial building works under way, one consequence of which is a substantial loss of car parking on both sites. Regrettably but unsurprisingly, this is causing some difficulties for some staff with regard to parking.

Health Tree Foundation – national funding

The Trust's charitable arm, the Health Tree Foundation (HTF), has been successful in its bid to NHS Charities Together for a Stage 3 Funding Grant. HTF's application (submitted in December 2020) for £143,000 has been accepted in full, and will support several NLaG staff wellbeing initiatives, including the funding for two years of the Health & Wellbeing Coordinator post within the Directorate of People. This sum was the largest HTF could have sought and is based upon our establishment and an allowance per post.

Peter Reading

28 January 2021

Classification: Official

Publications approval reference: 001599

Skipton House
80 London Road
London
SE1 6LH

To:

- Chief executives of all NHS trusts and foundation trusts
- CCG Accountable Officers

Copy to:

- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Chairs of ICSs and STPs
- NHS Regional Directors

26 January 2021

Reducing burden and releasing capacity to manage the COVID-19 pandemic

The NHS is facing unprecedented levels of pressure from the COVID-19 pandemic. Whilst numbers of admissions are plateauing and beginning to decline in some parts of the country, they continue to grow in others and the number of patients in hospital and in critical care with COVID-19 will take some time to reduce. At the same time the NHS is delivering a national COVID vaccination programme of unparalleled scale and complexity, whist also continuing to provide non-COVID care.

Therefore we will continue to support you to free up management capacity and resources to focus on these challenges. Following our letters in March and July last year, this letter updates and reconfirms our position on regulatory and reporting requirements for NHS trusts and foundation trusts, including:

- pausing all non-essential oversight meetings
- streamlining assurance and reporting requirements
- providing greater flexibility on various year-end submissions
- focussing our improvement resources on COVID-19 and recovery priorities
- only maintaining those existing development workstreams that support recovery.

We will keep this under close review, making further changes where necessary to support you. In addition, we will review and update the measures set out in this letter in Q1 2021/22.

Once again, we appreciate the incredible level of commitment and hard work from you and your teams that has helped the NHS rise to meet the challenges of the last year, and in particular these past four weeks.

Yours sincerely

Amanda Pritchard

Chief Operating Officer, NHS England & NHS Improvement

The system actions

Changing NHSE/I engagement approaches with systems and organisations

Oversight meetings will continue to be held by phone or video conference and will focus on critical issues. Teams will also review the frequency of these meetings on a case-by-case basis to ensure they are appropriate. We have reprioritised our improvement and support effort to focus on areas directly relevant to the COVID-19 response, in particular:

- GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge coordination.
- National transformation programmes (outpatients, diagnostics and pathways) now focus on activity that directly supports the COVID response or recovery, e.g. video consultation and patient-initiated follow up, maximising diagnostics and clinical service capacity, supporting discharge priorities etc.
- With CQC, we continue to prioritise our special measures work to give the appropriate support to the most challenged systems to help them manage COVID-19 pressures.

1) Governance and meetings

No.	Areas of activity	Detail	Actions
1.	Board and sub-board meetings	Trusts and CCGs should continue to hold board meetings but streamline papers, focus agendas and hold virtually, not face-to-face. No sanctions for technical quorum breaches (e.g. because of self-isolation). For board committee meetings, trusts should continue quality committees, but consider streamlining other committees. While under normal circumstances the public can attend at least part of provider board meetings, Government social isolation requirements constitute 'special reasons' to avoid face to face gatherings as permitted by legislation. All system meetings to be virtual by default.	Organisation to inform audit firms where necessary
2.	FT Governor meetings	Face-to-face meetings should be stopped at the current time[1] - virtual meetings can be held for essential matters e.g. transaction decisions. FTs must ensure that governors are (i) informed of the reasons for stopping meetings and (ii) included in regular communications on response to COVID-19 e.g. via webinars/emails.	FTs to inform lead governor
3.	FT governor and membership processes	FTs free to stop/delay governor elections where necessary. Annual members' meetings should be deferred. Membership engagement should be limited to COVID-19 purposes.	FTs to inform lead governor

[1] This may be a technical breach of FTs' constitution but acceptable given Government guidance on social isolation

No.	Areas of activity	Detail	Actions
4.	Annual accounts and audit	We wrote to the sector on 15 January to make the following adjustments to reporting requirements: • extending the 2020/21 accounts and audit year end timetable • allowing providers to apply for a further extended timetable for submitting 2020/21 financial accounts • deferring introduction of IFRS 16 (new leases accounting standard) to 2022 • simplifying the 'agreement of balances' exercise	Organisation to continue with year-end planning in light of updated guidance
5.	Quality accounts - preparation	The deadline for quality accounts preparation of 30 June is specified in Regulations. DHSC is currently reviewing whether Regulations should be amended to extend the 30 June deadline for 2020/21.	No action for organisations at the current time
6.	Quality accounts and quality reports - assurance	We are removing requirements for FTs to include this within their 2020/21 annual report.	Organisations to inform external auditors where necessary
7.	Annual report	We wrote to the sector on 15 January confirming that the options available to simplify parts of the annual report that were introduced in 2019/20 are available again for 2020/21.	Organisation to continue with year-end planning in light of updated guidance
8	Decision-making processes	While having regard to their constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	

2) Reporting and assurance

No.	Areas of activity	Detail
1.	Constitutional standards (e.g. A&E, RTT, Cancer, Ambulance waits, MH LD measures)	See Annex A.
2.	Friends and Family test	Reporting requirement to NHS England and NHS Improvement has been paused. However, Trusts have flexibility to change their arrangements under the new guidance and published case studies show how Trusts can continue to hear from patients whilst adapting to pressures and needs.
3.	Operational planning	The 21/22 planning and contracting round will be delayed; it will not be initiated before the end of March 2021 and we will roll over the current financial arrangements into Q1 21/22.
4.	Long Term Plan: system by default	System by Default development work (including work on CCG mergers) has been restarted. NHSEI actively encourages system working where it can help manage the response to COVID-19. We will keep this work under review to ensure it continues to enable collaborative working and does not create undue capacity constraints on systems.
5.	Long Term Plan: Mental Health	NHSE/I will maintain Mental Health Investment guarantee. As a foundation of our COVID-19 response, systems should continue to expand services in line with the LTP.
6.	Long Term Plan: Learning Disability and Autism	NHSE/I will maintain the investment guarantee.
7.	Long Term Plan: Cancer	NHSE/I will maintain its commitment and investment through the Cancer Alliances and regions to improve survival rates for cancer. NHSE/I will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response, and restoration and maintenance of cancer screening and symptomatic pathways.
8.	NHSE/I Oversight meetings	Be held online. Streamlined agendas and focus on COVID-19 issues and support needs.

No.	Areas of activity	Detail
9.	Corporate Data Collections (e.g. licence self-certs, Annual Governance statement, mandatory NHS Digital submissions)	Look to streamline and/or waive certain elements. Delay the Forward Plan documents FTs are required to submit. We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.
10.	CQC routine assessments and Use of Resources assessments	CQC has suspended routine assessments and currently uses a risk-based transitional monitoring approach. NHSE/I continues to suspend the Use of Resources assessments in line with this approach.
11.	Provider transaction appraisals CCG mergers Service reconfigurations	Complete April 2021 transactions, but potential for NHSE/I to de-prioritise or delay transactions appraisals if in the local interest given COVID-19 factors. Complete April 2021 CCG Mergers. Where possible and appropriate we will streamline the process to review any reconfiguration proposals, particularly those designed in response to COVID-19.
12.	7-day services assurance	Suspend the self-cert statement.
13.	Clinical audit	Given their importance in overseeing non-Covid care, clinical audits will remain open. This will be of particular importance where there are concerns from patients and clinicians about non-Covid care such as stroke, cardiac etc. However, local clinical audit teams will be permitted to prioritise clinical care where necessary – audit data collections will temporarily not be mandatory.
14.	Pathology services	We need support from providers to manage pathology supplies which are crucial to COVID-19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent, and consumables.

3) Other areas including HR and staff-related activities

No.	Areas of activity	Detail
1.	Mandatory training	New training activities – refresher training for staff and new training to expand the number of ICU staff – is likely to be necessary. Reduce other mandatory training as appropriate
2.	Appraisals and revalidation	Indications are that the Appraisal 2020 model is helping to support doctors during the pandemic, however we recognise with rising pressures in the system appraisals may need to be reprioritised so appraisals can be declined. If appraisals are going ahead, please use the revised shortened Appraisal 2020 model The GMC has now deferred revalidation for all doctors who are due to be revalidated between 17 March 2020 and 16 March 2021. The Nursing and Midwifery Council (NMC) has also extended the revalidation period for current registered nurses and midwives by an additional three months for those due to revalidate between March and December 2020.
3.	CCG clinical staff deployment	Review internal needs in order to retain a skeleton staff for critical needs and redeploy the remainder to the frontline CCG Governing Body GP to focus on primary care provision
4.	Repurposing of non-clinical staff	Non-clinical staff to focus on supporting primary care and providers to maintain and restore services
5.	Enact business critical roles at CCGs	To include support and hospital discharge, EPRR etc

Annex A – constitutional standards and reporting requirements

Whilst existing performance standards remain in place, we continue to acknowledge and appreciate the challenges in maintaining them during the continuing COVID-19 response. Our approach to tracking those standards most directly impacted by the COVID-19 situation is set out below:

A&E and ambulance performance – Monitoring and management against the 4-hour standard and ambulance performance continues nationally and locally, to support system resilience.

RTT – Monitoring and management of RTT and waiting lists will continue, to ensure consistency and continuity of reporting and to understand the impact of the suspension of non-urgent elective activity and the subsequent recovery of the waiting list position that will be required. Application of financial sanctions for breaches of 52+ week waiting patients occurring during 2020/21 continue to be suspended. Recording of clock starts and stops should continue in line with current practice for people who are self-isolating, people in vulnerable groups, patients who cancel or do not attend due to fears around entering a hospital setting, and patients who have their appointments cancelled by the hospital.

Cancer: referrals and treatments – We will continue to track cancer referral and treatment volumes to provide oversight of the delivery of timely identification, diagnosis and treatment for cancer patients. The Cancer PTL data collection will continue and we expect it to continue to be used locally to ensure that patients continue to be tracked and treated in accordance with their clinical priority.

Screening: Cancer (Breast, Bowel and Cervical) and Non-Cancer (Abdominal Aortic Aneurysm, Diabetic Eye and Antenatal and Newborn Screening) – We will continue to track the maintenance of all the screening programme pathways (including the initial routine invitations, and the ongoing diagnostic tests).

Immunisations – All routine invitations should continue to be monitored via the NHSEI regional teams.

The Weekly Activity Return (WAR) will continue to be a key source of national data, and the Urgent and Emergency Care daily SitRep. This is vital management information to support our operational response to the pandemic, and we require 100% completion of these data with immediate effect. Guidance can be found here.

Note: it has been necessary to institute a number of additional central data collections to support management of Covid, for example the daily Covid SitRep and the Critical Care Directory of Service (DoS) collections. These collections continue to be essential during the pandemic response, but in order to offset some of the additional reporting burden that this has created, the following collections will continue to be suspended:

Title	Designation	Frequency
Critical Care Bed Capacity and Urgent Operations Cancelled	Official Statistics	Monthly
Delayed Transfers of Care	Official Statistics	Monthly
Cancelled elective operations	Official Statistics	Quarterly
Audiology	Official Statistics	Monthly
Mixed-sex Accommodation	Official Statistics	Monthly
Venous Thromboembolism (VTE)	Official Statistics	Quarterly
Mental Health Community Teams Activity	Official Statistics	Quarterly
Dementia Assessment and Referral Return	Official Statistics	Monthly
Diagnostics weekly PTL	Management Information	Monthly
26-week Patient Choice Offer	n.a. - trial	weekly

(this has already been communicated to data submission leads via NHS Digital)

NLG(21)028

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

DATE	2nd February 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Shaun Stacey, Chief Operating Officer
CONTACT OFFICER	Richard Peasgood, Executive Assistant
SUBJECT	COVID-19
BACKGROUND DOCUMENT (if any)	COVID-19
PURPOSE OF REPORT	To assure the Trust Board around COVID-19
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Appendix 1 has been approved by the Trust Management Board
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	To provide the Board with an overview of the latest actions being taken in our response to managing the COVID-19 pandemic within our hospitals and community services The Trust continues through the Command and Control Structures in place since the commencement of the pandemic to provide direction and response the changes in activity and clinical demands seen as a result of the pandemic. The paper provides a brief update on these responses and the outcomes it has seen.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	COVID-19
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: Note the actions taken

Covid-19 Update

The Trust experienced its highest number of inpatients related to Covd-19 in November 2020 at one point there was over 200 patients across the Trust being treated for Covid-19.

On 7th November 2020 a major incident was declared across DPOW and SGH due to the flow rate of oxygen to ward areas, this was caused by the number of patients requiring oxygen therapy which was at its highest level throughout the pandemic. This was not due to the amount of oxygen available but the pressure within the system and the risk to the infrastructure to supply patients needing oxygen. A new oxygen trust plan was developed along with a revised super surge plan. This has enabled the trust to mitigate, as removal of the risk is only possible with capital investment, any future risk of our oxygen infrastructure being under pressure. This has enabled us to manage the demand for high flow oxygen throughout the two acute hospital sites without applying the previously seen stress to the system.

To further ensure our oxygen infrastructure can manage the demands being placed upon them we have installed additional oxygen manifolds at both DPOW and SGH. This provides a separate supply into areas of the Trust where oxygen demand is high releasing the pressure on the existing system. We are presently undertaking a review of the wards supported by these new manifolds. With consideration being given to the move of our Red wards to ensure the oxygen flow risks are further mitigated across the Trust, this will unfortunately result in further ward moves, the reduction of the oxygen supply risk is important for us to address in the planning of the next surge of Covid19.

The Trust has also purchased an additional 30 Redirooms split 16 at DPOW and 14 at SGH this has increased our isolation capacity across the Trust and reduces the risk of hospital acquired infection of covid. Cubi screens an alternative to the use of redirooms has also been installed across our sites. These screens allow temporary hard surface separation of patients within a bay between the bed spaces to support the management of cross infection where Redirooms are not in use. The application of these two devices has seen a reduction in the loss of bed spaces through cross infection across both our sites from 126 bed spaces being unused to 20 spaces unused.

In December lateral flow testing commenced for our patient facing staff with over 5,000 kits issued. A trial of lateral flow testing of all EC admissions was commenced at SGH on the 27th December 2020 following an NHSE directive to improve the flow of patients to an appropriate area from the Emergency Department. On the 4th January 2021 this was withdrawn as it had not shown an increased improvement in patient flow from the emergency department and a number of false positives results had been recorded in patients after a PCR swab, taken at the time, results were returned with a negative result increasing the risk to patients being exposed to covid.

Elective work is continuing to be completed at DPOW, Goole and St Hugh's Private Hospital. As previously informed the Trust is maintaining the 92% activity delivery against the trajectory set in the phase 3 recovery plan. We continue to see cancellations as patient's want to wait until after the pandemic recovers, we are not taking actions to manage the risks of these patient decision in a better and more understandable way involving the patient, their GP and the Consultant responsible for their care. This development is being undertaken in line with national guidance. As shown in the performance report the Trust is seeing a static level of the number

of patients been treated during December and January, this is contrary to that being across the rest of the country.

The Trust has been able to launch its 'Rapid PCR' testing capacity at DPOW with an increase of an additional 8 analysers installed within the Lab. This has allowed for rapid testing of emergency department admission and supports an improvement in patient flow across the whole hospital site. Likewise rapid testing is also possible at the Scunthorpe site using the same principles with the existing equipment.

To date the Trust has seen 1,205 Covid 19 patients since March 2020, we have seen 386 patients die with a positive swab in the last 28days, have had a high number of patients managed within our Intensive Care units and discharged 819 patients from hospital.

The Trust continues to see a number of staff affected by Covid19 either directly or indirectly with currently 140 staff absent out of 366 staff absent from work, on average of 2% of our workforce is absent from work due to Covid19.

Shaun Stacey

Chief Operating Officer

25/01/2021

Appendix 1

NLaG Phase 3
COVID-19 Response 1

NLG(21)029

DATE	2 February 2021
REPORT FOR	Trust Board - Public
REPORT FROM	Shaun Stacey, Chief Operating Officer Helen Harris, Trust Secretary
CONTACT OFFICER	Shaun Stacey, Chief Operating Officer Helen Harris, Trust Secretary
SUBJECT	Board Assurance Framework (BAF) – Quarter 3: Deep Dive of Strategic Objective 1, Risk 3: Adverse Impact of External Events
BACKGROUND DOCUMENT (if any)	BAF
PURPOSE OF THE REPORT	To present to the Trust Board the BAF for assurance and for members to undertake a deep dive of Strategic Objective 1, Risk 3: Adverse Impact of External Events.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Audit Risk and Governance Committee Quality and Safety Committee Trust Management Board
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The BAF focusses on the risks identified that impact on the Trust achieving its strategic objectives and is designed to: • provide the Board and Board Sub-Committees with assurance as to the actions being taken to mitigate the strategic risks; and • provide an executive overview of achievements each month alongside priorities for the forthcoming month The BAF, whilst providing assurance on how well the Trust's 11 strategic risks are being managed, also provides links to and greater visibility of the risks that are being managed divisionally that underpin the work to mitigate against the related strategic risk. These are demonstrated pictorially in a heatmap summary, grouped wherever possible to demonstrate relationships across divisions between similar or related risks. The full list of related divisional risks is available for information as an appendix to this report As the framework is updated regularly, the risk rating trend diagrams will demonstrate performance against the management of these risks over time Please see the exception report that prefaces the

	framework for key points and then the full detail contained within the full framework. Members of the Trust Board are to seek assurance from the Chief Operating Officer in relation to Risk 3: Adverse Impact of External Events.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	All
BOARD / COMMITTEE ACTION REQUIRED	The Trust Board is asked to: - receive the Board Assurance Framework for assurance - undertake a deep dive of Strategic Objective 1, Risk 3.

Trust Secretary

Board Assurance Framework (BAF)

EXCEPTION REPORT

Key Points – December 2020 Edition:

- **Movement in month: Risk ratings**

- There have been no changes in strategic risk ratings since October 2020.

- **<u>Strategic Objective 1: To give great care</u>**

- **<u>Strategic Risk 1:</u> Risk of non-delivery of constitutional performance targets, specifically: (a) Cancer 62 day, (b) A&E, (c) RTT - 18 weeks, (d) Diagnostics - DMO1.**

- **ASSURANCE: RED/AMBER; Risk Rating: 20**

    - **Cancer pathways:** Key issues are:
        - Prior to Covid-19, there was a challenge in meeting 28 day time to diagnosis. Covid-19 has exacerbated delays in pathways with the +62 days backlog increasing (need to see data during January to determine if mitigations have supported in reducing the backlog);
        - Delays in some pathways as a result of gaps in oncology service due to staffing. Raised to Humber cancer board with HUTH. Lack of capacity at present leading to longer waits in some pathways.

    - Key mitigation:
        - Faster diagnosis / straight to test; triage of referrals;
        - Transformation monies from Cancer Alliance obtained working to develop plans for Rapid Diagnosis Pathway with surgery, Working to develop pilot with 3 PCNs with the aim of starting pilot at the end of Q4.

- Development of a joint NLAG/HUTH Cancer Transformation Plan and link to the interim clinical plan of the HASR.

- **RTT/Waiting lists:** Key issues:
  - (1) Significant impact of Covid-19 on waiting lists linked to the lack of activity during March and April 2020, the reduction in capacity available, resulting in increasing number of >52 & >40 week waiters. Continuing increase in the length of time some patients are waiting above 52 weeks.

- Key mitigation:
  - Risk stratification work to prioritise in-patient lists and longest OPD waiters according to clinical priority. Some gaps in terms of resource available to risk stratify, working up plans to use GPs as part of this work, particularly in medicine,
  - Progress in reducing backlog through various workstreams, not able to keep pace with the rate of new patients being added to the backlog waiting list as a result of capacity constraints;
  - Progress with backlog waiting list improvement plan, but capacity constraints resulting in increasing backlog waiting list position and longer waits for some patients.

- **DMO1 performance:** Key issues:
  - Significant impact of Covid-19 on diagnostics. In particular CT and MRI with DMO1 performance significantly above 1% (although reducing month on month in the main following Covid);
  - Progress made with getting back to towards pre-covid activity levels. CT and Endoscopy still most challenged areas;
  - Conflict between meeting demands for urgent diagnostics for RTT long waiters and Diagnostic 2ww & DMO1 targets;
  - Resource difficulties in providing robust demand and capacity planning data due to a lack of central support.

- Key mitigation:
  - Focus on increasing activity levels to pre-Covid;
  - PHE guidance enabling increased capacity in Endoscopy (from 4 points immediately post Covid to 8 (normal is 10), work to increase further;
  - Capital for Naso-endoscopes agreed which will increase endoscopy capacity and support reductions in patient waits.

- **<u>Strategic Risk 2:</u> Risk of non-delivery of agreed quality and clinical improvements (includes the risk of non-delivery of a reduction in the mortality ratio):**

- **ASSURANCE: RED/AMBER; Risk Rating: 15 (Reduced from 20 in October 2020)**

    - **Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups:** Key issues:
        - Outpatient waiting lists not yet fully risk stratified, given significant number of patients and clinical resource required. Surgical specialties undertaking risk stratification as part of the patient consultation and are prioritising those patients who are over their due date by 50% then 25%;
        - Covid-19 wave 2 response will have an adverse impact on recovery work as some elective activity was cancelled during November to ensure patient safety on inpatient wards. Some elective activity has commenced in December, but there will likely be constraints. Patients waiting for more than 40 and 52 weeks have increased.
        - The focus on cancer recovery may also impact adversely some patients waiting on RTT lists in priority 3 and 4 waiting list categories.

    - Key mitigation:
        - Risk stratification: Assurance that the in-patient (RTT) waiting list has been risk stratified, recognising the higher risk to this group of patients from Covid-19 related elective cancellations during wave 1 and 2.
        - Some assurance that patients are being managed in line with risk stratification. There is also a plan (approved by Q&S) to strengthen controls around this area by further alignment of risk stratification and clinical harm processes, but to do this, will require all waiting lists to have been risk stratified which is at present a gap that has not yet been addressed with ongoing work to mitigate the performance strategic risk.
        - Mitigation options being worked through with local independent providers and system partners (HUTH and York) to maximise use of available urgent elective activity. Elective activity also commencing within the main hospital sites again during December.

    - **Mortality:** Key issues:

- Monthly SHMI data (published in December) for Aug 19-Jul 20 is 105.4. 9th consecutive monthly reduction. 'As expected' range.
- The underpinning mortality risk on the risk register has been reduced from 20 to 15 (August 2020) and again from 15 to 10 (September 2020).
- Risk identified at MIG in connection with the number of mortality reviews possible during the operational pressures in response to Covid-19.
- Due to operational pressures, divisional assurances to MIG have been reduced to allow focus on operational delivery, this results in risk around progress in some areas i.e. M&M meeting performance, response to Trust wide audits relevant to mortality i.e. DNaCPR and train the trainer SJR plans.
- The Trust is an outlier against 'secondary malignancies' SHMI diagnosis group.

- Key mitigation:
  - Working with shielding clinicians, although less impacted during wave 2 compared to wave 1 so limited impact;
  - Successful pilot of linking together clinician led coding and quality of care screening which will be expanded to support achievement of quality priority to review >50% of deaths from December 2020 onwards.
  - Review commenced to look at deaths within the SHMI diagnosis group 'secondary malignancies'. To review collaboratively with local CCGs to understand system issues and what improvements are needed as part of the community action plan,
  - Work is planned to review the Trust's mortality strategy and other recommendations made by NHSE/I with a further meeting with them in January.

- **EOL:** Key issues:

  - Not yet clear on KPIs for RESPECT training or roll-out which poses a gap in assurance.
  - EOL training competencies have to date focussed on the wider Specialist Palliative Care Team (SPC). There is a risk that medical education / competencies required has not yet been mapped and further assurance is needed that medical training needs are understood and rationalised against other training needs and the plan being worked towards, whilst ensuring RESPECT training is prioritised.
  - Roll out of the pain assessment tool for EOL delayed further. Planned to launch now during January 2021.

- Mitigation
    - The multi-agency EOL group are prioritising improvement in the provision of 7-day specialist palliative care services, this should include clarity on the models of service delivery and the role of consultants in palliative care.

- **Deteriorating patient and sepsis:** Key issues:
    - Gap in assurance that sepsis management is appropriate due to inconsistent use of the E-sepsis screening tool and lack of any other data to evidence.
    - Ward based champion role delayed in response to operational pressures.
    - Fluid balance theme identified from mortality screening reviews.

- Mitigation:
    - Audit planned to evaluate sepsis and deteriorating patient action against policy. Delayed due to operational pressures.
    - Lead sepsis nurse has returned to their normal role following a period of redeployment to take a lead role and liaise with ward based staff and build a network of champions.
    - Fluid balance requested from MIG to be picked up as part of the Deteriorating Patient and Sepsis group.

- **DISCHARGE TO ASSESS (Replaces former SAFER work programme):** Key issues:
    - New programme of work with oversight and meeting structure including NLAG and CCG partners.
    - Need to focus on effective Board rounds, minimise interruptions to wards for information relating to discharge and implement new national Discharge guidance and right to reside.

- Mitigation:
    - Divisional General Manager in Medicine leading this programme of work with a Medical and nurse lead alongside regular task and finish groups with CCG involvement.
    - Medical lead actively looking at Board rounds and education to clinical colleagues.
    - Proactive discharge to assess event during December and planned during January to identify patients not meeting criteria for right to reside and ensure process for assessing these patients for continuing care is planned and not necessarily completed in the acute hospital.

- **7 DAY SERVICES:** Key issues:
  - WebV document prepared and ready, no group yet piloting this for effectiveness.
  - Business case development in Medicine for temporary mitigation of gaps concerning echocardiography and standard 5, surgery divisions plan for 7DS have both been delayed due to operational pressures.
  - Audit undertaken by Medicine division. No significant improvements noted in performance against 7DS standards. Action plan to be developed.

- Mitigation:
  - Interventional Radiology scoping changes to work collaboratively with HUTH/STP, SOP has been approved, roll out plans to commence. Go live now agreed.
  - Integrated AAU for medicine and surgery patients now live. Plan an audit 3-6months post implementation to evaluate impact on 7DS standards. Review in January 2021.

- **COMPLAINTS:** Key issues:
  - Operational pressures and demand on clinician time may make achievement of some of the complaints KPIs difficult during wave 2 response.
  - Whilst the new complaints process has gone live, there are risks to capacity in the central team in closing down the ‘old’ process (as measured by two new KPIs) and running the new process as complaints and patient feedback increase back to ‘normal’ pre-covid levels.
  - Concerns around data accuracy and recording on DATIX persist.

- Mitigation:
  - New KPIs introduced to support measurement against closing down complaints being managed as part of ‘old’ process.
  - Seeking support with DATIX and complaints systems to make some system adjustments.

- **Ophthalmology:** Key issues:
  - Overdue and un-booked f/u waiting list in Ophthalmology continues to increase (Nov: 6,935 vs. Oct: 5,326; Sept: 3,695; Aug: 1,581; Jul: 710);
  - Shortfall in capacity within the service impacted upon by covid mitigation measures in out-patients.

- Mitigation:
    - Temporary mitigation of current shortfall in capacity includes: HCV, Transfer of patients to independent providers, 'Lift and Shift' and waiting list initiatives (as well as increased theatre capacity where surgery is required).
    - Risk stratification of inpatient waiting lists completed and quality risks to patients requiring timed treatments has been mitigated by identification of patients waiting who require timed treatments and oversight of these by failsafe officers.
    - As a result of the transfer to the independent sector of 1,062 patients and the discharge of others, the total caseload reduces by 2,000 patients to 16,391.

- **PAEDIATRICS MANAGEMENT IN ED:** Key issues:
    - Capacity to train ED staff on EPALS remains a significant risk that has been escalated regionally and nationally, recognising it is not just the Trust this impacts upon.
    - ED Consultant in post and able to take on the medical lead role for paediatrics, however awaiting job plan and PA time allocation.

- Mitigation:
    - New standardised documentation which includes approved pain chart completed. Re-audit to be undertaken to assess the impact of the new documentation in March 2021.
    - All RNs to undertake RCN competencies for Paediatric Emergency Nursing (level 1 includes paediatrics), through new competency framework with study days starting in January 2021. Trajectory for L1 is April 2021 to have completed study days followed by clinical study day to sign off competencies in July 2021.

- **<u>Strategic Risk 3:</u> Adverse impact of external events (i.e. Britain's exit from the European Union; Pandemic) on business continuity and the delivery of core services.**

- **ASSURANCE: RED/AMBER; Risk Rating: 16**

    - Unlike during wave 1 lockdown, there has been a higher demand on Trust services with A&E attendances and emergency admissions increasing resulting in some elective work being cancelled. Wave 2 is having a much greater impact on the Trust. The incident has been escalated to a National Level 4. A further national lockdown has taken effect from the 31 December 2020.

- Key issues:
    - New variant covid-19 spreading throughout the UK;
    - Available ward staffing and staff mix have been adversely affected by the pandemic. Redeployment initiatives have begun to free up nursing time;
    - Testing capabilities are being put under increased pressure with analysers running 24/7;
    - Limitations in maximum capacity levels of oxygen system resulting in the need to spread red/green areas out throughout the hospital estate to mitigate resulting in additional staff mix challenges;
    - Some staff risk assessments outstanding.

- Mitigation:
    - Redi-rooms have been made available (30 in place) to increase isolation facilities;
    - Focus on maintain Goole as a green site to maintain elective activity;
    - Aiming to roll out rapid testing to support zoning arrangements and flow during January;
    - Lateral flow testing launched for staff and staff vaccinations have commenced;
    - Redeployment hub established to support wards focus on delivery of clinical care with non-clinical staff being deployed to support other functions, not yet fully supporting mitigation of risks;
    - Ongoing planning for maximising oxygen supply to support patient needs, alongside Estates and Facilities teams, including review of zoning arrangements and best use of current ward areas based on oxygen capabilities. New oxygen system manifold that will help support pressures in the system being installed;
    - Brexit has taken place, no significant risks or issues identified requiring additional mitigation.

- **<u>Strategic Objective 2: To be a good employer</u>**

- **<u>Strategic Risk 4:</u>** Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and longer term.

- **ASSURANCE: RED/AMBER; Risk Rating: 20**

- Recruitment pipeline has led to a steady reduction in the nurse vacancy rate with new staff from overseas able to join the Trust. Nurse vacancies have recently increased during November from 158 in October to 179 in November. Medical and Dental vacancy rate has increased slightly in November to 108.70 from 107.92.

- Key issues:
  - Risk remains high as a result of the extremely challenging operational pressures which could lead to an increased turnover rate and difficulties with retention.

- Mitigation:
  - Other mitigating actions being explored including uplift agreed for bank staff and additional HCA recruitment to the bank to support filling vacancies;
  - Trust successful in receiving NHSI/E funding to recruit Organisational Development (OD) practitioners. Successful in obtaining funds to recruit for additional OD post and HR posts. These posts will support focus on retention of staff through the engagement agenda (outlined in People Strategy) as well as supporting more effective HR helpdesk function to support staff who are struggling better;
  - Agree at Board level the appropriate risk stratification actions for those staff scoring a risk above 6 and who wish to remain working. Shielding letters are being issued during November. The risk to the workforce is not fully understood;
  - A Trust wide launch of the Trust's People Strategy has been paused as a result of the second wave of the pandemic. This links with requirements of NHS People Plan;
  - Development completed of live dashboard data with mandatory training performance by division / discipline to support more focus on mandatory training performance.

- **Strategic Risk 5:** Ineffective staff engagement and ownership of Trust agenda affects morale and failure to change and improve the culture

- **ASSURANCE: AMBER; Risk Rating: 12**

- Good progress has been made with mandatory training and PADR rates, with a deep dive pending into areas specifically falling below target;
- A substantive Director of People and Organisational Effectiveness has been appointed and will take up post in January 2021;
- National Staff Survey released, current uptake is 31% vs. 38% UK average.

- **Strategic Objective 3: To live within our means**

- **Strategic Risk 6:** Finance risk, specifically:
  (a) Not achieving the control target total agreed with NHS Improvement for the Trust and failure to achieve the overall system target;
  (b) Risk of non-delivery of the long term financial plan to produce a balanced financial position, working in conjunction with everyone else to achieve a system balance.

- **ASSURANCE: RED/AMBER; Risk Rating: 12**

    - The Trust has been (during the first 6 months of 20/21) receiving a monthly top-up payment to ensure the Trust breaks even. This top-up payment has included any reimbursement for Covid-19 expenditure. The risk rating was reduced from 15 (5x3) to 12 (4x3) given the fact that the top up payments being made to the Trust should ensure a break even position;

    - For months 7-12 a control target has now been set for the Humber and the Trust as part of the Humber. The Trust have developed a plan which is considered achievable which includes Covid-19. There may need to be additional costs associated with quality which may threaten the plan but these are being worked through. There may also need to be investment in waiting list improvement which could add additional cost pressures;

    - Whilst arrangements for months 7-12 are clear, post-Covid with associated recovery plans may present further risks. There is a significant uncertainty as to the financial framework for 2021/22. At this time, whilst awaiting clarification, the risk for 21/22 cannot be quantified;

    - Awaiting release of planning guidance may not be received until Q1 2021/22.

- **Strategic Objective 4: To work more collaboratively**

- **Strategic Risk 7:** Risk of failure of the Trust's infrastructure; specifically:
  (a) Ageing estate and equipment;
  (b) Longer term estates sustainability;
  (c) IT / Digital Strategy / Cyber Security.

- **ASSURANCE: RED/AMBER; Risk Rating: (a) 20; (b) 20; (c) 16**

    - BLM allocation for 20/21 is set at £1.828m. The current BLM requirement is £97.7m;

    - The Trust has been awarded £3.496m critical infrastructure risk funding. This will be used for Fire alarm system replacement at all 3 sites, focussing at DPoW and water infrastructure upgrades;

    - The Trust submitted the 19/20 Data Security Protection Toolkit return on the 30th September 2020. Due to the impact of COVID-19 a number of actions have been put on hold. An improvement plan has been developed and agreed by both the Trust's Senior Information Risk Owner and NHS Digital. Until all actions are completed the Trust's status is one of 19/20 Standards Not Fully Met (Plan Agreed);

- **Strategic Risk 8:** Inability to pursue a clear organisational strategy that staff and stakeholders are aware of and support

- **ASSURANCE: AMBER; Risk Rating: 12**

    - Trust has an agreed capital investment plan which has delivered significant in year capital funding to support changes in emergency care and diagnostics;

    - Trust is engaged with local authority and academic partners in developing capital bids for SGH and DPoW.

- **Strategic Risk 9:** Lack of an integrated ICS, Humber and Trust clinical strategy which delivers long term system, service and organisational sustainability including the ability to attract inward investment

- **ASSURANCE: AMBER; Risk Rating: 15**

    - New Director Humber Acute Services in post. Executive Oversight Group already established;

    - Programme SROs in place; Risk registers in place for individual projects underway;

    - Recommendations to Executive Oversight Group on 9 December, on revised Governance Framework for 3 programmes; strengthened PMO and clinical leadership for programme 1.

- **Strategic Risk 10:** The risk of ineffective relationships with stakeholders

- **ASSURANCE: GREEN; Risk Rating: 8**

    - Continued meetings with Partnership Board and the Northern Lincolnshire Senior Leadership Group. Continued engagement with the Humber Coast and Vale Acute Collaborative. Regular dialogue with other Acute Hospital Trusts;

    - Wave 2 Covid-19 has led to the instigation of incident management board assurance mechanisms being reinstated. Continue to work intensely with Humber Acute Services Review partners and Acute Providers as part of incident management;

    - Continued weekly briefings provided to local MPs regarding the Trust handling of Coronavirus.

- **Strategic Risk 11:** Risk of insufficient investment and development of the Trust's leadership (including clinical leadership) - capacity and capability

- **ASSURANCE: AMBER; Risk Rating: 12**

    - The Trust's appointed Chief Information Officer has now resumed their role within the organisation. The Trust's Director of Strategic Development has also been appointed as the Programme Director for the Humber Acute Services Review working jointly between the Trust and HUTH;

    - Appointed new Divisional General Manager for Clinical Support Services Division;

    - Assurance and Governance requirements in Wave 2 of Covid-19 for Board Meetings, Sub-Committees and Council of Governors and sub-groups clarified by Trust Chair to enable focus on operational pressures.

Northern Lincolnshire and Goole NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)
DECEMBER 2020

EXTERNAL ASSURANCE: **Positive:** Audit Yorkshire internal audit: Board Assurance Framework: Significant Assurance, Q3 2019/20

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6) Risk to strategic objective: Finance: Risk of not achieving the control target and financial plan;
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(c) IT / Digital Strategy / Cyber Security;
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9) Risk to strategic objective: Clinical strategy: Lack of an integrated ICS, Humber and Trust clinical strategy;
10) Risk to strategic objective: The risk of ineffective relationships with stakeholders;
11) Risk to strategic objective: Leadership: Risk of insufficient investment and development.

Section 3: Appendix: Full list of underpinning divisional/directorate risks underpinning strategic risks.

BAF Overview 2020/21

Strategic Objective	Strategic Plan 2019-24 Priorities	Draft Trust Priorities for 2020/21 (as outlined within the Operational Plan)	Enabling / Supporting Strategies & Sub Strategy	Risk to Strategic Objective	Executive Lead	Management / Oversight Group	Board Assurance Committee	Current Risk Score *	Target Risk Score *
To give great care: • **Never compromise on safety** • **Give care which works and is clinically proven** • **Work on what matters to patients** • **Always seeks to learn and made improvements**	Improve performance Reduce Waiting Times Improved Patient Flow	Waiting lists (13) Effectiveness of Cancer pathways (14) Safe flow and discharge (15) Achieve CQC Must Do Actions (9)	Quality Strategy: QI Strategy Patient Safety Strategy Risk Management Strategy Learning Strategy Nursing & Midwifery Strategy Clinical Strategy: • Divisional Strategies	Risk of non-delivery of constitutional performance targets, specifically: (a) Cancer 62 day (b) A&E (c) RTT – 18 Weeks (d) Diagnostics	Shaun Stacey	Operational Management Group	Finance & Performance Committee	20	8
	Reduce Mortality Improvements to the management of the deteriorating patients Improved Patient Experience Learning Organisation	Mortality & End of Life (10) Management of Diabetes (11) Complaints (12) Quality Improvement (3) Waiting lists (13) Achieve CQC Must do Actions (9)		Risk of non-delivery of agreed quality and clinical improvements (includes the risk of non-delivery of a reduction in the mortality ratio	Kate Wood / Ellie Monkhouse	Quality Governance Group	Quality & Safety Committee	15	10
				Adverse impact of external events (i.e. Britain's exit from the European Union; Pandemic) on business continuity and the delivery of core services.	Shaun Stacey	Trust Management Board	Audit, Risk & Governance Committee	16	8
To be a good employer: • **Developed a skills and motivated workforce** • **Promote staff wellbeing** • **Create a safe and nurturing environment** • **Listen to the concerns and ideas of staff**	Improved retention Skills & Leadership Development Develop & increase the number of new roles Developing Apprenticeships	Improve the Trust's staff retention rate (5) Improve the Trust's vacancy rate (6) Ensure safe staffing across our clinical areas, focussing specifically on A&E, paediatrics and critical care (7)	Workforce Strategy Leadership Development Strategy Nursing & Midwifery Strategy	Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and long term	Claire Low	Performance Improvement Meeting / People & Organisational Effectiveness / SMT??/ Trust Management Board	Workforce Committee	20	8
	Maximising Recruitment Wellbeing New Employment Models & Approaches Talent Management & Upskilling Workforce	Leadership development (2) PADRs (4) Mandatory Training (4) Implement Mental Health Support for staff (8)		Ineffective staff engagement and ownership of Trust agenda affects morale and failure to change and improve the culture	Claire Low	Performance Improvement Meeting / People & Organisational Effectiveness / SMT??/ Trust Management Board	Workforce Committee	12	8

Strategic Objective	Strategic Plan 2019-24 Priorities	Draft Trust Priorities for 2020/21 (as outlined within the Operational Plan)	Enabling / Supporting Strategies & Sub Strategy	Risk to Strategic Objective	Executive Lead	Management / Oversight Group	Board Assurance Committee	Current Risk Score *	Target Risk Score *
To live within our means: • **Deliver value for money** • **Work to eliminate the deficit** • **Spend every pound wisely** • **Innovate and educate to save** • **Secure more investment**	Deliver Financial Plan	Deliver year–end control total (16) Achieve financial recovery fund (17) Deliver CIP (18) Set a balanced plan (19)	Finance Strategy	Finance risk, specifically: (a) Not achieving the control target total agreed with NHS Improvement for the Trust and failure to achieve the overall Northern Lincolnshire system target (b) Risk of non-delivery of the long term financial plan to produce a balanced financial position, working in conjunction with everyone else to achieve a system balance	Lee Bond	Performance Improvement Meeting / Finance Review Group	Finance & Performance Committee	12	10
To work more collaboratively: • **Work with others to provide sustainable services** • **Develop talent for the health community** • **Use resources in the best way we can**	Service Development Ambitions Imaging Facilities and AAUs by 2023 Integrated AAU and Same Day Emergency Care by 2023 Achieve Required Standards for Healthcare Buildings	Access and Flow (15) Wave 4 capital business cases (21) Development of strategic outline business case for investment in Humber's hospitals (22)	Estates Strategy: • Community Estates Strategy	Risk of failure of the Trust's infrastructure; specifically: (a) Ageing estate and equipment; the inability to maintain legislative compliant and improve the current estate and equipment due to a lack of capital and backlog maintenance (includes Legionella)	Jug Johal	Estates & Facilities Governance	Finance & Performance Committee	20	10
		Wave 4 capital business cases (21) Development of strategic outline business case for investment in Humber's hospitals (22)	Estates Strategy: • Community Estates Strategy	Risk of failure of the Trust's infrastructure; specifically: (b) Longer term estate sustainability: failure to secure a sustainable estate future for SGH (and to a lesser extent DPOWH) this may give rise to buildings or parts of buildings becoming unsafe to occupy	Jug Johal	Estates & Facilities Governance	Finance & Performance Committee	20	10

Strategic Objective	Strategic Plan 2019-24 Priorities	Draft Trust Priorities for 2020/21 (as outlined within the Operational Plan)	Enabling / Supporting Strategies & Sub Strategy	Risk to Strategic Objective	Executive Lead	Management / Oversight Group	Board Assurance Committee	Current Risk Score *	Target Risk Score *
	Shared Health Records Diagnostic Image Collaboration Population Health Management	Develop a Digital Transformation Strategy (24)	Digital Strategy	Risk of failure of the Trust's infrastructure; specifically: (c) IT / Digital Strategy / Cyber Security: failure of the IT infrastructure and adverse impact on the delivery of the Digital Strategy and on business continuity and the delivery of safe care; and the lack of adequate controls to defend the Trust's IT Systems when a cyber–attack occurs	Shauna McMahon	WebV, Information Technology / Information Governance Group	Finance & Performance Committee	16	12
	Integrated Urgent & Emergency Care Transformed Out-patient services Worked in Partnership with Primary Care Networks Reconfigured Specialties to one site where appropriate Restructured Cancer Services Created a sustainable hospital at Goole	Humber Acute Services Review (20) Develop interim clinical services plan (23)	Trust Strategy (Strategic Framework) 2019 - 2024	Inability to pursue a clear organisational strategy that staff and stakeholders are aware of and support	Ivan McConnell	Trust Management Board	Finance & Performance Committee / Trust Board	12	8
		Develop interim clinical services plan (23) Complete the Wave 4 capital business cases (21) Commence the development of the strategic outline case for the investment in Humber's hospitals (22)	Clinical Strategy: • Divisional Strategies	Lack of an integrated ICS, Humber and Trust clinical strategy which delivers long term system, service and organisational sustainability including the ability to attract inward investment	Ivan McConnell	Trust Management Board	Finance & Performance Committee / Trust Board	15	9
			Communication & Engagement Strategy	Risk of ineffective relationships with	Peter Reading	Trust Board	Trust Board	8	8

Strategic Objective	Strategic Plan 2019-24 Priorities	Draft Trust Priorities for 2020/21 (as outlined within the Operational Plan)	Enabling / Supporting Strategies & Sub Strategy	Risk to Strategic Objective	Executive Lead	Management / Oversight Group	Board Assurance Committee	Current Risk Score *	Target Risk Score *
To provide strong leadership: • Ensure professional standards • Be ambitious and aspirational • Role model values and behaviours • Develop skills and knowledge • Strengthen team working	Skills & Leadership Development Talent Management & Upskilling Workforce	Board development (1) Leadership Development (2)	Workforce Strategy Leadership Development Strategy	Risk of insufficient investment and development of the Trust's leadership (including clinical leadership) – capacity and capability	Peter Reading	Trust Management Board	Workforce Committee / Trust Board	12	8

*Risk scoring trend overtime is shown overleaf

Risk Rating Matrix

Likelihood of recurrence \ Severity / Impact / Consequence	None / Near Miss (1)	Low (2)	Moderate (3)	Severe (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Certain (5)	5	10	15	20	25

RISK	Green – Risk Score 1-3	Very low	Yellow – Risk Score 4-6	Low	Orange – Risk Score 8-12	Moderate	Red – Risk Score 15-25	High

Section 1: Trend over time - Mitigation of Trust's 11 strategic risks

Strategic Risk Number	Linked to Strategic Objective	Strategic Risk Title		CURRENT Dec 20	TREND Nov-20	TREND Oct-20	TREND Sep-20	TREND Aug-20	TREND Jul-20	TREND Jun-20	TREND May-20	TREND Apr-20	TREND Mar-20	TREND Feb-20	TREND Jan-20	TREND Dec-19	TREND Nov-19	TREND Oct-19	TREND Sep-19	TREND Aug-19	TREND Jul-19	TREND Jun-19	TREND May-19	Lead Director
1	1. To give great care	Risk of non-delivery of constitutional performance targets, specifically: (a) Cancer 62 day, (b) A&E, (c) RTT - 18 weeks, (d) Diagnostics.		20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	Shaun Stacey
2	1. To give great care	Risk of non-delivery of agreed quality and clinical improvements (includes the risk of non-delivery of a reduction in the mortality ratio)					20	20	20	20	20	20	20	20		15	15	15	15	15	15	15	15	Kate Wood / Ellie Monkhouse
3	1. To give great care	Adverse impact of external events (i.e. Britain's exit from the European Union; Pandemic) on business continuity and the delivery of core services. *[Note amended scope of strategic risk from March 2020; and further clarification in June 2020]*		16	16	16	16	16	16	16	16	16		8	8	8		16	16	16		8	8	Shaun Stacey
4	2. To be a good employer	Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and longer term.									15	15	15	15	15		10		15	15	15	15	15	Claire Low
5	2. To be a good employer	Ineffective staff engagement and ownership of Trust agenda affects morale and failure to change and improve the culture.		12	12	12	12	12	12	12	12	12	12	12	12			12	12	12	12	12	12	Claire Low
6	3. To live within our means	Finance risk, specifically: (a) Not achieving the control target total agreed with NHS Improvement for the Trust and failure to achieve the overall Northern Lincolnshire system target; (b) Risk of non-delivery of the long term financial plan to produce a balanced financial position, working in conjunction with everyone else to achieve a system balance.		12	12	12	12	12	12	12		15	15	15	15	15	15	15	15	15	15		10	Lee Bond
7a	4. To work more collaboratively	Risk of failure of the Trust's infrastructure; specifically: (a) Ageing estate and equipment: the inability to maintain legislative compliant and improve the current estate and equipment due to a lack of capital and backlog maintenance (includes Legionella);		20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	Jug Johal
7b		Risk of failure of the Trust's infrastructure; specifically: (b) Longer term estate sustainability: failure to secure a sustainable estate future for SGH (and to a lesser extent DPOWH) this may give rise to buildings or parts of buildings becoming unsafe to occupy;	10	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	Jug Johal
7c		Risk of failure of the Trust's infrastructure; specifically: (c) IT / Digital Strategy / Cyber Security: failure of the IT infrastructure and adverse impact on the delivery of the Digital Strategy and on business continuity and the delivery of safe care; and the lack of adequate controls to defend the Trust's IT systems when a cyber-attack occurs.	12	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	Shauna McMahon
8	4. To work more collaboratively	Inability to pursue a clear organisational strategy that staff and stakeholders are aware of and support.	8	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	Ivan McConnell
9	4. To work more collaboratively	Lack of an integrated ICS, Humber and Trust clinical strategy which delivers long term system, service and organisational sustainability including the ability to attract inward investment.	9	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	Ivan McConnell
10	4. To work more collaboratively	The risk of ineffective relationships with stakeholders.	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	Peter Reading
11	5. To provide strong leadership	Risk of insufficient investment and development of the Trust's leadership (including clinical leadership) – capacity and capability.	8	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	16	16	16	16	16	Peter Reading

The potential impact of the above risks materialising include:

- Poor quality care / harm
- Damage to the Trust's reputation
- Further regulatory action and inability to exit quality and financial special measures
- Lack of longer term sustainability

Northern Lincolnshire & Goole Trust's Risk Appetite: "The Trust will not accept risks that impact adversely on patient safety and therefore has a greater appetite for financial risk in that it is prepared to take the necessary actions to safeguard safety despite the potential financial consequences and regulatory impact. The Trust also has a greater appetite to take considered risks in pursuit of innovation which may challenge established working practices and may pose a risk to its reputation, where positive gains can be seen"

Strategic Objective:	**1. TO GIVE GREAT CARE**
Risk to Strategic Objective:	1) Risk of non-delivery of constitutional performance targets, specifically: (a) Cancer 62 day, (b) A&E, (c) RTT - 18 weeks, (d) Diagnostics - DMO1.
Risk Description:	The risk is that the Trust fails to deliver or fails to demonstrate robust improvement plans in delivering constitutional performance targets which impairs the Trust's provision of quality services and adversely impacts on its reputation with service users and regulatory bodies.

Monthly Executive Highlight Report:

* The Trust is currently unable to deliver these 4 performance targets due to demand and capacity constraints. An agreed trajectory for each to maintain delivery of care has been agreed.

a) Cancer 62 day target: Aim to meet national target in 2021. Current local agreed target 85%.
Performance during November 20: **68.0%.**

b) A&E target: Aim to meet national target in 2021. Current local agreed target: 92%
Performance during November 20: **71.0%.**

c) RTT - 18 weeks target: Aim to meet national target in 2021/22. Current local agreed trajectory: 92%
Performance during November 20: **66.1%.**

d) 6-week wait for diagnostics - DMO1: Aim 1% of diagnostic requests breach the 6 week target.
Performance during November 20: **40.4%.**

* Risk rating for performance strategic risk reviewed in July 2020 amid the significant impact of Covid-19 on Trust performance. The primary mitigation being employed is ongoing risk stratification and prioritisation. As such, the risk rating has been left at 20, with a review again at the end of Quarter 3 2020.
Achievement of target risk rating: April 2022; currently working to recover back to improved performance seen pre-Covid (March 20).

* **Cancer pathways:** Key issues are: (1) the challenge of meeting 28 day time to diagnosis, a particular challenge for colorectal cancer tumour site. Wave 2 of Covid-19 has impacted on planned cancer treatments resulting in increased 62+ and 104+ day waiting. (2) Majority of Inter Provider Transfers sent after national timescales (38 days). (3) Delays in some pathways as a result of gaps in oncology service due to staffing.
Cancer pathways: Key mitigation: Faster diagnosis / straight to test; triage of referrals; working to develop plans for Rapid Diagnosis Pathway for colorectal cancer tumour site to develop pathways with Primary care to reduce number of 2WW referrals; Joint NLAG/HUTH Cancer Transformation Plan aiming to streamline pathways. **Assurance: Red/Amber**

* **ED performance: Key gaps:** Not yet consistently achieving >90% ED 4-hour performance
ED performance: Key mitigation: Development of tracker tool to support increased awareness of daily performance to support movement of the average to 90-92% performance; UTC staffing difficulties in NEL being mitigated by ED doctors; SAFER project to improve flow; National ECIST team working within the Trust to support improvement up to December 2020. **Assurance: Red/Amber**

* **RTT/Waiting lists: Key gaps:** Significant impact of Covid-19 on waiting lists linked to the lack of activity during March and April 2020, the reduction in capacity available. Result: increasing number of >52 & >40 week waiters. Continuing increase in the length of time some patients are waiting above 52 weeks. Gaps in approach for risk stratification for OPD.
RTT/Waiting lists: Key mitigation: Risk stratification work to prioritise in-patient lists. Medicine to work up a plan for risk stratification with GP involvement. Divisions to refresh recovery and working with Independent providers.
Assurance: AMBER: Capacity constraints resulting in increasing backlog waiting list position and longer waits for some patients; performance against planned phase 3 trajectory demonstrates progress.

* **DMO1 performance: Key gaps:** Significant impact of Covid-19 on diagnostics. In particular CT and MRI with DMO1 performance significantly above 1% (although reducing month on month in the main following Covid). Progress made with getting back to towards pre-covid activity levels. CT and Endoscopy still most challenged areas. Conflict between meeting demands for urgent diagnostics for RTT long waiters and Diagnostic 2ww & DMO1 targets. Resource difficulties in providing robust demand and capacity planning data due to a lack of central support.
DMO1 performance: Key mitigation: Focus on increasing activity levels to pre-Covid, accessing additional scanning capacity with support from NHSE/I.
Assurance: Red

Monthly Executive Highlight Report: Plans for next month:

* Risk stratification implementation plan to be developed and brought into use.

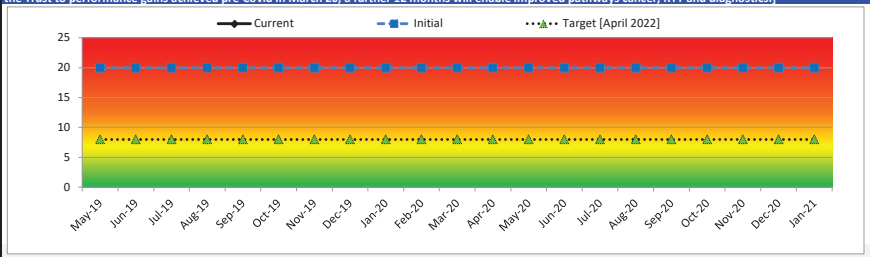
* Continue to operationalise the Trust's recovery plan.

Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

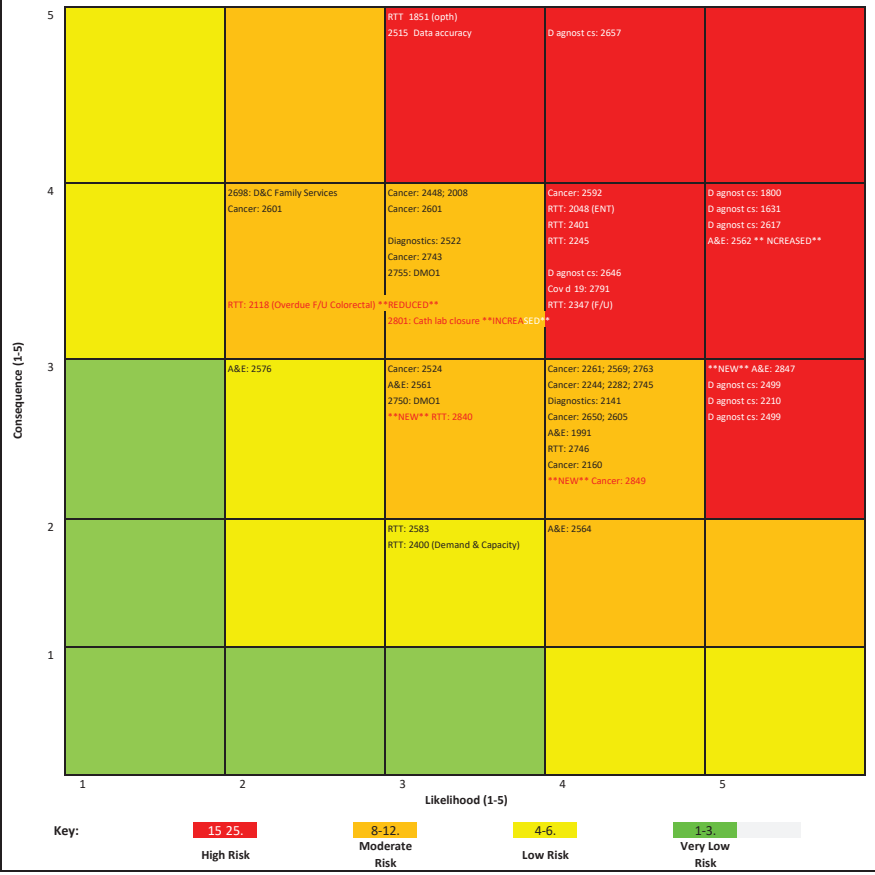
* The heatmap demonstrates the current local risks that relate to or underpin the management of this strategic risk.

CHANGES SINCE LAST MONTH:
Cancer 62 day target:
* **NEW** 2849: Quality Surveillance (Formerly Peer Review) for Cancer Services and NHS Spec Comm (Risk rating: 12; C3xL4)
A&E Target:
* 2562: Failure to meet constitutional targets in A&E (Risk rating: 20; C4xL5) [Risk Rating INCREASED from 16 to 20, Jan 2021]
* **NEW** 2847: Ambulance Handover Delays (Risk rating: 15; C3xL5)
RTT - 18 weeks target:

Risk tracking trend over time: Catastrophic consequence: 5 x 4: Likely RR of 20; Target risk rating achievement trajectory: April 2022. [Post Covid recovery will return the Trust to performance gains achieved pre Covid in March 20, a further 12 months will enable improved pathways cancer, RTT and diagnostics.]



Linked Corporate or High Level Risk Rating HEATMAP:



STRATEGIC OBJECTIVE:	1. TO GIVE GREAT CARE						
Risk to Strategic Objective:	1) Risk of non-delivery of constitutional performance targets, specifically: (a) Cancer 62 day, (b) A&E, (c) RTT - 18 weeks, (d) Diagnostics - DMO1.		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Shaun Stacey Operational Management Group Finance & Performance Committee		**Date added:** 01-May-19 **Last updated:** 13-Jan-21	
Consequences of Risk Materialising:	* Impact on provision of quality services to our patients; * Adverse impact on the Trust's reputation and its standing with patients and regulators; * Adverse impact on ability to exit quality and financial special measures or receiving needed support.			**Assurance that the issues impacting on this risk are being managed:**			Trend RAG Rating: RED
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**		**Assurance / Oversight Group**
(a) Cancer performance	Central cancer team, with Cancer lead in post. **PTL:** Cancer weekly PTL and escalation process; Weekly Cancer PTL meeting - changed to 6 weekly focus on top 5 specialties which account for 80% of breaches; Looking to change this to focus on a 'tiered' approach, to discuss at OMG; **Oversight:** Weekly Divisional General Manager Waiting List Assurance Meetings with all divisions; Weekly attendance by Path Manager to PTL to improve turnaround times/escalation; PRIM meetings with divisions includes focus on Cancer; Cancer Board meeting; underpinned by individual tumour specific MDT Business Meetings; **Improvement planning:** System wide 62 day improvement plan in place focussing on 7-day 1st appt, 28 day definitive diagnosis, IPT by Day 38, Treatment by Day 62 (approved at Planned Care Board Sept 19); Outsourcing contract for diagnostics has supported reducing turnaround times; Patient Triage arrangements in place for all cancer pathways; Planning has commenced for recovery post-Covid-19 in terms of potential capacity and demand; AD of cancer support divisions link thematic analysis to pathway improvement planning within divisions. **Management of demand:** Consolidation of HUTH Oncology Services onto the DPOW site within NLAG (Jan 20); Single site MDT implemented for Lung Cancer (Jan 20) and Colorectal (Apr 21). All referrals are also now being clinically assessed and where appropriate streamlined for straight to test telephone assessment; Capacity and demand planning for recovery has commenced. **Recovery:** Elective Care Cell within the ICS (including cancer services) focussed on recovery across the ICS; Elective Care Task and Finish Group supporting focus on recovery; Divisional risk stratification and re-prioritisation process in place; New Public Health England guidance released that will increase capacity within Endoscopy enabling more access for patients requiring cancer diagnosis.	*Assurance data:* (1) **Negative:** Cancer Waiting Times: 28 day Faster Diagnosis: November: 62.9%; October: 59.7%; September: 53.9% August: 63.1% (against a target of 75%). (2) **Negative:** Cancer Waiting Times - 62 Day GP Referral: November: 66.7%; October: 70.5%; September 63.6%; August: 67.8% (against target of 85%). (2) **Negative:** Cancer Waiting Times - 104 day+ backlog: November: 45 October: 25; September: 40; August: 52 [Reducing]. (2) **Negative:** Cancer Waiting Times - 62 day+ backlog: November: 129; October: 109 September: 97; August: 111 [Increasing]. (3) **Negative:** Care of patients with confirmed diagnosis transferred by day 38: November: 14% failure; October: 41%; September: 22%; August: 27%; July: 39% (against a local target of 75%). (4) **Positive:** Request to test report turnaround to be no more than 14 days: November: 100%; October: 100%; September: 100%; August: 100%; July: 100% (against a target of 100%). (5) **Positive:** Number of combined site MDTs: 100% (against a target of 100%). (6) **Negative:** Quality Surveillance (QSIS) annual submission: no improvements in recent years. *Assurance sources:* *IPR. Power BI reporting (including ability to compare tumour site performance);* *Not meeting 62 day performance targets (62 day RTT and screening);* *PRIM divisional update;* *Continued improvement seen in Pathology turnaround times;* *Quality Priority: Positive results seen to date from the implementation of triage/straight to test in Lung, Urology and Colorectal;* *Faster pathways defined and in place for all 4 priority pathways: Lung, Urology, Colorectal and upper GI (supported by necessity linked to Covid-19);* *The Trust's 2019-2024 Quality Objectives.*	Insufficient capacity / not able to flex capacity to meet demand. Impact of Covid-19 Wave 2 pandemic resulting in elective activity cancellations including cancer treatments. Projected further impact of Christmas period on recovery plans and patient choice for treatments. Delays in some cancer tumour sites in accessing Oncology.	Gap in assurance 1, 2 and 3: Not meeting cancer key performance targets: (a) 28 day time to diagnosis; (b) 62 day cancer performance targets; (c) IPT transfers by day 38. Gap in assurance 1 & 2: Colorectal cancer tumour site is significantly impacted upon by gaps in Endoscopy/Colonoscopy capacity resulting in a significant proportion of the Trust's backlog being within colorectal tumour site. Gap in assurance 2 & 3: Not meeting cancer key performance targets: (b) 62 day cancer performance targets; (c) IPT transfers by day 38.	Recovery work underway making use of Goole for elective surgery and Independent Sector facilities, Review in Feb 21. Currently not fully mitigating the backlog risk and backlog increased.	R	Cancer Board; Planned Care Board; Quality & Safety Committee; Quality Governance Group
					Test colorectal cancer pathway compliance (post Covid-19) using IST analyser tool. Feedback to clinical teams and agree improvement plans Q1 2021/22 as part of Rapid Diagnostic Centre pathways.	A	
					GP FIT testing has a high failure rate relating to patient compliance factors and some educational awareness needed with GPs. Reviewing as part of the Secondary/Primary Care group, with GP focus on. Review in Feb 21.	A	
					Agree trajectories for what proportion of patients would be expected to require a FIT test to support more accurate measures of performance as a KPI to support improvement. Review in February 2021.	A	
					Rapid Diagnostic Centre Pathway for upper and lower GI (Colorectal) tumour site. Funding received from Cancer Alliance. Aim: Reduce 2WW referrals with non-specific symptoms. Pilot to involve 3 PCNS and aligned GP surgeries to develop and trial pathways. Draft pathway by end of Feb 21 and commence pilot in Mar 21.	A	
					HUTH Oncology services consolidation onto single site (DPoW; Jan 2020). CCG led review of centralisation commenced, patients being surveyed, outcomes to be reported back to OSC in Q4, 2020.	G	
					Current gaps in Oncology service (staffing). Raised to Humber cancer board with HUTH. Lack of capacity at present leading to longer waits in some pathways. Oncology working group established with Trust representation looking at improving pathways with oncology. This is a sub group of joint Humber Cancer Board. Review in February 2021. Structure in place, but not yet mitigating and improving outcomes.	R	
					Development of a joint NLAG/HUTH Cancer Transformation Plan for pathways which cross both organisations. Prioritised tumour sites to be identified and link to the interim clinical plan of the HASR. Developing the plans and timetable by Q3. Sign off by Humber Cancer Board in January 2021. [This will identify areas where	A	

					further joined up work can be undertaken as a single service between NLAG and HUTH to streamline pathways and provide better access to diagnostics and treatment]		
			Cancer MDT Business meetings not quorate.	Gap in assurance 9: Quality Surveillance (QSIS) annual submission: no improvements in recent years.	Divisions with higher risk Cancer Tumour site gaps as measured by QSIS to provide assurance via Quality Governance Group that risks have been identified and recorded and that improvement plans are in place. Review at QGG in October 2020.	A	
			Cancer Board meeting but not quorate.	Gap in assurance 9: QSIS improvement plans delivery; lack of assurance in monitoring of delivery.			
			Tumour site MDTs not focussed on QSIS Standards.				
			Clinicians not reviewing root causes for breaches monthly.		Develop divisional dashboards containing improvement plan within PowerBI, 2021.	A	
			Lung cancer: no MDT for mesothelioma.		Temporary arrangement in place to discuss Mesothelioma within Hull MDT. Collaborative approach agreed. SOP to be amended to outline formal arrangement, Q3 20/21.	A	
(b) A&E	Meeting oversight structure in place: Emergency Care Quality & Safety Group; PRIM performance challenge; ED Performance and Ambulance Handover Group; A&E Delivery Board and a system wide focus; Urgent Treatment Centre (UTC)/minors and Majors approach. UTC reduces the burden of non-emergency walk-ins from the ECC department; Acute Assessment Unit (3 phases: Phase 1: live on CDU and AMU and Ambulatory Care/SDEC (12 hour service), Phase 2: (ward reconfiguration) was due for Q2 but delayed due to Covid-19, now replaced with Integrated AAU work progressing through task and finish group, scheduled for 28 October 2020 go live; Phase 3: (integrated AAU include Surgery and Gynae and extension of hours, linked to refurb work) scheduled to commence February 2022, go live 2022/23) work and focus on ambulatory pathways to pull from A&E model; Additional staff in A&E and UTC (medical and nursing); establishment review completed and additional establishment agreed; Senior positions in the department extended (i.e. Consultant cover from 08:00 to midnight, 7 days a week). Some cost pressures. Matron of the day present at Ops meetings to consider staffing; A&E board rounds refocussed to 2 hourly and including Acute Care Physician to support pull of patients out of A&E; Refocussed twice daily huddle with lead doctor and lead nurse to review in more detail activity/acuity. Escalation to medicine management and ops centre; Implementation of COVID-19 response plans to ensure A&E can continue to function safely with zoning. Covid-19 affected performance in A&E by improving availability of beds and increasing patient flow; New escalation triggers live from Monday 20 July; Patient breach validation undergoing daily to examine root causes/themes and learning as a result; Assistant General Manager to support the Unscheduled care pathway now in post; B7 Clinical Co-ordinator post to provide senior nursing leadership started and now in post. Further recruitment to achieve 24/7 cover.	*Assurance data:* (1) **Negative:** Accident and Emergency Performance: November: 66.31% August: 87.8%; ABOVE local trajectory aim *[Local trajectory > 84%].* (1) **Negative:** Accident and Emergency Performance: November: 66.31% August:87.8%; BELOW National Target [Target: 95% by 2024] and <90%. *Assurance sources:* *Performance data: Symphony A&E system; Bed state;* *Sitrep reports;* *A&E live dashboard;* *IPR reported to F&P committee and PRIM;* *The Trust's 2019-2024 Quality Objectives.* *Quality assurance:* *ED Nursing Dashboard (to be developed into the Ward Assurance Tool for the ED);* *Matron retrospective review of patients waiting over 10 hours to assess for clinical harm.* **EXTERNAL ASSURANCE:** (Ext) **Positive:** Audit Yorkshire internal audit: A&E 4 Hour Wait (Breach to Non-Breach): Significant Assurance, Q2 2019.		Gap in assurance 1: Not yet meeting >90% ED 4 hour performance.	Local breach tracker tool developed to support increased awareness of daily ED performance, aiming for 90-92% performance. Went live in September 20 and work progressing to embed into daily operational management. End of October 2020.	A	A&E Delivery Board; Emergency Care Quality & Safety Group; PRIM
					Talk before you walk initiative with Urgent Emergency Care Network. Project focuses on: (1) UTC bookable appointments; (2) regional triage tool to support determination of appropriate patients for ED; (3) updates to DOS to ensure correct primary/community care alternative service provision. Launch mid October 20.	A	
					National ECIST team working with the Trust to focus on streaming and improved SDEC performance, started September running through to December 2020.		
					NEL UTC operating with ED doctors funded through NLAG at cost pressure, no funding confirmed for UTC provision in NEL, Finance and Contracting Team working with CCG to resolve, review in September 20.	R	
			Unfunded additional ECC staffing cost pressure.	Gap in assurance 1: Cost pressure as unfunded.	Business case developed but not approved. Ongoing monitoring of cost pressure. Review in October 2020.	R	
			Flow challenges at both Trust sites resulting in capacity challenges for patients needing to be admitted.	Gap in assurance 1: Potential for more patients to be on ambulatory/zero LOS pathways.	Increase amount of ambulatory attendances through use of existing clinical pathways and supporting decision making, part of the IAAU project, review due to go live in October 2020.	A	
				Gap in assurance 1: Potential for more patients to be discharged within 72 hours.	Task and finish group established to oversee collaborative approach to SAFER to support improvements in LOS and discharge [See quality BAF for more detail on SAFER], Review in October 2020.	A	
				Gap in assurance 1: Potential for SAFER bundle to be utilised more.	Ongoing work through ECIST and Patient Flow Task and Finish Group, [See quality BAF for more detail on SAFER], Review in October 2020.	A	

(c) RTT/18 weeks	Divisions are operationally managing the risks, reporting into PRIM (and for assurance F&P committee). Patient Access and Administration Team focus on the processes to support operational management of the risks. RTT Recovery Programme Manager appointed. Performance team established. Elective Task and Finish Group established and meeting bi-weekly, with Executive PTL meetings still in place. Performance reporting against phase 3 plans and trajectories for RTT 52 week waiters and overdue OPD reviews. Planned care board has system wide membership. Refresh of Capacity and Demand Plans and development of action plans to reconcile differences being developed to support 20/21 Business Planning. Phase 3 planning by divisions completed. Trust working collaboratively with Independent providers and System NHS partners to maximise elective activity during the pandemic. Intercollegiate Royal College of Surgeons risk stratification guidance received for Surgery during the pandemic. Guidance incorporated into Trust approach to risk stratification. Local risk stratification approach paper adopted to ensure consistent approach to risk stratification based on national guidance where available and to provide local approach in areas where no national guidance exists. Paper aims to mitigate the patient safety risk. Paper deals with 4 categories of patient for risk stratification: (1) 'Live' inpatient waiting list; (2) 'Planned' awaiting treatment (inpatient) (3) 'New' OPD PTL and (4) 'Review' OPD follow up list. Ongoing control in place with progress reporting available in PowerBI. Primary and Secondary care collaborative outpatient transformation programme is underway. Governance arrangements to enable group to continue to meet to approve/change care models and care pathways at pace approved. Live from July 2020. NLAG Most Challenges Specialties: Medium/Long term: Directly linked to Interim Clinical Plan, 3 phases. Programme group established for delivery transformation of the 7 specialties and governance arrangements agreed. Longer term: Outpatient Transformation Programme group is established. Transformational plans being developed in line with the strategic aims of the ICS. Local plan adapted and adopted National Plan to improve outpatient position. Oversight is retained through the Programme Board.	*Assurance data:* (1) **Negative:** Number of incomplete RTT pathways >52 weeks: November: 630 [increasing] August: 293 *[Target: Zero by March 20]* . (1) **Negative:** Phase 3 Plans: RTT 52 Weeks: Delivery of 52 week waits by 31/3/21: RAG: RED: Concerns unless additional support: ENT; Orthopaedics; Diabetes (2) **Negative:** Number of incomplete RTT pathways >40 Weeks: November: 2445 August: 2,277 [Increasing] *[Target: Zero by 20/21]* . (3) **Positive:** As at 11/11/2020: 99.5% of the 'live' inpatient PTL has been risk stratified. (3) **Positive:** As at 11/11/2020: Most urgent patients (1a; 1b; 2; 2a) are being seen within risk stratification due dates. (4) **Negative:** As at 11/11/2020: 28.7% of the 'planned' (review) inpatient PTL has been risk stratified. (5) **Negative:** As at 11/11/2020: 4.06% of the 'new' OPD PTL has been risk stratified. (5) **Positive:** As at 11/11/2020: >90% of 2WW referrals are seen within 2weeks (14 days). (6) **Negative:** As at 11/11/2020: Majority of the 'FU' (review) OPD PTL has not been risk stratified. (7) **Negative:** Number of Overdue Outpatient Review Appointments: August: 26,413 [Increasing] *[Target: 9,000 by Mar 2021].* *(7) Negative: Phase 3 Plans: Overdue Out-Patient Reviews: Delivery of Trajectory to support Trust target of 9000 maximum by 31/3/21: RAG: RED: Concerns unless additional support: Ophthalmology* (8) **Positive:** OPD Transformation Project: Pilot in 8 clinics: Virtual MDT (GP, Consultant): 78 patients assessed, 72% discharged from NLAG waiting list. (9) **Negative:** Incidents and SIs linked to waiting times. (10) **Positive:** Data quality gaps previously identified in connection with 'clock stops' resulting in incorrect waiting list categorisation in some instances. Audit report received. No significant issues identified from audit (July 2020). (11) Negative: Phase 3 Plans: Modelling to deliver 100% of 19/20 levels: RAG: RED: Concerns unless additional support: Endocrine, Cardiology, Dermatology. *Assurance sources:* *IPR report;* *Finance and Performance Committee and Trust Board review of IPR;* *PRIM review and challenge of IPR performance data;* *RCA's process for patients who wait > 52w for treatment to understand reasons and share lessons. Process to review RCAs for Harm and escalation to full clinical harm review and SI route if indicated;* *The Trust's 2019-2024 Quality Objectives;* *External audit report undertaken to examine the Trust's recording of 'clock stop' times* .	Impact of pandemic response on elective and planned activity (RTT and 18weeks); Waiting list improvement plan/performance adversely impacted.	Gap in assurance 11: Modelling to deliver 100% of 19/20 levels	Waiting list initiatives to reduce backlog in Cancer, OPD, 52 week waits have been extended to end of year in line with phase 3 planning, December 2020.	A	[Aim: Amber Assurance by Jan 21, impact/delayed by Covid-19] PRIM; Planned Care Board; Quality & Safety Committee
				Gap in assurance 1: Pre-Covid-19: Single numbers of over 52 week wait patients (Aim: 0 by Mar 21). Covid-19 impact: national target changed to be zero by March 21. Zero 26 week wait patients target affected.			
				Gap in assurance 2: Pre-Covid-19: Reduction in patients waiting more than 40 weeks (Aim: 0 by Mar 20). Covid-19 impact: Deterioration of performance.	Working with independent sector and System partners to carve out elective capacity to see urgent/priority patients on the waiting list, December 2020. Businesses being presented at TMB for funding to support Medinet and New medica.	A	
					Working with York and Hull to develop single access policy across the STP. Delayed whilst awaiting new risk stratification national guidance, expected Jan/Feb 21.	A	
				Gap in assurance 1 & 2: Patient safety risk due to increased waiting lists.	Risk stratification work ongoing to mitigate risk of harm from long waiters.	A	
				Gap in assurance 4, 5 and 6: Risk stratification not fully completed for inpatient planned PTL or OPD PTL. (Aim: all waiting lists to be risk stratified).	Expansion of risk stratification work to focus on seeking patient's wishes as to their place on the in-patient 'live' admitted PTL (~5,000 patients) and determine if they want to (1) stay on the waiting list; (2) come off; (3) stay on but defer until later or (4) require a conversation with a clinician. December 2020.	A	
					Diagnostics waiting list and OPD risk stratification strategic approach paused as national guidance is expected in the new year. Review in Jan/Feb 21. Medicine division working with Primary care to start working on risk stratifying	A	
					Divisional plans in place to focus on risk stratification, with oversight by PRIM. Covid-19 has impacted adversely on some divisions plans (i.e. medicine). Review in December 2020.	R	
			Insufficient resource to undertake improvement programme to meet Trust targets set for March 2023, complicated further by pandemic impact.	Gap in assurance 7: Outpatient follow-up trajectory not being met; impacted upon by Covid-19. (Aim: 9,000 overdue by 2021 and 4,000 by 2022).	Rapid Rollout of Patient Initiated Follow-Up. In use but still rolling out; delayed by operational pressures and clinicians focus on ward work over outpatient clinics. Review in December 2020.	R	
					OPD transformation programme making progress: MDT approach (GP and consultant) virtual review of records to agree how best to manage the patient. Outcome: 72% overdue F/U list were discharged. Planned Care Board approved paper proposing expansion, but unable to resource to expand project at pace. Expanded to include another PCN. Covid-19 focus on non-elective ward work has impacted on progress. [18month project; aim: March 2022 include all PCNs.]	R	
					System business rules audit has identified further priorities for		

					validation. Complete validation. Delayed as a result of increased work to focus on high risk / long waiting position validation, review in December 2020.	G	
			Data Validation Team in place and have been validating all new clock stops from 01/01/2020. Covid-19 impact as team re-deployed.	Gap in assurance 7: Data validity for clock stops for recent patients	Process for high priority/risk specialties paused due to priority validation work arising from the business rules audit, the team are unable to validate all high priority/risk areas, but do review a sample/proportion. Not yet resumed. Review in December 2020. (Aim was all clock stops; impacted by higher number of 52 weeks).	R	
			Most challenged specialties with significant mismatch between capacity and demand leading to long waiting times in 7 specialties (1) ENT; (2) Ophthalmology; (3) Colorectal Surgery; (4) Gastroenterology; (5) Cardiology; (6) Respiratory; (7) Urology.	<u>Gap in assurance 1, 2, 3 and 9:</u> Increased number of incidents and SIs in Ophthalmology; Gastroenterology and ENT relating to waiting times.	Short/Medium term: System outpatient transformation plan developed for each of the 7 specialties. [Each plan has dedicated timescales] 2022/23. Reviewing each of the local plans in line with HASR principles. Phased in as part of the HASR phasing.	A	
					Agreement reached with HUTH regarding development of different delivery models HASR programme group. Plans not yet developed as part of HASR. Review in December 2020.	A	
(d1) Diagnostics - DMO1 [Radiology]	Daily activity huddles for radiology, weekly activity PTL meetings, Radiology Management Meetings, Monthly Business and Governance Meetings. Take part in Trust's weekly PTL, weekly PTL escalation process approved. Expanded remit for reporting radiographers which increases reporting capacity. Outsourcing contract with 3rd party provider now in place for reporting to mitigate delays between scan and reporting, 5 year contract with guaranteed capacity. Controls in place to escalate any scans not meeting internal KPIs to outsourced 3rd party for reporting (KPIs: suspected cancer, not reported same day - escalate to outsourced 3rd party; routine scans, not reported by day 21 - escalate to outsourced 3rd party). Full business case approved by Board in December for MRI scanners at Grimsby. Building work underway. Demand management of MSK on all imaging in place via the MCATS solution (Jan 20). Weekly KPIs/Monitoring Report in Power BI available in draft and being piloted with Heads of Service. Being used at weekly business meetings from the 20 May 2020. 'Live' activity document being used to support activity recovery with links to Executive Team. 5 year service strategy agreed, with the potential need to review post Covid-19. Phase 3 diagnostic recovery planning completed. Expansion of plain film reporting with backfill arrangements, increased from 3 to 5 sessions per week per reporting radiographer, 6 week advanced rota, Ongoing Business As Usual to help mitigate shortage of radiographers. NHSE/I identified and supported with funding of additional independent sector slots in Hull, Lincoln and Grimsby to help with demand management (July 2020). Additional independent resource using St Hughes mobile pads (July 2020). For both CT and MRI. Additional CT Scanner project at DPoW completed and available for use, Jan 2021.	<u>Assurance data:</u> (1) **Negative:** DMO1 performance: Dec 20 43.8%; Nov 20: 40.4%; Oct 20: 40.1%; Sept 20: 44.1%; Aug 20: 48.2%; Jul 20: 44%; Jun 20: 51.5%; May 20: 65.7%. *[Target: Reduced to 1% by 2024]* . (2) **Positive:** Performing within Reporting KPI limits, September 20. (3) **Negative:** MRI Breach (routine >6weeks): Dec 20: 41.6%; Nov 20: 41.1%; Oct 20: 45.7%; Sept 20: 50.8%; Aug 20: 52.1%, Jul 20: 47%; Jun 20: 56.2%; May 20: 71%. [Reducing] [Breach target agreed for MRI 19/20: Aim: < 15% of PTL breach; no locally agreed target for 20/21] (4) **Negative:** CT Breach: Dec 20: 33.8%; Nov 20: 29.4%; Oct 20: 26.3%; Sept 20: 31.8%; Aug 20: 47.2%; Jul 20: 45%.[6 Weeks Diagnostic Target <1%]. (5) **Positive:** Aim to get back to 95-100% of pre-Covid activity levels: [September 2020 vs. September 2019] CT: 100% (+11.3% from Aug); MRI: 93% (+1.1% from Aug); Non-Obstetric Ultrasound: 78% (-6%) *(deterioration due to staffing COVID risk assessment/flex staffing)* . (6) **Positive:** 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. <u>Assurance sources:</u> Power BI data monitored daily; PTL data and live dashboard submitted to PRIM; PRIM meetings review and escalation; The Trust's 2019-2024 Quality Objectives.	Insufficient MRI capacity until new schemes complete.	<u>Gap in assurance 1:</u> CT and MRI performance against DMO1 position; impact on performance as a result of priority focus on RTT improvement/Covid-19.	Additional MRI: DPoW: Scheme in progress; completion date: April 21.	G	PRIM
					Additional MRI: SGH completion due: Q3 2021/22.	G	
					Ongoing work with NHSE/I to secure additional scanner capacity each month. Review in Feb 21.	A	
			Reduced productivity within core capacity as a result of Covid-19 measures needing to be taken including social distancing, increased cleaning time which reduces the capacity to meet the unchanged demand on the service resulting in increased number of breaches against DMO1 target.	<u>Gap in assurance 3:</u> Internal Breach target agreed for MRI 20/21: Aim: < 15% of PTL breach. Covid-19 adverse impact.	Additional MRI capacity approved. Now extended to the 31 March 2021.	G	
				<u>Gap in assurance 1:</u> Demand & Capacity for CT needs to be reworked post Covid-19.	Business planning underway for 2021/22. Insufficient resource to fully understand demand and capacity to enable confident business planning. Currently there is a risk that planning purpose data may not be as accurate as needed to enable good planning. Central support was available, this is no longer available to support. Review in February 2021.	R	
			Radiology Diagnostic capacity		Radiographer vacancies. Recruitment completed from overseas, some delays in getting started. Risk being mitigated by adequate backfill arrangements. Review in March 2021.	G	
					MSK service tender by Trust and partners reduced demand on MRI scanning capacity. Review in March 2021. Currently supporting mitigating risks to MRI capacity.	G	
				Gap in assurance 1: Trust's priority focus of RTT impacts adversely on DMO1 waiting times performance.	Discussion at OMG. Remains a conflict between RTT clinical urgency/risk stratification diagnostics and the DMO1 routine performance target. Risk remains. Review in February 2021.	R	
					Trust's Improvement Director to support conversations with Clinical Lead and Radiologist colleagues regarding workforce		

			Due to expanded remit for reporting, shortage of radiographers identified.		planning and expansion of scope and practice. Delayed due to Covid-19. Improvement Director not able to meet with stakeholders for face to face conversation. External support needed, not able to mitigate adequately without support. Review in March 2021.	R	
(d2) Diagnostics - DMO1 [Audiology]	Weekly huddle. PRIM meeting oversight. 5 year service strategy agreed, with the potential need to review post Covid-19. 'Live' activity document being used to support activity recovery with links to Executive Team. Implementation of the Covid-19 recovery plan resulting in improvements in DMO1 performance.	Assurance data: (1) **Negative:** DMO1 performance: Dec 20 43.8%; Nov 20: 40.4%; Oct 20: 40.1%; Sept 20: 44.1%; Aug 20: 48.2%; Jul 20: 44%; Jun 20: 51.5%; May 20: 65.7%. [Target: Reduced to 1% by 2024]. (2) **Positive:** DMO1 performance - Audiology: Dec 20: 4.4%; Nov 20: 9.5%; Oct 20: 10.6%; Sept 20: 21.1%; Aug 20: 32.4%; Jul 20: 51.7%; Jun 20: 69%; May 20: 88%. [Reducing] [Target: Not exceed 1% of PTL breach]. Assurance sources: DMO1 improvement trajectories in place for 2020/21; Complete data validation manually and informatics to apply greater controls; The Trust's 2019-2024 Quality	Change in service provision between ENT and Audiology resulting in triage of patients direct to Audiology. Forecast: This may have a negative impact on DMO1 performance. Unsure at this time the scale of the impact.		Undertake deep dive into Diagnostics to understand impact of ENT recovery on Audiology and monitor impact of change in service, review in February 2021.	A	
(d3) Diagnostics - DMO1 [Echocardiography]	Weekly reporting and monitoring of DM01 position in weekly Statutory Performance Standards Meeting, Monthly PRIM. Patients on WL clinically triaged and elective activity recommenced w/c 08.06.2020. Activity recovery plans in place. Standard Operating procedure in place for Cardiology Diagnostics with social distancing, PPE, IPC regimes and appointment timings. Daily validation of Data Quality in place.	Assurance data: (1) **Negative:** DMO1 performance: September: 53.1%; August: 58.8%; July: 50.7% June: 56.8%; May: 63.4%, [Reducing] [Target: Reduced to 1% by 2024]. Assurance sources: DMO1 improvement trajectories in place for 2020/21; Internal Breach target agreed for modality, to not exceed 1% of PTL breach; The Trust's 2019-2024 Quality Objectives.	Covid-19 impact on Echocardiography performance as elective diagnostic work paused, with only clinically urgent inpatient work being undertaken.		Additional sessions arranged by staff working flexibly, to offer alternative sessions to maximise capacity, review in October 2020.	R	
				Gap in assurance 1: Data quality gaps have been identified in connection with clinics not being fully closed after they have happened and patient data left open.	Daily validation of Data Quality in place, ongoing.		
(d4) Diagnostics - DMO1 [Endoscopy: Colonoscopy; Cystoscopy; Flexi Sigmoidoscopy; Gastroscopy]	Daily Huddle. Weekly PTL Meeting, standards meeting. Monthly Business and Governance meetings. PRIM meeting oversight. 'Live' activity document being used to support activity recovery with links to Executive Team. 5 year service strategy agreed, with the potential need to review post Covid-19. Year 2 of business plan being delivered. Demand and Capacity work completed for Endoscopy. £1.2m investment in decontamination and additional scopes. Further £150k for scope and patient monitoring. Expanded remit for non-medical endoscopists. Deviation from National Guidance approved by Clinical Reference Group (CRG) and refusal rates have returned to 'normal'. NICE guidance also supported recovery. New PHE Guidance clarifies IPC precautions to be taken between patients increasing capacity within Endoscopy. Increased to 8points per list, from 4points (pre-covid 10 points). Clinical Harm risk due to increased waiting list. Clinical Harm risk stratification framework in place and commenced post Covid-19 impact on activity. NLAG are a part of the 'adapt and adopt' HCV programme to share/learn from innovation, commenced in August 2020	Assurance data: (1) **Negative:** DMO1 performance: Dec 20 43.8%; Nov 20: 40.4%; Oct 20: 40.1%; Sept 20: 44.1%; Aug 20: 48.2%; Jul 20: 44%; Jun 20: 51.5%; May 20: 65.7%. [Target: Reduced to 1% by 2024]. (1) **Negative:** DMO1 performance: Colonoscopy Dec 20: 49.9%; Nov 20: 52.5%; Oct 20: 50.8%; Sept 20: 51.9%; Aug 20: 52.1%; Jul 20: 44.3%; Jun 20: 58%; May 20: 58%; Apr 20: 65.7% [Reducing]. (2) **Negative:** Aim to get back to 95-100% of pre-Covid activity levels: [September 2020 vs September 2019: 83% (+30.1% on Aug 20). (3) **Positive:** New PHE Guidance: Increasing capacity within Endoscopy: Increased to 8 points per list, from 4 points (post-Covid) [Context: pre-covid *normal* was 10 points]. [Other Trusts: back to 10 points per list] (4) **Positive:** Assurance from JAG: Covid-19 impact on waiting times to not adversely impact on JAG accreditation as long as robust recovery plan in place by June 21. Assurance sources: Integrated Performance Report including the DMO1 position; JAG accreditation against quality standards; Weekly KPIs and monitoring report Internal Breach target agreed for modality, to not exceed 1%	Endoscopy post Covid-19 capacity reduced.	Gap in assurance 1: DMO1 improvement trajectories in place for 2020/21. Adverse impact from Covid-19. Non-emergency endoscopy stopped during pandemic.	Additional capital from ICS of £240,000 to purchase equipment for naso-endoscopes which require less infection control preventions and will reduce the number of gastroscopies needed, resulting in increased capacity. Procure through ICS underway. Business case for revenue for maintenance costs to be submitted, review in February 2021.	A	PRIM
				Gap in assurance 5: Not yet meeting national targets to get back to pre-Covid activity levels: Key area of concern: Endoscopy.			
			One full time NME scopist vacancy having impact on Endoscopy activity.	Gap in assurance 1: Patient safety risk due to increased waiting lists.	Recruitment a challenge. Risk being mitigated through backfill arrangements within the Trust and also enacting SLA with Rotherham. Review in February 2021.	A	
			Impact of pandemic on Endoscopy waiting times, a component of the JAG accreditation process	Gap in assurance 4: Risk to continued JAG accreditation as a result of Covid-19 pandemic impact on Endoscopy waiting times.	JAG Accreditation waiting times recovery paper outlining robust plans to recover within 12 months required for submission to JAG in June 2021.	A	
			Staffing gaps for hard to recruit to vacancies results in increased costs for temporary staff.		Non-medical endoscopy review against 5-year strategy, determine progress and further action needed. Phase 3 work ongoing. Review in February 2021.	A	
	Weekly huddle. Daily meeting with booking office.	Assurance data: (1) **Negative:** DMO1 performance: Dec 20 43.8%; Nov 20: 40.4%; Oct 20: 40.1%;					

(d5) Diagnostics - DMO1 [Medical Physics: Dexa scan; Neurophysiology; Urodynamics]		Skill mix reviewed and flexibility of roles/role redesign. PRIM meeting oversight. 5 year service strategy agreed, with the potential need to review post Covid-19. 'Live' activity document being used to support activity recovery with links to Executive Team. Implementation of the Covid-19 recovery plan resulting in improvements in DMO1 performance.	Sept 20: 44.1%; Aug 20: 48.2%; Jul 20: 44%; Jun 20: 51.5%; May 20: 65.7%. [Target: Reduced to 1% by 2024]. (2) **Positive:** DEXA: DMO1: Dec 20: 3.3% (Green); Nov 20: 2.7%; Oct 20: 5.6%; Sept 20: 8%; Aug 20: 10.7%; Jul 20: 29.5%; Jun 29: 48.4%; May 20: 63%. [breaches are small numbers (n=8), all patient initiated]. (3) **Positive:** Urodynamics: Dec 20: 15.4%; Nov 20: 19.5%; Oct 20: 19.5%; Sept 20: 23.6%; Aug 20: 28.9%; Jul 20: 46.9%; Jun 20: 47.2%; May: 83.6%. [breaches are small numbers (n=8), all patient initiated]. (4) **Positive:** Neurophysiology: Dec 20: 0%; Nov 20: 14.3%; Oct 20: 31.2%; Sept 20: 19.2%. <u>Assurance sources:</u> Weekly KPIs and monitoring report; DMO1 improvement trajectories in place for 2020/21; Internal Breach target agreed for modality, to not exceed 1% of PTL breach; The Trust's 2019-2024 Quality				G
RAG RATING KEY:	G	Green: Fully assured that progress is being made in mitigating issues, impacting on strategic risk.					
	A	Amber: Partially assured, progress is being made in mitigating the issues.					
	R	Red: Not assured; limited signs of progress being made to mitigate issues leading to increased risk.					

Strategic Objective:	**1. TO GIVE GREAT CARE**
Risk to Strategic Objective:	2) Risk of non-delivery of agreed quality and clinical improvements (includes the risk of non-delivery of a reduction in the mortality ratio)
Risk Description:	The risk is that the Trust could fail to deliver consistent levels of service quality which negatively impacts on the Trust's reputation with service users and regulatory bodies.

Monthly Executive Highlight Report:

* Strategic risk rating reduced from 20 to 15 following confirm and challenge at Quality & Safety Committee in October in response to reduced SHMI and other improvements in quality controls.
* Operational response to Covid-19 Wave 2 has had a significant impact on progress with operational performance, recovery plans and improvement activity related to the Trust's Quality Priorities.
* Risk stratification of waiting list included within the quality risk to determine assurances available. Whilst inpatient (live) PTL has almost fully been risk stratified, significant further resource will be required to risk stratify all PTLs (I/P Planned; Outpatient new; Outpatient F/U: majority have not yet been risk stratified).
* Monthly SHMI data (published in December for Aug 19-Jul 2020 is 105.4. 9th consecutive monthly reduction. 'As expected' range. The underpinning mortality risk on the risk register has been reduced to 10 (September 2020) following agreement at MIG and confirmation of this at QGG in October.
* Pilot commenced to merge clinician led coding processes and quality of care screening process during October; aim: increase the number of deaths screened identifying cases for further review using SJR.
* Discharge to Assess programme has been restructured and commenced in month with a detailed improvement action plan to build on the previously launched small steps for change pilot work. Structured event planned during December in the acute Trust and for community beds to discharge patients not meeting the 'right to reside' criteria.

* Overdue and unbooked f/u waiting list in Ophthalmology continues to increase (Nov: 6,935 vs. Oct: 5,326; Sept: 3,695; Aug: 1,581; Jul: 710). Shortfall in capacity within the service impacted upon by covid mitigation measures in out-patients. Temporary mitigation of current shortfall in capacity includes: HCV, Transfer of patients to independent providers, 'Lift and Shift' and waiting list initiatives (as well as increased theatre capacity where surgery is required). The total caseload has reduced by 2,000 patients to16,391 as a result of transfers to an independent provider and discharge of patients. Risk stratification of inpatient waiting lists completed and quality risks to patients requiring timed treatments has been mitigated by identification of patients waiting who require timed treatments and oversight of these by failsafe officers.

Monthly Executive Highlight Report: Plans for next month:

* Improvements to feature within Learning From Deaths improvement plan with MIG oversight and with NHSE/I support, commencing during October 2020.
* Fastrack the development of a pain assessment tool designed specifically for patients at end of life. Amend the guidelines to support. Launch during December 2020.
* Monthly audit to provide assurance of action taken when (a) NEWS of >5 and (b) NEWS of >7 and (c) when a patient is admitted to Critical Care (CQUIN for 20/21) to include consideration of sepsis.
* Launch of the revised sepsis screening tool, escalation policy and oxygen policy with support from ward based champions.
* Intermediate Paediatric Resuscitation (PILS) gap at DPoW to be resolved with training planned and trajectory compliance is 95%.

* EXTERNAL ASSURANCE:
(Ext) **Positive:** Audit Yorkshire internal audit: Quality Impact Assessments: Significant Assurance, Q2 2019.
* EXTERNAL ASSURANCE:
(Ext) **Positive:** Audit Yorkshire internal audit: Incident Management (inc Lessons Learned) (cfwd 18/19): Significant Assurance, Q1 2019.

Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

* The heatmap demonstrates the current local risks that relate to or underpin the management of this strategic risk. During the month the following changes were made to underpinning divisional risk registers:

CHANGES SINCE LAST MONTH:

Quality Priority 1:

* 2770: Lack of workforce to run Haematology Services (Medicine) (RR: 15; C5xL3)
*
2118: Overdue Follow Up Colorectal Patients (risk rating: 8; C4xL2) [Risk Rating Decreased from 12 to 8, Jan 2021]

Quality Priority 2:

* 2653 Ceilings of care and advance care planning [C&T] (risk rating: 8; C4xL2) [Risk Rating Reduced from 12 to 8, Jan 2021]
* 2797: Backlog number of Mortality reviews requiring review and theming (RR: 8; C4xL2) [Risk Rating Reduced from 12 to 8, Jan 2021]

Quality Priority 4:

* **NEW** 2849: Quality Surveillance (Formerly Peer Review) for Cancer Services and NHS Spec Comm (Risk rating: 12; C3xL4)

Clinical Service Concern (CSC): Ophthalmology:

* **NEW** 2841: Nidek AR-310A Autofractor [Ophthalmology] (Risk rating: 16; C4xL4)
* **NEW** 2840: Cyclodiode Machine [Ophthalmology] (Risk rating: 9; C3xL3)

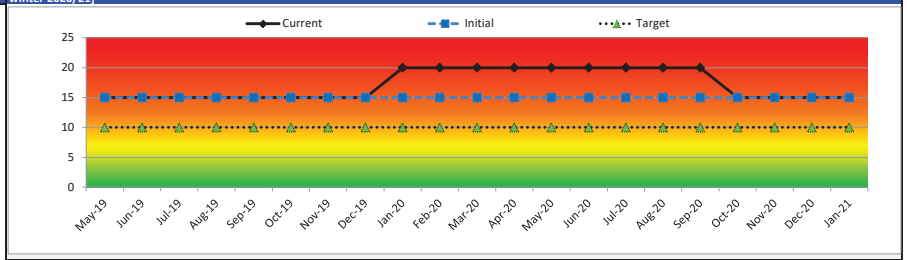
Clinical Service Concern (CSC): Care of the Paediatric Patient in the Emergency Department:

* 2449: Paediatric staffing (not meeting national guidance) W&C (risk rating: 9; C3xL3) [Risk Rating Reduced from 12 to 9, Jan 2021]

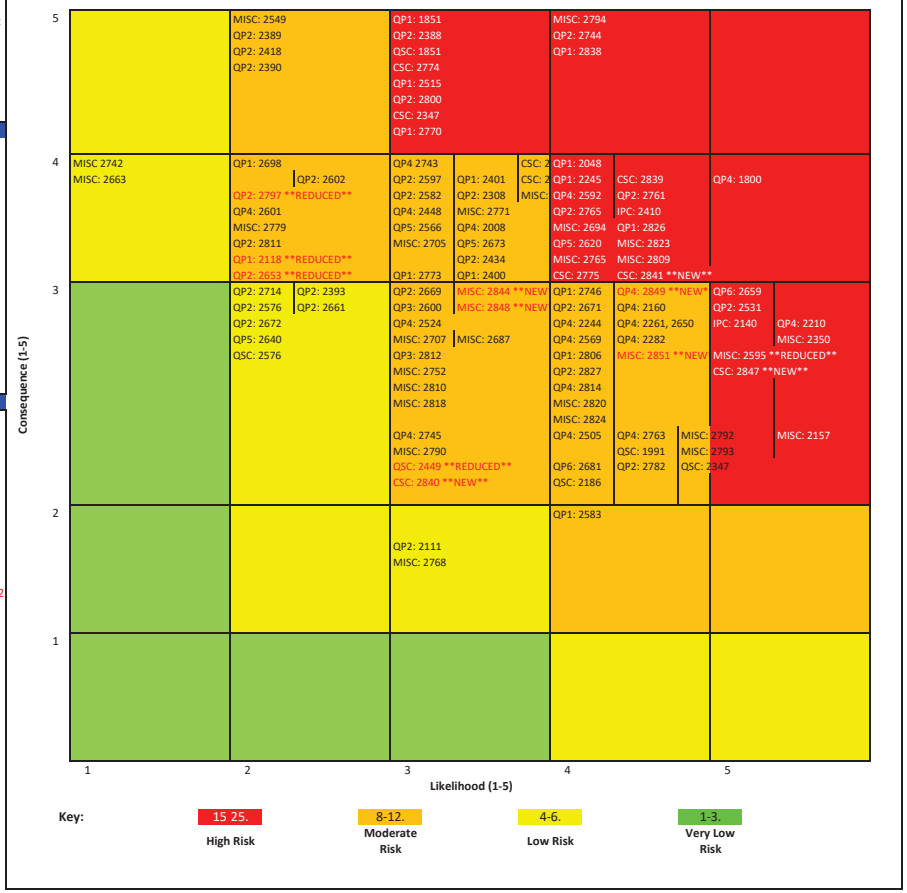
Miscellanious Quality Related:

* **NEW** 2847: Ambulance Handover Delays (Risk rating: 15; C3xL5)
* 2748: Misc: Restrictive bed capacity on Rainforest Ward due to the closure of the PAU which was co-located to ECC due to COVID-19 [Fam Serv] (RR: 12; C3xL4) [Risk removed from RR, Jan 2021]
* 2595: Lack of a Local Quality Dashboard – displaying quality indicators (risk rating: 16; C3xL5) [Risk Rating Reduced from 16 to 15, Jan 2021]
* **NEW** 2851: Non Compliance with NICE Guidance [Medicine] (Risk rating: 12; C3xL4)
* 2760: Misc: Consultant Pharmacist - Antimicrobials [CSS] (RR: 10; C2xL5) [Risk removed from RR, Jan 2021]

Risk tracking trend over time: Catastrophic consequence: 5 x 3: Likely RR of 15 [Target Risk Rating Achievement Date: Not yet set. Focus on maintaining 15 RR during winter 2020/21]



Linked Corporate or High Level Risk Rating HEATMAP:



STRATEGIC OBJECTIVE:	1. TO GIVE GREAT CARE						
Risk to Strategic Objective:	2) Risk of non-delivery of agreed quality and clinical improvements (includes the risk of non-delivery of a reduction in the mortality ratio)		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Kate Wood / Ellie Monkhouse Quality Governance Group Quality & Safety Committee		**Date added:** 01-May-19 **Last updated:** 13-Jan-21	
Consequences of Risk Materialising:	Negative impact on the provision of quality services resulting in adverse affect on the Trust's reputation with service users and regulatory bodies.		**Assurance that the issues impacting on this risk are being managed:**				Trend RAG Rating: AMBER / RED
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**		**Assurance / Oversight Group**
	Risk Stratification: Risk stratification is an approach designed to determine the clinical urgency of patients on the waiting list to support prioritisation of patients being seen by clinical urgency (and risk of harm) as opposed to length of time waited; Inpatient (live) waiting list contained higher risk patients following large scale cancellation of elective activity during Covid-19 wave 1; Vast majority of (live) inpatient waiting list has been risk stratified; Divisions access and oversee risk stratification and this supports booking of patients as part of the operational management; Oversight weekly PTL meeting focusses on priority patients risk stratification and seeks assurance these have been booked in for treatment; Clinical Harm process in place that is triggered by long waiting patients (>52 weeks).	(1) **Positive:** 99.5% of live inpatient waiting list risk stratified (Oct 20) (2) **Positive:** 80% of priority 1b (Live, inpatient PTL) patients seen on or before risk stratification due date (Oct 20) (2) **Positive:** 89.7% of priority 2 (Live, inpatient PTL) patients seen on or before risk stratification due date (Oct 20) (2) **Positive:** 91.0% of priority 2a (Live, inpatient PTL) patients seen on or before risk stratification due date (Oct 20) (2) 75.2% of priority 3 (Live, inpatient PTL) patients seen on or before risk stratification due date (Oct 20) (2) 44.8% of priority 4 (Live, inpatient PTL) patients seen on or before risk stratification due date (Oct 20) (3) **Positive:** >90% of patients referred as 2WW are seen within 2 weeks (Oct 20) (4) **Negative:** 71% of planned, inpatient PTL not yet risk stratified (Oct 20) (5) **Negative:** 96% of new outpatient PTL not yet risk stratified (Oct 20) (6) **Negative:** 92% of follow up outpatient PTL not yet risk stratified (Oct 20)		Gap in assurance 2: Some patients not seen on or before risk stratification due date.	Paper being taken to Q&S committee to approve closer alignment of risk stratification and clinical harm reviews which will result in patients going over their risk stratified date by 50% to have a prioritised review and refreshed risk stratification. Additional trigger points for clinical harm reviews also proposed. December 2020.	A	
				Gap in assurance 4, 5 and 6: Risk stratification as yet incomplete for patients on an inpatient review/follow up PTL or OPD PTL (although these groups of patients hold less risk than the live inpatient PTL)	Review approach for wider risk stratification work and resourcing required in line with CQC improvement plan, 31 March 2021.	A	
	Division of Family Services: Weekly performance update and weekly meetings with five divisional clinical leads; Risk stratification process in place to manage waiting lists, with new patients risk stratified on the day of their being first seen; maximising use of other providers; PTLs validated on a weekly basis in established Family Service specialties, with Breast service just commencing a programme of weekly PTL validation. Breast service has a large waiting list but none overdue; In-specialty PRIM meetings held at a local level to understand finance, performance and quality issues.	(1) **Negative Assurance:** Number of incomplete RTT pathways: 3,202 (2) **Negative Assurance:** Number of incomplete RTT pathways > 40 weeks: 60 [Reducing] (3) **Negative Assurance:** Number of incomplete RTT pathways > 52 weeks: 11 (vs. target of: 0) [Increasing] (4) **Negative assurance:** Number of overdue outpatient review appointments: 3,034 (5) **Positive assurance:** 100% of family services (inpatient) patients with risk stratification in place. (5) **Negative assurance:** 31% of family services (OPD) patients with risk stratification in place. *Assurance Sources: Weekly performance data; PowerBI*	Covid-19 impact on service provision	Paediatric Orthopaedic Service provided by Sheffield has a backlog which is impacting on NLAG waiting times.	Create an SLA between the Trust and Sheffield, December 2020. *[to discuss with CCG and make aware of]*	A	
			Covid-19 impact on workforce		Gaps identified in Gynaecology. Existing workforce covering on-call arrangements. New consultants starting in January and February 2021.	A	
					Workforce gaps identified in Paediatrics following Covid-19 staff risk assessments. Locums for 4 months backfill being sought with existing staff mitigating gaps, review in January 2021.	A	
			Impact on out-patient performance as Ward 19 staff redeployed to Red Covid-19 wards meaning that Gynaecology OPD clinics are not able to be staffed.	Gap in assurance 2 & 3: Increasing number of patients waiting >40 and >52 weeks.	Making use of capacity at independent providers and Goole for Cancer and urgent treatments, ongoing, review in January 2021.	A	
			As a result of Covid-19 there is a lack of Theatre space and day case procedure rooms.		Additional capacity is forecasted to resolve number of patients waiting >52 and >40 weeks, end of January 2021.	A	
	Division of Surgery and Critical Care: **40 weeks:** PRIM and FIMS oversight; Weekly operational performance meeting with Divisional Manager; Weekly performance reports:	(1) **Negative Assurance:** Number of incomplete RTT pathways: 17,023 [Increasing] (2) **Negative Assurance:** Number of incomplete RTT pathways > 40 weeks: 2,186			Elective activity work stood down to support safe management of patients within ward areas. Covid positive patients spread out across ward areas to		

Quality Priority 1: Patient Experience: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups	Weekly performance reports; PTL / PowerBI data checked for accuracy; Validation of waiting lists and incomplete pathways. Plan/forecasts developed to tackle increasing waiting list and planning completed for winter and surge planning. Recruitment of substantive and temporary staff undertaken between wave 1 and wave 2. Still some gaps. Job planning exercise undertaken with consultants across majority of specialities. Not take effect until elective work commences again. Mapping of pathways completed with consultants and CNS. Covid incident response likely to impact on implementation with CNS redeployment to wards. **Outpatient follow-ups:** Change in process to ensure consultant (senior decision maker) sees f/u patients in clinic; OPD PTL tracking systems.	pathways > 40 weeks: 2,186 [Increasing] (3) **Negative Assurance:** Number of incomplete RTT pathways > 52 weeks: 457 (vs. target of: 0) [Increasing] (4) **Negative Assurance:** Number of overdue outpatient review appointments: 13,868 [Increasing] *Assurance Sources: PowerBI*	Covid-19 impact on elective activity	Gap in assurance 1, 2 and 3: Increasing number of long waiting patients >40 weeks and >52 weeks as a result of incident management of risks associated with Covid-19.	support maximising oxygen capacity available. Adverse impact on 40 week / 52 week improvement work. Key actions: (1) Maximise use of St Hughes with 16 sessions being transferred, focus on cancer work, with some clinically urgent, with routine surgery to fill gaps and ensure 100% utilisation. To support emergency cover a 4 bedded HOBS area being established with out of hours medical staffing and a Registrar based there. Go live 23 November 20. (2) Discuss with and seek system capacity with HUTH and York for major cancer work above what can be fitted into St Hughes. To determine from Division and Family Services what major cancer work is required. November 2020.	R	PRIM; Finance and Performance Committee (Performance focus).
				Gap in assurance 4: Increased overdue outpatient review appointments.	In response to cessation of elective surgical work to support safety of inpatients, outpatient activity will increase to reduce backlog follow up list in line with Phase 3 recovery plans. Ongoing monitoring. Review in December 2020.	A	
				Gap in assurance 4: Further breakdown of the data to understand with greater clarity the number of referrals in vs. number of discharges to support planning.	OPD Clinic Configuration between Consultant and Middle Grade staff to determine ratios of new/FU patients to support focus on discharging patients able to be discharged, to go live on 1 November 2020. Complete in Urology, some gaps in other areas of Surgery. During response to Covid a greater consultant presence will be felt in outpatient clinics. Review in December 20.	A	
	Community & Therapy Services: Weekly activity reporting; Weekly patient level long waits 40+ week report; Monthly SPC trend analysis reporting; Validation of waiting lists and incomplete pathways; PTL validation; Risk stratification for new / FU / planned patients; Outpatient follow-ups: Change in process to ensure consultant (senior decision maker) sees f/u patients in clinic; OPD PTL tracking systems	(1) **Negative Assurance:** Number of incomplete RTT pathways: Nov: 157; Oct:161 (2) **Negative Assurance:** Number of incomplete RTT pathways > 18 weeks: Nov: 137; Oct: 142 (3) **Negative Assurance:** Number of incomplete RTT pathways > 45 weeks: Nov: 54; Oct: 23 (4) **Positive Assurance:** Number of incomplete RTT pathways > 52 weeks: Nov: 3; Oct: 0 (vs. target of: 0) (5) **Positive Assurance:** Number of overdue outpatient review appointments: Nov: 1; Oct: 1 Assurance Sources: SPC Charts; Weekly/Monthly data	Covid-19 impact on service provision and elective cancellations during November 2020	Gap in assurance 3: Increased number of long waiting patients >40 weeks.	Convert current general anaesthesia activity in acute theatres to shift to IV sedation in primary care enabling more resilient treatment capacity and additional capacity. Update in Jan 2021.	A	
					Reinstated GA treatments following Covid-19 in October. Working to upgrade air exchange in clinics to increase further capacity. Review in January 2021.	A	
					Restarted elective Theatre sessions during December following cancellations linked to operational pressures. Have secured the two lists at DPOW Monday and Friday PM and are working to secure more. No update on GA sessions at SGH. All patients have been validated to move what we can to DSU and to Primary care once we have the MINISCAV available. Constraints still for some patients requiring GA, patient safety risks being mitigated through risk stratification. Review in January 2021.	A	
					Procurement of MINISCAV (waste gas evacuation) for use within community dental. Order processed and awaiting installation date. Daily updates being sought	A	

					Daily updates being sought. Review in January 2021.		
	Medicine: To meet with division.	(1) Number of incomplete RTT pathways: 5,799 [Increasing] (2) Number of incomplete RTT pathways > 40 weeks: 344 (3) **Negative Assurance:** Number of incomplete RTT pathways > 52 weeks: 65 (vs. target of: 0)					
Quality Priority 2: – Clinical Effectiveness: Reduce mortality rates and strengthen end of life care; **2a) Mortality Improvement**	Mortality clinical lead in post, with improved divisional ownership arrangements. Mortality Improvement Group, reporting to QGG. Additional project management support from October 2019. Medicine appointed divisional mortality clinical lead from November 2019. Collaborative review processes established with NEL and NL CCGs to share cases with system wide learning. Greater use of CCG incidents reporting mechanism from Jan 2020 to ensure wider sharing of primary care / community 'issues' identified by hospital reviewers with CCGs as incidents to investigate for learning purposes. Mortality analyst in post from November 2019. Development of draft community mortality improvement plan led on by colleagues in CCGs, with regular feedback to MIG and oversight by CCG 'Unexpected Mortality Group' with NLAG membership a part of the group. Mortality strategy agreed at MIG in January 2020. Grant Thornton SHMI focussed Clinical Data Improvement Project commenced to review all deaths from February 2020 for 3 months. Scope approved by MIG in March; monthly updates planned from April MIG onwards for duration of project. Extension of project agreed for a further 6 months from June 2020. Specific plan agreed to review Wave 1 Covid-19 related deaths for learning and improvement purposes; with feedback of themes back to MIG. Project completed. Themes identified and shared with Divisions to outline actions taken in response. Specific EOL themes identified from a triangulation of mortality review themes, incidents and family/carer feedback. Themes shared with divisions to support focus on improvements in mortality and EOL. Mortality Screening Tool developed and in use with the aim for 2020/21 to screen 50% of deaths. Risk of adverse impact of Covid-19 on mortality review processes successfully mitigated by use of shielding clinicians during the pandemic wave 1. 312 cases reviewed. Process agreed (July 2020) for the oversight and action in response to reported mortality outlier data within the Monthly Mortality report. Process approved at SI Panel enabling SJRs with poor care/avoidability of death scores to be validated by the SI Panel and amended if necessary following confirm and challenge (August 2020). Strengthened divisional assurance template provides MIG greater insight into M&M meeting processes and compliance, went live during September 2020. Mortality lead clinicians in divisions identified to support clinical coders in continuing to embed improved quality of clinical coding. 2x in Surgery, 3x in Medicine and 1x in Family Services, Sept 20. Revised mortality report agreed by MIG and now in operation, Sept 20. Divisional Clinical Governance Leads trained in undertaking SJR reviews and to lead on train the trainer type cascade training, Oct 20. Pilot completed linking the coding clinician sign off process and the quality of care screening review identifying the two could be done together at the same time with minimal impact, Oct 20. MIG approved process flowchart including how the Lead ME role will link with the Learning from Deaths process (LFD) (Dec 20).	<u>Assurance data:</u> (1) **Positive:** Quality Priority 2a: SHMI 'As Expected' (Nov 2020, Jul 19-Jun 20) *[Target: Reduce the Summary Hospital-level Mortality Indicator (SHMI) to 'as expected' and maintain position by 2024]* . (1) **Positive:** Quality Priority 2a: SHMI SPC statistically significant improvement noted, 8 months of reducing SHMI; Jul 19-Jun 20: 105.8). *Context: Clarification from NHS Digital that SHMI will exclude Covid-19 deaths from the indicator.* (2) **Positive:** Quality Priority 2a: Expected deaths component seen to be increasing; reducing headline SHMI. (Professor Mohammed Mohammed's report on mortality statistics, 2019: Disparity in recording of risk leading to a lower level of expected deaths; Grant Thornton summary report: data quality gaps identified; Feb-May 2020.) (3) **Negative:** Quality Priority 2a: 1 SHMI group alerting as an official SHMI outlier: Secondary malignancies. (Oct 2020; Jun 19-May 20). (3) **Negative:** Quality Priority 2a: Continuing higher reported out of hospital SHMI vs. in-hospital SHMI. Secondary malignancies likely to be linked to out of hospital / community factors, Oct 2020. (4) **Negative:** Quality Priority 2b: Mortality screening: 50% of deaths reviewed for the first 5 months of 2020 (January - May 2020), June 2020 not yet achieving 50%, competing demands on clinicians time and shielding clinicians have resumed normal duties adds additional pressure to process complicated further by wave 2 of the pandemic. (4) **Negative:** Quality Priority 2b: Mortality SJR reviewed where indicated: Not yet 100% compliance, and trajectories shown a declining number completed related to the operational pressures of dealing with wave 2. October 20. (4) **Positive:** Quality Priority 2b: Mortality reviews have met targets set for 2018/19 and 2019/20. (5) **Negative:** Gaps in M&M evidence following meetings were cases are discussed for learning lessons; divisional highlight reports to focus on this in greater detail. (5) **Positive:** Divisional reporting templates monthly to MIG demonstrates improvement in process and divisional accountability, Sept 2020. (5) **Positive:** Assurance received by MIG that divisions are developing action plans in response to Covid-19 identified themes, Sept 2020. (5) **Negative:** Not yet able to review Covid-19 wave 2 deaths to determine key learning points and demonstrate learning from wave 1, Oct 2020. *(6)* **Positive:** Policy approved by MIG to better support bereaved relatives/carers, to be ratified by Quality Governance Group in January 2021.	Divisionally owned meeting structures to generate improvement plans / learning lessons.	<u>Gaps in assurance 5:</u> M&M evidence not fully available to demonstrate cases presented and lessons identified and learnt.	Divisional oversight of adequacy of arrangements with assurance reporting to MIG, October 2020. Operational pressures have resulted on standard reporting processes to MIG.	R	Mortality Improvement Group; Quality Governance Group; Quality & Safety Committee.
					Central team working with divisions to ensure M&M meeting evidence is maintained, review in Dec 20.	A	
				<u>Gaps in assurance 4:</u> Mortality review processes and forums for discussing and learning lessons disrupted/delayed by Covid-19/Recovery.	Shielding clinicians have mitigated risk during the acute response to the pandemic in wave 1. Fewer clinicians impacted during wave 2, prioritised mortality reviews are being undertaken by shielding clinicians during wave 2. Review progress in Jan 2021.	G	
			Policy for dealing with those bereaved not yet in place.	<u>Gaps in assurance 6:</u> Low number of NQB SJRs requested via complaints/PALS routes. Strengthened policy still in draft, not yet finally approved.	Policy to support recently bereaved relatives agreed by MIG in December 2020. To ratify at QGG in January 2021.	G	
				<u>Gaps in assurance 4:</u> Insufficiently trained SJR reviewers	Divisions to confirm train the trainer plans, delayed as a result of wave 2. Review in Jan 21.	R	
					Review training materials produced by NHSE/I that may support Trust approach to training, Dec 20.	A	
				<u>Gap in assurance 7:</u> Mortality Strategy KPIs not yet in place to monitor impact.	KPIs agreed. To collate and begin reviewing for reporting purposes, Jan 21.	A	
					Review and refresh the Trust's Mortality Improvement Strategy, meeting with NHSE/I scheduled in December 2020 to review.	A	
			NHSE/I Learning from Deaths Supportive Desktop review has identified areas for improvement.		Improvements to feature within LFD improvement plan with MIG oversight and with NHSE/I support, review plan in Jan 21.	G	
			SHMI statistic and high Out of Hospital (OOH) SHMI / HSMR.	<u>Gaps in assurance 2:</u> Disparity between statistically calculated expected deaths and the observed deaths.	Improved Charlson co-morbidities capture through WebV agreed. Pilot roll out commenced, progress update received at MIG in November. Review in Jan 21.	A	
				<u>Gaps in assurance 3:</u> Grant Thornton updates are identifying gaps in assurance with regard to historic recording/coding of SHMI impacting risk factors/Primary diagnoses.	Grant Thornton SHMI focussed Clinical Data Improvement Project, ongoing for 3 months; 6 month extension agreed from June 2020. December 2020.	G	
					Review and replacement of coding software (Encoder), November 2020.	R	
					Review some cases of 'secondary malignancy' linked to SHMI outlier data and determine approach to link in with Community/Primary care, Jan 21 (delayed due to operational pressures).	A	
			Reduction in the proportion of cases being reviewed for learning from deaths following	<u>Gaps in assurance 4:</u> Need to embed clinician involvement in mortality coding to ensure sustainability	Expansion of the pilot agreed at MIG during November to include other clinicians in the process, ongoing, review in Jan 21.	G	
					Development of local KPIs to track for assurance purposes divisionally led clinician	A	

		(7) **Negative:** Mortality strategy KPIs not yet available to measure progress. (8) **Positive:** Medical Examiner role appointed to and in place to support Trust focus on learning from deaths. (8) **Positive:** Process for ME involvement in learning from	changed coding processes on commencement of Grant Thornton's project from February 2020.	following end of GT's with project extension and at the same time support sustainability of improved quality review process.	involvement in coding with escalation reporting into PRIM and MIG, January 2021.		
					Assurance required from Surgery that clinicians available to lead on signing off mortality related coding data. Dec 20.	R	
Quality Priority 2: – Clinical Effectiveness: Reduce mortality rates and strengthen end of life care; **2b) End Of Life (EOL) Improvement**	NLAG EOL Implementation Group (reformed); EOL also moved internally to sit within Community & Therapies Division. System chair appointed to chair the multi-agency EOL Strategy Group with wide membership with improvement action plan to focus further on EOL improvements (Q1 2020). Commitment from partners to work collaboratively as a system. NHSE/I support with partnership working to strengthen arrangements and multi-agency Governance structure. Operational lead and strategic lead for the Trust identified. Care in the last days of life document in place. Palliative Care Consultant in place at SGH; good links with Hospice arrangements. RESPECT working group established. RESPECT Project Lead appointed to and in post and policy agreed in July; rollout in September 2020. Local annual audit plan based on CQC feedback. Strengthened definition of EOL staff groups in line with CQC core services. Rolling report triangulating key themes from a variety of sources (i.e. Claims, Patient Feedback, Mortality and Incident data) to be received quarterly at the EOL project meeting. RESPECT Launched in the Trust on the 16 September 2020. KPIs agreed to monitor medical staff training rates in using RESPECT. Project group to continue to oversee and now include EPaCCs within the focus of the project to ensure this is used to support improved communication of RESPECT. Working within Care Homes in North Lincolnshire to increase proportion of residents with an advanced care plan in place and to record on EPaCCs and to generally support the patient stay at home, Nov 20. CRT commissioned by CCG, until March 2021, Nov 20.	<u>Assurance data:</u> (1) **No Assurance Data Yet:** Quality Priority 2e: Gather patient and carer feedback for end of life care. (2) **Negative:** CQC report findings (February 2020) identified further improvement work required for EOL. (2) **Positive:** Improved compliance with 3 core EOL mandatory training indicators: (1) EOL pain/symptom: 92%; (2) EOL Care planning: 87%; (3) Syringe driver update: 65% (Nov 2020). (2) **Positive:** Increased mandatory training compliance amongst the Specialist Palliative Care Team: 93%, Nov 2020 [increase from 50%, Sept 19]. (3) **Positive:** Themes from Incidents, Complaints, Mortality reviews triangulated and 6 key themes identified (NLAG EOL Meeting). Ongoing themes feeding into NLAG EOL Group on a monthly basis. (4) **Negative:** Theme from mortality reviews: Gaps in advanced care planning (Primary and Secondary Care) leading to poor EOL experience; increased 'inappropriate' admissions; increased SHMI. (4) **No assurance yet:** KPI linked to RESPECT: Number of 'avoidable' admissions to hospital with RESPECT (5) **Negative:** Lower level of palliative care coding at DPoW compared to SGH. (6) **No Assurance Data Yet:** Target: Better support patients at end of life and reduce admissions to hospital where this could be avoidable through improved care planning in collaboration with primary care networks to improve effectiveness of care. Reduction in out-of-hospital SHMI to 'as expected' by 2024. (7) **No Assurance Data Yet:** Key Performance Indicators not yet available to evidence changes/improvements in advanced care planning. (7) **No Assurance Data Yet:** RESPECT training relates. (8) **Negative:** Higher than expected out of hospital SHMI, Nov 2020 (data to end of Jul 20). *<u>Assurance sources:</u>* *EOL KPIs reported to NLAG EOL group.* *Complaints and Incidents relating to EOL.* *Mandatory training data relating to EOL.* *Mortality themes relating to EOL.*	Current Trust Palliative care arrangements not optimal - SGH does not have 7 day service; DPoW service is not comparable to SGH	<u>Gap in assurance 5:</u> Differences in palliative care provision between DPoW and SGH; impact on HSMR and quality of EOL planning.	NHSE/I Process mapping work complete. Results supporting local priority and development of draft strategy developed by Steering Group. forward. 7-day access to specialist palliative care is one of the steering group priorities. Task and Finish group established to scope out best practice with strategic partners. January 2021. This will include clarity on 7 day service access and member of the team accessing including consultant or other member of the SPC team and how support and advice can be gained via SPA. [7-day Specialist Palliative Care service is a national priority. NHSE/I are still providing independent support to the multi-agency approach]	A	Mortality Improvement Group; Quality Governance Group; Quality & Safety Committee; NLAG EOL Implementation Group.
			There is a need to improve the identification, planning and communication of EOL care with greater use of advanced care planning tools.	<u>Gap in assurance 4:</u> Patients at EOL admitted to hospital when no advanced care plan. <u>Gap in assurance 4 and 7:</u> No KPIs yet to monitor / track changes / improvements in advanced care planning. <u>Gap in assurance 8:</u> Consistently high out of hospital SHMI.	KPIs to support understanding of RESPECT rollout / progress agreed. Data from KPIs awaited, November 2020.	R	
			IT Communication: Joined up communication with system partners.	<u>Gap in assurance 4 and 5:</u> Communication of EOL advanced care plans or palliative care planning could be strengthened.	Following launch of RESPECT during September, EPaCCS launch to move at pace with RESPECT project group now focussing on EPaCCS as a key communication tool. Delays due to operational pressures. Internal plan not yet delivered. Review in January 2021.	R	
			Mandatory EOL training: In place for nursing staff; no current training in place for medical staff.	<u>Gap in assurance 4:</u> Medical education needs additional focus to support identification of end of life, advanced planning and use of anticipatory medicines.	Task and finish group assessing impact on mandatory training across organisations. System Strategy group to approve. Learning directory drafted. End of December 20 to have clear plan on what competencies are required and content of training and planning for who needs training and how. Being linked into this is the NLAG Specialist Palliative Care Team (SPC) mapping of learning outcomes to better demonstrate/evidence competencies using HSEE learning outcomes. Potential gap is that work to date has focussed on the wider SPC team and may not have been specifically focussed on training needs for medical staff. There is a risk of asking doctors to do to much training. To liaise with MDs office to support setting appropriate levels of medical staff training. *[Purpose: Define the standard of training across the region, ensuring harmony & ensure all disciplines are included with appropriate training competencies.]*	R	

				Gap in assurance 7: No assurance available on RESPECT training compliance.	Steering group training priority is on RESPECT. RESPECT training will cover off for medical staff issues such as advanced planning. Review in January 2021.	A
			CQC improvement work: No standardised pain assessment tool across the Trust.		Fastrack the development of a pain assessment tool designed specifically for patients at end of life. Was aiming to launch in Sept 20. Operational pressures have delayed. Task group to meet virtually to edit/approve guidance and tool. Launch was planned in December 2020. Launch delayed. Review in January 2021.	R
				Gap in assurance 2 and 3: Need to improve documentation and cater for EOL patient needs i.e. chronic pain management.	Review the content of the Last Days of Life Pathway with operational users to determine usefulness and reasons for why not used and make changes as necessary. Reviewed by NLAG EOL steering group. To be presented again in December NLAG EOL Meeting. December 2020.	G
					Identify good examples of best practice i.e. SWAN; Bluebell model; patient diaries model for what good EOL care looks like. Patient engagement plan in place delayed due to Covid. Discussing with surgery and medicine and small pilots to test. January 2021 to pilot it.	G
				Gap in assurance 1: No data yet available to measure Quality Priority 2e (Gather patient and carer feedback for end of life care with local hospices.)	Develop local plan for patient and carer feedback using patient diaries, link to development of other patient experience approaches to support with SWAN etc.; and carer feedback. January 2021.	A
				Gap in assurance 1: No data yet available to measure Quality Priority 2e (Gather patient and carer feedback for end of life care with local hospices.)	Patient engagement plan in place. Plan for patient/carer feedback presented at last EOL meeting. Agreed. To implement with focus groups, delayed because of Covid-19. Survey element of the plan can go ahead prior to focus groups meeting. Survey to go live in November 2020.	A
	E-NEWS on WebV. Deteriorating patient and Sepsis working group. Updated deteriorating patient policy for inpatients ratified by the working group, to be approved by Governance groups. Sepsis specialist nurse. Work stream within Improving Together. Central budget identified for replacement of hand-held devices and workstations on wheels. Ward areas reissued NEWS escalation toolkits containing guidance and ward based education provided. Refreshed sepsis training being provided. WebV data collection and reporting process resolved to enable ongoing monitoring and reporting. WebV amendment live on 26 April to change the process for the screening tool to enable this to retrigger sepsis screen in 12 hours time. Escalation policy (including Oxygen) has been streamlined and simplified. Approved within divisional governance groups for Surgery and Medicine during June/July 2020. Sepsis screening tool remodelled on Web V in July 2020.	Assurance Data: (1) **Positive:** Quality priority 2c: (Adults) NEWS completed within timescales to 85% (with 30min grace): SPC - consistently above 85% target; August: 91.31%] *[Target >90% by 2024]* ; (1) **Positive:** All Divisions achieving 85% target; 2 Wards in Medicine at SGH not achieving 85% consistently (May 20); (2) **Mixed:** Quality priority 2c: (Children) PEWS completed within timescales to 85%; [Snapshot sample of 10 patients per month/per site], August 2020: (a) Every 4 hours: 88%; (b) 12hrly: 100%; (c) New admissions on assessment: 78%; Insufficient data for SPC trend; (3) **Negative:** Quality priority 2d: Improve frequency of sepsis screening and robustness of reporting *[Target: improved compliance with all elements of sepsis six bundle]* ; Performance in June: 3.78%; July: 6.70%; August: 4.67% (E-sepsis screening recorded on WebV). (4) No assurance data yet: Audit of action taken in response to NEWS: April 2020 data: 54% not escalated (included within this are those		Gap in assurance 3: Poor performance / evidence of screening (E-sepsis screen recorded on Web-V) Gap in assurance 3 & 4: Electronic data not available to provide assurance that action taken in response to NEWS >5 either: (1) Sepsis screening/actions or; (2) Non-sepsis, appropriate escalation.	Monthly audit to be undertaken to provide assurance of action taken when (a) NEWS of >5 and (b) NEWS of >7 and (c) when a patient is admitted to Critical Care (CQUIN for 20/21) to review action taken (including consideration of sepsis) from a review of paper based medical records. Planning for audit methodology, commence in September 2020.	R
					Launch of the revised sepsis screening tool, escalation policy and oxygen policy, October 2020. Delayed by Covid-19. Policy approved and rolled out. Plan for this to be live in December 2020.	A
				Gap in assurance 1, 3 and 4: Poor ward based performance with E-sepsis screening. Some Ward areas not meeting improvement trajectories. Gaps from audit in escalation when NEWS <7.	Ward based champions to support education and sharing of ward level performance data for NEWS and Sepsis. List identified in Surgery. Not yet in other divisions, affected adversely by OPEL 4. Lead Sepsis nurse now back and picking this up, recovery plan for January 2021 to have resolved.	R
					Plan for WebV V3.0 which will enable notifications to	

Quality Priority 2: – Clinical Effectiveness: Reduce mortality rates and strengthen end of life care; **2c) Deteriorating Patient & Sepsis**		where escalation was likely not appropriate i.e. at EOL phase; had previously been escalated and treatment was still in line with the plan). (5) **Negative:** Increasing rate of mortality associated with Sepsis from Feb 2020 [July Mortality Report]. (6) **Negative:** Oxygen prescribing practice. WAT Audit Results demonstrate inconsistent prescribing of Oxygen. (7) **Positive:** OEWS performance data: (a) Full observations within 30mins of antenatal admission: >85%: June: 100%; insufficient data for SPC trends; (7) **Negative:** OEWS performance data: (b) Within 1 hour of delivery: Not consistently achieving >85%: June: 72% Insufficient data for SPC trends; (8) **Negative:** Fluid balance themes from mortality screening reviews. *Assurance sources:* *PowerBI dashboard;* *Sepsis manual audits link with DATIX incident reporting process should there be significant delays identified;* *Oxygen added to the Ward Assurance Tool for assurance purposes.*			be issued based on NEWS, draft SOP for how this will work for approval by Deteriorating Patient group, Review in January 2021.	A	
				Gap in assurance 5: Higher incidence of mortality associated with sepsis condition specific mortality during February 2020.	Specific mortality review project to be undertaken to look at sepsis related mortality, commenced in August 2020 with shielding staff undertaking, complete in October 2020.	A	
			Gap in funding identified for digital devices to support electronic recording of observations and sepsis.		Gap identified in funding for further devices. At present this is mitigated by extra ward based devices purchased for EPMA. Different devices are being trialled to determine what devices are needed, once clear, business case to be developed. Significant risk if unable to fund devices as EPMA roll-out intensifies and access to IT kit increases. Amber at present as mitigated. Review in February 2021.	A	Deteriorating Patient Group reporting to Mortality Improvement Group
			Application for QSM funds to appoint dedicated improvement post unsuccessful.		Insufficient resource. Attempting to mitigate gap with Divisional Head of Nursing – Surgery and Critical Care taking lead role with project support from the improvement team, review in January 2021.	A	
			Oxygen policy not yet finally approved.	Gap in assurance 5: Ward Assurance Tool Audit data demonstrates Oxygen is not being consistently prescribed.	Audit plan needed to evaluate and measure compliance with Oxygen policy, January 21.	G	
			No clinician lead supporting the improvement work of the deteriorating patient and sepsis group.		Clinician representation from Medicine agreed at MIG in July. Previous funding for post being clarified. Review scheduling of meetings to enable clinician attendance, Delayed, review in January 2021.	A	
				Gap in assurance 7: OEWS performance data - not meeting >85% target.	OEWS performance data did not take into account when a woman went into active labour and e-observations stopped when manual MEWS observations commenced. Performance data now takes this into account with a pause of OEWS data with resumption 1 hour following delivery, monitor impact on data, October 2020.	G	
				Gap in assurance 8: Fluid balance identified as a theme for improvement from mortality screening reviews against NICE guidance.	Deteriorating Patient and Sepsis Group asked to pick this up as part of the group's improvement plan, review in detail at their next meeting in January 2021.	A	
	Diabetes Nurse Specialists in post at both sites and see ward referred patients. Access to blood glucose results via UNIPOC system. Clinical Lead in post for Diabetes within the Trust and a regular business and governance meeting in place. Diabetes Nurse Specialist at both sites working to share lessons learnt, raise awareness regarding insulins, undertake training and follow up on DATIX incidents. Safety Medications Group considers the findings from the Safer Medicines dashboard, including insulins. National E-learning package has been reviewed and deemed approved for use in the Trust in the future [000 Safer Use of Insulin]. Now rolled out for access by staff. Covid-19 mitigations in place ensuring business continuity making use of other non-face to face methods to manage diabetes patients needing to see the specialist team including telephone / video / face to face where needed. App developed and in use to support pregnant women with diabetes record and report blood glucose monitoring results to the Diabetes CNS for improved monitoring. Mortality reviews identifying DKA reviewed again for learning. No harm or significant learning identified from this review. Minor improvement opportunities identified. Monthly diabetes task and finish improvement group	Assurance data: (1) **Positive:** Quality Priority 3d: Blood glucose checked when indicated by NEWS; SPC demonstrates consistent performance for NEWS; Oct 20: 97.5%; Mean performance 95%. (1) **Negative:** Quality Priority 3d: Blood glucose checked when indicated by PEWS; SPC does not demonstrate meeting target consistently; Oc 20: 77.5%; Mean performance 86%. (2) **Positive:** Quality Priority 3b: No significant harm from reported insulin incidents; SPC demonstrates meeting target consistently; Oct 2020: 0%. (3) **Negative:** Hypoglycaemia management within the Trust from the monthly audit data is not meeting target of 80%. (4) **Positive:** Insulin mandatory training data has achieved the 85% target: Oct 20: 85% (Medical staff: 63%).		Gap in assurance 4: Insulin related medication safety incidents reported via DATIX identifies gaps in insulin medication awareness. Mandatory training not yet meeting 85% target.	Deep dive audit undertaken with Pharmacy to review all insulin related incidents. Feed into diabetes improvement task and finish group. Progress delayed due to operational pressures. Present for discussion/action in January 2021.	A	
					Learning from insulin incidents reviewed at Nursing Metrics Meeting and shared with Medicine Ward Managers and Clinical Sisters. Agreed to focus on improvement in 2 specific audit standards that relate to post hypoglycaemic management. Improvement focus impacted upon by operational pressures. To renew focus once current operational pressures subside. Review in January 2021.	R	

	established, commenced meeting in October 2020.	(5) Positive: No harm identified from DKA focussed mortality reviews. Oct 20. (6) **Negative:** DKA identified as a theme from incidents within medicine. Assurance sources: *National audit results.*			Share insulin learning within Medicine division Governance meetings for Medical input into improvement programme. Delayed due to operational pressures. Pick up in January 2021.	R
				Gap in assurance 4: Availability of insulin leading to medication safety incidents	Meeting between Pharmacy and Diabetes Team held and agreement reached on standard stocklist of insulin products. To implement with pharmacy procurement team and EPMA, September 2020. Delayed due to operational pressures, review in January 2021.	R
Quality Priority 3: Patient Safety: Improve the management of diabetes;				Gap in assurance 6: Improvement themes identified relating to DKA	DKA theme identified through the SGH ECC fortnightly governance meeting relating to incident themes. Identification or initial management of DKA main theme. Further education on DKAon the adult and paediatric pathways are being arranged. DKA improvement plan. Review in January 2021.	A
			Sickness in the Specialist Diabetes Nursing team. Monthly audit data not available for DPOW.	Gap in assurance 3: Data not available for October relating to diabetes management in the Trust due to sickness in the diabetes nurse specialist team.	Scope out options to cover sickness absence and continue to provide assurance data. January 2021.	A
					CNS targeting training on needs identified through incident reporting, update from CNS to Safer Medications Group, July 2020.	R
				Gap in assurance 3: Monthly audit data demonstrates gaps in the management and responsiveness to hypoglycaemia	Consider at monthly improvement T&F group: (1) Audit data; (2) DATIX incidents relating to insulin; (3) Mandatory training compliance with safe use of insulin; (4) Impact of the pregnancy app. Review in January 2021.	G
					Share hypoglycaemia theme outside of Medicine with Surgery and Family Services heads of Nursing for raising awareness/action, September 2020. Delayed due to operational pressures, pick up in January 2021.	R
				Gap in assurance 1: Blood glucose checked when indicated by PEWS not meeting the target set.	Investigation undertaken into this. Paediatric Emergency Team (PEN) have been working to a different PEWS threshold (>6 not >1). Threshold lowered for ED due to risks identified previously. PEN team have picked this up during November. Monitor data going forward to ensure embedded. Review in January 2021.	G
					Review use of app with Pregnant women with diabetes during January 2021 to test effectiveness.	G
	Central cancer team, with Cancer lead in post. **PTL:** Cancer weekly PTL and escalation process; Weekly Cancer PTL meeting - changed to 6 weekly focus on top 5 specialties which account for 80% of breaches; Looking to change this to focus on a 'tiered' approach, to discuss at OMG; **Oversight:** Weekly Divisional General Manager Waiting List Assurance Meetings with all divisions; Weekly attendance by Path Manager to PTL to improve turnaround times/escalation; PRIM meetings with divisions includes focus on Cancer; Cancer Board meeting; underpinned by individual tumour specific MDT Business Meetings; **Improvement planning:** System wide 62 day improvement plan in place focussing on 7-day 1st appt, 28 day definitive diagnosis, IPT by Day 38, Treatment by Day 62 (approved at Planned Care Board Sept 19);	*Assurance data:* (1) **Negative:** Cancer Waiting Times: 28 day Faster Diagnosis: November: 62.9%; October: 59.7%; September: 53.9% August: 63.1% (against a target of 75%). (2) **Negative:** Cancer Waiting Times - 62 Day GP Referral: November: 66.7%; October: 70.5%; September 63.6%; August: 67.8% (against target of 85%). (2) **Negative:** Cancer Waiting Times - 104 day+ backlog: November: 45 October: 25; September: 40; August: 52 [Reducing]. (2) **Negative:** Cancer Waiting		Gap in assurance 1, 2 and 3: Not meeting cancer key performance targets: (a) 28 day time to diagnosis; (b) 62 day cancer performance targets; (c) IPT transfers by day 38.	Recovery work underway making use of Goole for elective surgery and Independent Sector facilities, Review in Feb 21. Currently not fully mitigating the backlog risk and backlog increased.	R
					Test colorectal cancer pathway compliance (post Covid-19) using IST analyser tool. Feedback to clinical teams and agree improvement plans Q1 2021/22 as part of Rapid Diagnostic Centre pathways.	A
					GP FIT testing has a high failure rate relating to patient	

Quality Priority 4 – Patient Experience & Clinical Effectiveness: Improve the effectiveness of cancer pathways focussing on time to diagnosis;	Outsourcing contract for diagnostics has supported reducing turnaround times; Patient Triage arrangements in place for all cancer pathways; Planning has commenced for recovery post-Covid-19 in terms of potential capacity and demand; AD of cancer support divisions link thematic analysis to pathway improvement planning within divisions. **Management of demand:** Consolidation of HUTH Oncology Services onto the DPOW site within NLAG (Jan 20); Single site MDT implemented for Lung Cancer (Jan 20) and Colorectal (Apr 21). All referrals are also now being clinically assessed and where appropriate streamlined for straight to test telephone assessment; Capacity and demand planning for recovery has commenced. **Recovery:** Elective Care Cell within the ICS (including cancer services) focussed on recovery across the ICS; Elective Care Task and Finish Group supporting focus on recovery; Divisional risk stratification and re-prioritisation process in place; New Public Health England guidance released that will increase capacity within Endoscopy enabling more access for patients requiring cancer diagnosis.	Times - 62 day+ backlog: November: 129; October: 109 September: 97; August: 111 [Increasing]. (3) **Negative:** Care of patients with confirmed diagnosis transferred by day 38: November: 14% failure; October: 41%; September: 22%; August: 27%; July: 39% (against a local target of 75%). (4) **Positive:** Request to test report turnaround to be no more than 14 days: November: 100%; October: 100%; September: 100%; August: 100%; July: 100% (against a target of 100%). (5) **Positive:** Number of combined site MDTs: 100% (against a target of 100%). (6) **Negative:** Quality Surveillance (QSIS) annual submission: no improvements in recent years. *Assurance sources:* *IPR. Power BI reporting (including ability to compare tumour site performance);* *Not meeting 62 day performance targets (62 day RTT and screening);* *PRIM divisional update;* *Continued improvement seen in Pathology turnaround times;* *Quality Priority: Positive results seen to date from the implementation of triage/straight to test in Lung, Urology and Colorectal;* *Faster pathways defined and in place for all 4 priority pathways: Lung, Urology, Colorectal and upper GI (supported by necessity linked to Covid-19);* *The Trust's 2019-2024 Quality Objectives.*	Insufficient capacity / not able to flex capacity to meet demand. Impact of Covid-19 Wave 2 pandemic resulting in elective activity cancellations including cancer treatments. Projected further impact of Christmas period on recovery plans and patient choice for treatments.		compliance factors and some educational awareness needed with GPs. Reviewing as part of the Secondary/Primary Care group, with GP focus on. Review in Feb 21.	A	
						Agree trajectories for what proportion of patients would be expected to require a FIT test to support more accurate measures of performance as a KPI to support improvement. Review in February 2021.	A	
				Gap in assurance 1 & 2: Colorectal cancer tumour site is significantly impacted upon by gaps in Endoscopy/Colonoscopy capacity resulting in a significant proportion of the Trust's backlog being within colorectal tumour site.	Rapid Diagnostic Centre Pathway for upper and lower GI (Colorectal) tumour site. Funding received from Cancer Alliance. Aim: Reduce 2WW referrals with non-specific symptoms. Pilot to involve 3 PCNS and aligned GP surgeries to develop and trial pathways. Draft pathway by end of Feb 21 and commence pilot in Mar 21.	A	
			Delays in some cancer tumour sites in accessing Oncology.	Gap in assurance 2 & 3: Not meeting cancer key performance targets: (b) 62 day cancer performance targets; (c) IPT transfers by day 38.	HUTH Oncology services consolidation onto single site (DPoW; Jan 2020). CCG led review of centralisation commenced, patients being surveyed, outcomes to be reported back to OSC in Q4, 2020.	G	Cancer Board; Planned Care Board; Quality & Safety Committee; Quality Governance Group
					Current gaps in Oncology service (staffing). Raised to Humber cancer board with HUTH. Lack of capacity at present leading to longer waits in some pathways. Oncology working group established with Trust representation looking at improving pathways with oncology. This is a sub group of joint Humber Cancer Board. Review in February 2021. Structure in place, but not yet mitigating and improving outcomes.	R	
					Development of a joint NLAG/HUTH Cancer Transformation Plan for pathways which cross both organisations. Prioritised tumour sites to be identified and link to the interim clinical plan of the HASR. Developing the plans and timetable by Q3. Sign off by Humber Cancer Board in January 2021. [This will identify areas where further joined up work can be undertaken as a single service between NLAG and HUTH to streamline pathways and provide better access to diagnostics and treatment]	A	
			Cancer MDT Business meetings not quorate.	Gap in assurance 9: Quality Surveillance (QSIS) annual submission: no improvements in recent years.	Divisions with higher risk Cancer Tumour site gaps as measured by QSIS to provide assurance via Quality Governance Group that risks have been identified and recorded and that improvement plans are in place. Review at QGG in October 2020.	A	
			Cancer Board meeting but not quorate.	Gap in assurance 9: QSIS improvement plans delivery; lack of assurance in monitoring of delivery.			
			Tumour site MDTs not focussed on QSIS Standards.				
			Clinicians not reviewing root causes for breaches monthly.		Develop divisional dashboards containing improvement plan within PowerBI, 2021.	A	
			Lung cancer: no MDT for mesothelioma.		Temporary arrangement in place to discuss Mesothelioma within Hull MDT. Collaborative approach agreed. SOP to be amended to outline formal	A	

					arrangement, Q3 20/21.		
Quality Priority 5: Patient Safety, Experience & Clinical Effectiveness: Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon; **5a) Discharge to Assess (replaces previous SAFER) Implementation**	Divisional General Manager leading on programme of work with Medical and Nursing leads established; Weekly task and finish group in place, twice daily meetings established, meetings with system partners (including all 4 CCGs) in place. Project action log established and in place with clear milestones; Programme of work aligns Trust with National Discharge guidance; 'Small steps for change' pilot commenced in September on 2 wards at SGH; now expanding to include additional wards at both sites. Discharge to assess documentation now in use at SGH to roll out at DPoW; Ward education completed at SGH and discharge to assess documentation and electronic document; PowerBI report for key indicators now active, further data to be added once WebV discharge module is live and rolled out; Governance process for escalation now formulated.	Assurance data: (1) **Negative:** Length of Stay for non-elective patients: 4.15 (Oct 20). [Target: (1) Reduction in non-elective length of stay to 3.9 days by 2024] (2) **Negative:** Super stranded patients: 55 (Oct 20). [Target: (2) Reduction in 21 day stranded patients to 50 by 2024] (3) **No Assurance Data Yet:** Key discharge to assess KPIs. *Assurance sources:* *Finance and Performance Committee assurance paper prepared and submitted to F&P for June 2020.*	Daily structured consultant led-board rounds needed supported by system MDT to mobilise daily discharges.		Education to improve focus on with Medical lead developing SOP and talking to lead clinicians. December 2020.	G	
			Not yet fully compliant with new DoH Discharge policy.	Gap in assurance 1: Not yet meeting targets for non-elective LOS patients.	Discharge to Assess programme commenced. Process mapping has identified numerous (19+) phone calls to wards relating to discharge which impacts adversely on staff time. Education for wards in using the Discharge to Assess E-documentation completed at SGH. Full Trust roll-out to be completed by 21 Dec 20.	G	
				Gap in assurance 3: Key performance indicators not yet clear to provide full assurance (programme newly established).	PowerBI report with key indicators developed, roll-out WebV discharge module across the Trust following trial at SGH on Ward 29. Review in January 2021.	A	Quality & Safety Committee; Quality Governance Group; PRIM
			Assessment for longer-term care and support needs to be undertaken in the most appropriate setting and at the right time for the person - not always in a hospital bed.	Gap in assurance 2: Not yet meeting targets for stranded patients.	System wide accelerated discharge event to be held on the 14-16 December 2020 to identify patients that do not meet the criteria and to discharge these within 24 hours. To replicate same process for patients in community beds.	G	
			Command centre for NLAG to support clinical decision making relating to discharge with the use of artificial intelligence / predictive analysis of data.		Discussed with CIO, agreed to place on hold until able to fully support the implementation from an IT perspective, 2021. Additional support for predictive analysis of flow information was agreed as mitigation by CIO, Q3 2020. This however will not replace the specialist knowledge and support that an expert in AI would provide NLAG with regard to maintaining good patient flow, and therefore does not provide complete assurance.	R	
Quality Priority 5: Patient Safety, Experience & Clinical Effectiveness: Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon; **5b) 7-Day Service Implementation**	Lead for 7DS identified from the Corporate perspective of the Medical Director's office; Interventional Radiology scoping changes to work collaboratively with HUTH/STP, SOP has been approved, roll out plans to commence. Go live now agreed; Implementation of an integrated AAU for medicine and surgery patients gone live during November.	Assurance data: (1) **Negative:** 7Day Services (7DS) Board Assurance Framework (2020). Gaps in specific specialties preventing compliance with standards 2, 6 and 8 *[Target: Delivery of the 4 priority 7 day standards by 2020]* . (2) **Positive:** Length of Stay for non-elective patients is very close to the target of 4.1 days, at 4.15 days in August 2020 [3.9 days by 2024]. (3) **Negative:** Results from Medicine focussed audit on 7DS did not show significant improvements. Assurance sources: *7 Day services generic action plan and gap analysis, greater assurance obtained in that specific divisional requirements is now available. Detailed understanding of gaps within divisions now available and to be reported to Q&S in March 2020.* *NHSE/I 7DS Board Assurance Framework.*	Lack of documentation to evidence compliance with 7 day standards.	Gap in assurance 1: 10% shortfall due to illegible and/or undated entries.	Amend WebV document to include grade of clinician reviewing pt. Meeting with Family Services to agree pilot in October 2020. Delayed, to seek agreement in January 2021.	A	
			Specific gap: CSS: Preventing the meeting of 7Day Service standards. Gap in Standard 6: *Consultant Directed Interventions*		Interventional Radiology scoping changes to work collaboratively with HUTH/STP, SOP has been approved, roll out plans to commence. Go live now agreed.	G	
			Specific gap: Medicine: Preventing the meeting of 7Day Service standards. Gap in Standard 5: *Access to diagnostic tests* and Standard 6: *Consultant Directed Interventions*	Gap in assurance 1: Gaps identified at divisional level in compliance with 7DS standards.	Medicine have been working with STP and Regional Network to make echocardiography and temporary wires 7DS compliant. Unable to progress solution to date, to be picked up as part of Phase 2 of the Humber Coast and Vale Clinical Plan, Q1 2021/22.	R	
					Medicine have provided an interim solution for echocardiography and temporary wires. This is a funding issue and will be a cost pressure for medicine, but can provide the service internally, until able to design and agree a fully networked service with HUTH Humberwide. Medicine to have drafted a business case by end of October 2020 to then progress for approval. Operational pressures have delayed this. Review in January 2021.	R	Quality & Safety Committee; Quality Governance Group; PRIM
					Surgery Divisions plan to be reviewed at meeting between Surgical Team and Trust's corporate lead for 7DS,	R	

			Specific gap: Surgery Preventing the meeting of 7Day Service standards. Gap in Standard 2: *Time to first consultant review* and Standard 8: *Ongoing review by consultant twice daily if high dependency patients, daily for others*		October 2020. Delayed due to operational pressures. Review in January 2021.		
					Integrated AAU for medicine and surgery patients now live. Plan an audit 3-6months post implementation to evaluate impact on 7DS standards. Review in January 2021.	G	
				Gap in assurance 3: Medicine audit against 7DS standards has not demonstrated significant improvement.	Prospective audit planned in Medicine between October and November to review the impact of the AAU on performance with standards 2 and 8, December 2020. Data collection complete. Audit reported. Significant improvements not seen. Medicine to develop action plan for improvement, review in January 2021.	A	
			7 day services are not explicitly underpinning the HASR Clinical Design group (CDG)		Corporate lead for 7DS to raise 7DS with HASR Clinical Design Group (CDG), review in November 2020. HASR meetings cancelled due to operational pressures. To review in January 2021.	A	
Quality Priority 6: Patient Experience: Improve the quality and timeliness of complaints responses using a more individualised approach.	Patient Experience Lead Nurse; PALS and Complaints Manager (recruited in June 2020); Fully established with Patient Experience Facilities, Project Lead appointed; Central Complaints Team; Monthly reporting to Divisions; PRIMs, Q&S Committee (Quality Priorities) monitor monthly; Quarterly reporting to Q&S - deep dive; Priority placed on patient experience and complaints by CEO and Trust Chair; Board level lead for Patient Experience is the Chief Nurse; Patient Liaison helpline introduced on the learning from Wave 1 to mitigate gaps in communication with ward staff for updates about patients receiving care.	Assurance data: (1) **Negative:** 85% Pals responded to in 5 working days by the 31 Jan 21: Dec: 53%; Nov: 53%; Oct: 49%; Sept: 48%; Aug: 45%; Jul: 46%. SPC trend does not indicate meeting target;	Gaps in understanding of effective complaint management across the Trust.	Gap in assurance: Need to be able to understand progress against the training plan.	Project lead appointed and developing plan for training programme commencement with Training and Development input. Basic Complaint Training now embedded in induction. Scope out timescales for targeted training and optional access. Baseline data being calculated (?12 months). December 2020. All complaints in the old process to be closed by the end of February 2020	G	Quality & Safety Committee
			Training plan needed for roll out of new complaint training programme covering which staff to be focussed, how best to deliver training.	Gap in assurance: Improved effectiveness of divisional relationships and engagement with divisions needed.	Central team to continue to focus on managing complaints and seek support from clinical teams in Divisions as available, but recognising extreme demands on clinical time during wave 2, review in January 2021.	R	
		(2) ****New Indicator**:** 100% of all complaints >120 days on 'old' process pathway to be closed by 31 Jan 21: Dec: 25; Nov 25; Oct: 28;	Capacity of clinicians within divisions	Gap in assurance 2 and 3: Challenges in running two complaints processes - the 'old' (new KPIs outline plans to close by end of Feb 21) and the 'new' process, balanced against significant increase of workload back to pre-covid levels.	Training and supporting teams in new process and close old process as quickly as possible. Review in January 2020.	A	
	Management of Complaints, Concerns and Compliments Policy; Complaints action plan; Weekly support and challenge meeting with the central team led by Senior Nurse;	(3) ****New indicator**:** 100% of all complaints on 'old' process pathway to be closed by the 28 Feb 21: Dec: 30; Nov: 30; Oct: 109;	Capacity of Divisions during wave 2 of the pandemic				
	New complaints training programme commenced; The new complaints process has now gone live (2 November 2020). This will support more timely closure for complainants. New KPI's confirmed to support measuring progress with closure of 'old' process: New KPIs are as follows: (2) **New Indicator**: 100% of all complaints >120 days on 'old' process pathway to be closed by 31 Jan 21; (3) **New indicator**: 100% of all complaints on 'old' process pathway to be closed by the 28 Feb 21; Established a tracking matrix tool to support implementation of new complaints process, and to indicate if individual handlers are over-stretched (September 2020);	(4) **Negative:** 85% of all complaints resolved within timescale by the 31 July 2021: Dec: 17%; Oct: 33%; Sept: 24%; Aug: 21%; Jul: 8%. SPC trend does not indicate meeting the target;		Gap in assurance 4: 85% of all complaints resolved within timescale by the 31 July 2021			
		(5) **Negative:** 85% of reopened complaints resolved within 20 working days by the 30 November 2020: Dec: 25%; Oct: No data; Sept: 0%; Aug: 9%; Jul: 0%;					
		(6) **Positive:** 100% Complaints acknowledged within 3 days by the 31 July 2021: Dec: 100%; Oct: 97%; Sept: 100%; Aug: 91%; Jul: 89%;		Gap in assurance 6 and 7: Significant risk: Accuracy of data: how this is captured and held on DATIX needs to be	Work to focus on DATIX recording of information to ensure it is clear when this is not applicable, as opposed to not happened. Review in January 2021.	A	
		(7) **Positive:** 100% complainants offered a face to					

	Central complaints team to record for reporting purposes those complainants offered a meeting (Nov 20) to support KPI 6 and 7, November 2020; DATIX Reporting Module;	face meeting during initial resolution planning by the 31 Dec 20: Dec: 100%; Oct: 100%; Sept: 83%; Aug: 96%; Jul: 94%;		reviewed.			
		(8) **Negative:** 100% of all upheld complaints to have evidence of learning by the 31 October 2021: Dec: 6%;		<u>Gap in assurance 8 and 9:</u> Lack of dedicated support for DATIX complaints module to support better reporting and data quality.	Seeking support of an experienced DATIX manager to provide expert oversight on a short term basis, January 2021.	A	
	Senior Nurse quality checks for all final complaint responses;	(9) **Positive:** 100% formal complaint responses reviewed by Senior Nurse by the 31 July 2020: Dec: 100%.					
		(10) **Positive:** 50% reduction in reopened complaints by the 31 January 2021: Dec: 80% reduction.					
		Assurance sources: *Reporting to divisions;* *PRIM data feeds;* *Quality & Safety Committee reporting.*					
Clinical service concern (CSC): Ophthalmology	Specialty Business and Governance Meeting. Clinical Lead appointed. Assistant Business Manager to focus on performance and activity Weekly meetings with team members; team leaders and with service lead to focus on backlog waiting list and management of PTL (daily for RTT and weekly for Lucentis). PTL identification of patient by condition, risk stratification employed to bring the patient forward based on risk/urgency. Policy to ensure all patients on an intravitreal pathway are tracked and seen in a timely and appropriate fashion in place and embedded to mitigate risks to patient safety with time critical Failsafe officers in post. Made permanent in July and fully recruited during August. Reduction of overdue f/u backlog: (a) Changes in working practices due to Covid-19 working restrictions; (b) Sourcing additional capacity from independent providers via the CCG - agreed and go live data of the 13 July planned. Lift and shift live and process embedded from July 2020. Fortnightly operational meetings with the CCG and Independent provider to monitor progress. Trajectories agreed and being monitored. Project remains on plan. Clinical surgical prioritisation for inpatient waiting lists. Risk stratification undertaken and ongoing using RC of Ophthalmologists and reconciled to Intercollegiate RC of Surgeons Guidance to ensure harmony of approach across division of surgery. OCT equipment networked allowing greater workforce flexibility for reporting and access to imaging (August 2020). Patient pathways changed to mitigate risks to patient safety (i.e. patient travel to another location for investigations / treatment). Ongoing mitigation. Continuing to schedule surgical patients as per their clinical categorisation utilising capacity at St Hughes and Goole to minimise the number of 40+ week breaches, secured a further Theatre space at Goole to increase capacity, working well. Theatre scheduling to return back to pre covid scheduling from 28 Sept 2020. Focussing on appointing those patients who are 50% overdue, then 25% overdue to manage long waiters. NHSE/I support with recovering waiting list. 3 pieces of critical equipment funded, to ordered (Dec 20).	<u>Assurance data:</u> (1) **Negative:** Overdue and unbooked f/u waiting list continues to increase; Nov 20: 6,935; Oct 20: 5,326; Sept 20: 3,695; Aug 20: 1,581; Jul 20: 710 [increasing]; [Majority remain at SGH] due to significant reduction in core capacity due to social distancing in OP clinics; (2) **Negative:** Nov 20: 42% (total caseload: 16,391;). Sept 20: (21.5%)Aug 20: 10.2%; (2) **Positive:** Nov 20: total caseload reduced to 16,391 by 2,000 patients, as a result of 1,062 patients being transferred to an independent provider and the remaining having been discharged; (3) **Negative:** insufficient diagnostic capacity to support virtual clinic and mitigate reduction in capacity due social distancing; (4) **Negative:** Adverse patient experience due to a change in pathways linked to older equipment/equipment gaps. Funding approved to network diagnostic equipment. Allows clinicians to virtually review images on any site. Patient needs to travel but timeliness of diagnosis speeds up; (5) **Negative:** External clinical harm review identified 4 Serious Incidents leading to moderate harm. Action plan ongoing; (6) **Positive:** Trajectories to monitor progress with 'Lift and Shift' agreed, fortnightly meeting, 1,062 transferred, on track to transfer 3,000 by 28 February 20; (7) **Positive:** All patients on the inpatient PTL have been risk stratified (Oct 20); (8) **Negative:** Patients on the OPD PTL have not yet been risk stratified (Oct 20); <u>Assurance sources:</u> *Weekly speciality tri meetings with the Assistant General Manager, Clinical Lead and Matron;* *Quarterly updates presented to Q&S committee for assurance;* *Quality Governance Group update on a monthly basis;* *Validation of patients on PTL without a due date; these are being reviewed as part of the Clinical Harm process and based on risk/urgency, provided with an appointment;* *Performance report submitted to senior tri on a weekly basis to assure and monitor backlog position;* *External expert reviewer appointed to review patients*		<u>Gap in assurance 8:</u> OPD risk stratification not completed and unlikely by 31 March 2020 due to the volume of patients (16,000 plus shortfall in capacity).	Not recorded prioritisation for all patients on the OPD PTL. Continue to add diagnosis codes and prioritise those patients who are 50% overdue appointments and continue mobilising recovery plan. Review in January 2021.	R	Quality & Safety Committee; Specialty Business & Governance Meeting.
			With cessation of elective work during November 2020 determine impact on ophthalmic theatre sessions. Shortfall in capacity, particularly in North Lincolnshire.	<u>Gap in assurance 1:</u> Root cause: Significant deficiency in capacity, particularly in North Lincolnshire.	Capacity & Demand review completed and forecast activity through to March 2021. Shortfall in capacity and clearing of backlog requirements detailed in recovery plans, submitted to senior tri and NHSE/I. Recovery plan mobilised 52 clinics to date (out of 297 needed). Review in January 2021. [Temporary mitigation of current shortfall in capacity includes: HCV, Transfer of patients to independent providers, 'Lift and Shift' and waiting list initiatives (as well as increased theatre capacity where surgery is required)]	R	
					Ophthalmic elective activity during wave 2 has enabled 15 theatres in Goole and St Hughes. Impact on some complex (GA / Paediatric) pathways that require Theatres on main hospital sites . Creating a bottleneck for some >52 week waits and complex pathways. All being risked assessed. Looking at making use of wider ICS providers. Review in January 2021.	A	
				<u>Gap in assurance 1:</u> Increased number of overdue and unbooked follow up patients. Patients had previously had their case notes reviewed and deemed to be unable to be discharged, but were deferred following a risk assessment. Subsequently, these patients now require follow-up (either face to face or virtual). These patients are now overdue an appointment to be seen.	50% of patients on the OPD waiting list now have diagnosis codes. All time critical patients are identifiable and are tracked by failsafe officers ongoing mitigation. Review in January 2021.	A	
					Continues to be ongoing significant Capacity shortfall which requires investment in workforce and infrastructure to mitigate the gap in secondary care. This can be considered as part of the wider HASR review with primary care and secondary care with NHSE/I and CCG input. Scheduled for phase 2. Timescales have not been confirmed. Review in January 2021.	R	
				<u>Gap in assurance 1:</u> High number of overdue follow ups continues in SGH and is starting to rise at DPOW and GDH due to increased shortfall in capacity from implementation of social	Changes in the way the service is provided to streamline process (accommodation; virtual working / clinics etc.). Requires investment in equipment and workforce. Part of overdue follow up recovery	R	

		who are potential moderate/severe harm; Clinical engagement with agreeing what elements of the Ophthalmology service can be 'Lift and Shift'.		distancing rules in face to face clinics. Overdue follow ups will continue to increase if core capacity is not increased and clearing of backlog is not commenced.	of overdue follow up recovery plan and 52 week improvement plan NHSE/I supporting. Business case drafted. To be taken through approvals process, December 2020.		
			Lack of system wide ophthalmology approach.		**Longer term actions:** Work with Humber Eye Services review. Focus on (1) Imaging hubs; (2) Post-op cataracts in the community and (3) paediatrics in the community. HUTH and NLAG collaboration phase 2 Fragile services. No timescales for delivery of any workstreams. Review in January 2021.	R	
			Multi-professional team (OP nursing and theatre teams) currently all working under different divisions which prevents effective staff development and flexibility of service provision.		Discussions with CSS to develop an integrated multi-professional team encompassing Theatres, Diagnostics and OPD Nursing. Operational pressures have delayed this, review once operational focus on Covid-19 has subsided. Review in Feb 21.	A	
			Older equipment coming to end of usable life and a shortage of equipment to support virtual working. No capital funds available to replace. Divisional risk registers updated.	<u>Gap in assurance 3:</u> Change of pathways to mitigate patient safety risk adversely impacts patient experience (i.e. increased patient travel).	Bid submitted against capital funding available nationally to support improve flow for extra equipment that will enable virtual review of images across site supporting remote working (mitigation for Covid-19). Outcome awaited from bid. Not heard back. Review in January 2021.	R	
				<u>Gaps in assurance 4:</u> Serious Incident identified moderate harm to patients linked to waiting times.	Implement all requirements as defined by the Royal College: To consider employ Eye Clinic Liaison Officers and promote a programme of safety culture within the service, December 2020. Business case needed, requires approval, Review in January 2021.	R	
	Medicine and Family Services have worked jointly to implement the Paediatric Emergency Nursing Team, with a dedicated team of Registered Sick Children's Nurses (RSCNs) on each site, 7 days a week, 10:00 - 22:30hrs; Band 7 Clinical Co-ordinators, 7 days a week, 24 hours a day, to maintain Senior Nurse Oversight; Nursing establishments reviewed and strengthened, particularly during out of hours to meet the demands of ED activity; Consultant with special interest in Paediatric Emergency Medicine in post and finalising PAs and training to enable cross site lead post; Joint ED governance meeting with improved cross site working. Paediatrics is a standing agenda item to support lessons learnt, triangulation of complaints, incidents; PEWS policy and Local out of hours process for escalation of the sick child, in hours covered by PEN team; RCPCH facing the future standards regarding resuscitation training are focussed on through mandatory resuscitation training and access to EPALS through internal and external providers; A paediatric escalation process for increased wait times to seek support from the Paediatric Registrar. Embedded Paediatric & Neonatal 2222 Teams to support resuscitation and stabilisation +/- short term critical care within the ED. Access to Paediatric Nursing advice and support 24/7 via Paediatric Service; Paediatric education mapping document developed with Paediatrics. Designed for every RCN to complete with Paediatric Competencies mapping to RCN competencies which will support evidence for Facing the Future standards. Level 2 competencies in development. Level 1 study days to commence in January 2021; ED launched new adult and paediatric documentation for majors and minors cards. Consistent approach across both EDs with updated A&E records that will become MDT records of the patients. To be linked into the Symphony Upgrade (live in December 2020) and the Manchester Triage Tool (accredited); NHS111 first will make direct bookings into ED. For any Safeguarding concerns, these will be called through directly to the department to advise them they will be attending. Process	<u>Assurance data:</u> (1) **Negative:** Not able to be compliant with CQC guidance: "Brief guide: Staffing in emergency departments that treat children (April 2020)". *[The RCPCH acknowledge the challenges in recruiting the workforce needed to meet these standards. CQC have liaised with both the RCPCH and the RCN to ensure that they take a consistent approach to the application of these standards, particularly in terms of enforcement activity. If services are unable to meet the workforce standards they should be able to demonstrate adequate mitigation of the risk to patients, covering: (1) Evidence of training programmes with Higher Education providers to increase knowledge, skills and competencies in paediatric care and (2) a work plan with timelines for both registered children's nurses and a PEM consultant].* (2) **Positive:** Local gap analysis performed against CQC Staffing guidance and regularly updated. This outlines the mitigation in place as required by the CQC. **(2a) Key mitigation 1: Training:** * **Negative:** Advanced Resuscitation Training: EPALS: Nursing: 9/32 trained; 10/32 booked on training; 13/32 left to be booked on training; Medical staff: SGH: Cons: 63%; Middle Grade: 60%; DPoW: Cons: 100%; Middle Grade: 40%; * **Negative:** Intermediate Resuscitation Training: EPILS: DPoW: 58% Compliant; SGH: 92% Compliant, September 20; * **Negative:** RCN Competencies		<u>Gap in assurance 2a:</u> Not fully compliant with CQC Guidance on staffing requirements in ED in relation to the management of the Paediatric patient. Mitigation gaps: Training	Intermediate Paediatric Resuscitation (PILS): Part of ED nursing Mandatory training. Gap at DPoW with 71% (up from 58%) trained. SGH at 78%. Training planned and staff booked on. 6 nurses not yet been able to attend due to staffing of the department. Review in January 2021.	A	
					Advanced Paediatric Resuscitation (EPALS): Training planned for all Band 6 ED nurses to ensure each shift has cover. Significant delay as EPALS training cancelled due to Covid-19. Petitioning training centres to make more training dates available/accept greater numbers of NLAG staff. This remains a significant gap. Escalation of risk to PRIM; Chief Nurse has raised at a regional level and national level.	R	
					All RNs to undertake RCN competencies for Paediatric Emergency Nursing (level 1 includes paediatrics), through new competency framework with study days starting in January 2021. Trajectory for L1 is April 2021 to have completed study days followed by clinical study day to sign off competencies in July 2021.	A	
				Gap in assurance 2b: Not fully compliant with CQC Guidance on staffing	ED Consultant appointment at SGH with previous experience of working in a paediatric ED		ED Governance Meeting;

Clinical service concern (CSC): Care of the Paediatric Patient in the Emergency Department		the department to advise them they will be attending. Process developed with Safeguarding team all non-attendance to then escalate safeguarding concerns.	Framework (L1 (Band 5) and L2 (Band 6)): Level 1 trajectory for completion is July 21; **(2b) Key Mitigation 2: Workforce plan:** * **Positive:** Paediatric Emergency Nursing Team (PEN) with dedicated team of Registered Sick Children's Nurses (RSCNs) on site between 10:00-22:30. * **Negative:** Consultant with special interest in Paediatric Emergency Medicine (PEM) in post; PAs and job plan require formalisation. * **Positive:** Senior decision makers within both EDs providing 16 hour cover against RCEM guidance. (3) **Negative:** There have been Serious Incidents within ED relating to the management of the Paediatric patient. (4) **Negative:** Quality Priority 3d: Blood glucose checked when indicated by PEWS; SPC does not demonstrate meeting target consistently; Oct 20: 77.5% against a target of 95%. *Assurance sources:* *Gap analysis for ED Paediatric Care against CQC Brief guide: Staffing in emergency departments that treat children, Division of Medicine, September 2020.* *Dedicated section as part of the ED Governance meeting to focus on learning lessons from incidents, feedback and audits related to paediatric care provision.*	Unable to meet guidance provided by CQC in relation to ED staffing levels; specifically unable to provide 24/7 cover from Registered Sick Children's Nurses (RSCNs) within ED.	Guidance on staffing requirements in ED in relation to the management of the Paediatric patient. Mitigation gaps: Staffing Workforce Plan	of working in a paediatric ED. Work currently being under taken on Job plan to take post cross site as lead on paediatric care with PA's and training time included in the job plan, review in January 2021.	R	Medicine Governance Meeting; Quality Governance Group; Quality & Safety Committee
					Gap in assurance 3: Pain re-audit undertaken to assess impact of actions from the first audit, findings awaited.	New standardised documentation which includes approved pain chart completed. Re-audit to be undertaken to assess the impact of the new documentation in March 2021.	G	
					Gap in assurance 3: Greater support for training and education in the ED to support learning and improvement.	Matrons working with NHSE/I and completing a staff development plan/career trajectory. Aligned to this is the completion of an establishment proposal to share with Chief Nurse which incorporates Clinical Education, end of January 2021.	A	

RAG RATING KEY:	G	Green: Fully assured that progress is being made in mitigating issues, impacting on strategic risk.
	A	Amber: Partially assured, progress is being made in mitigating the issues.
	R	Red: Not assured; limited signs of progress being made to mitigate issues leading to increased risk.

Strategic Objective:	**1. TO GIVE GREAT CARE**
Risk to Strategic Objective:	3) Adverse impact of external events (i.e. Britain's exit from the European Union; Pandemic) on business continuity and the delivery of core services.
Risk Description:	Risks to the provision of core Trust services following external events on the Trust (i.e. 'Brexit' and access to medicines/medical treatments, devices, the workforce and access to some forms of diagnostics; ability to meet the demands from pandemics).

Monthly Executive Highlight Report:

* Trust Executive lead overseeing the Trust's response with other Executives taking lead roles on critical related areas to ensure a prioritised response.
* Covid-19 classified by WHO as a pandemic. Affecting countries across the world. UK Government took strict measures during wave 1. Further regional restrictions taken and a further national lockdown during November 2020. Further UK wide national lockdown announced starting in January 2021.
* The Trust's response to the pandemic during wave 1 tested capabilities and provided assurance the management had been appropriate. Wave 2 has had a much greater impact on the Trust. The incident has been escalated to a National Level 4.
* Unlike during wave 1 lockdown, there has been a higher demand on Trust services with A&E attendances and emergency admissions increasing resulting in some elective work being cancelled. Seasonal flu will start to circulate putting additional pressure on inpatient capacity. Available ward staffing and staff mix have been adversely affected by the pandemic. A further national lockdown was announced and commended on the 31 December 2020.
* 30 Redi-rooms have been deployed to mitigate against gaps in isolation facilities on the two main sites. These temporary and portable devices enable greater isolation facilities. Testing capabilities have continued with additional back-up available from Boston should there be any unplanned outages. Work underway to launch rapid testing to support management of patient flow. Covid-19 vaccinations have commenced for Trust Staff taking a risk factor based approach.
* A deal between the EU and the UK government means that the 'Brexit' transition is concluded on the 31-December 2020. Mitigations in place against potential 'Brexit' related risks.

Monthly Executive Highlight Report: Plans for next month:

* Maintain readiness via central Brexit mailbox to receive cascade information and to maintain Brexit lead persons. Ongoing management of the Covid-19 pandemic and communication of key messages.
* Continued management and response to phase 2 of Covid-19 including further implementation of actions within the Trust's premises to ensure social distancing and adherence to other guidance.
* Review of point of care testing capabilities for winter/influenza/Covid-19 and identification of risks to business continuity.

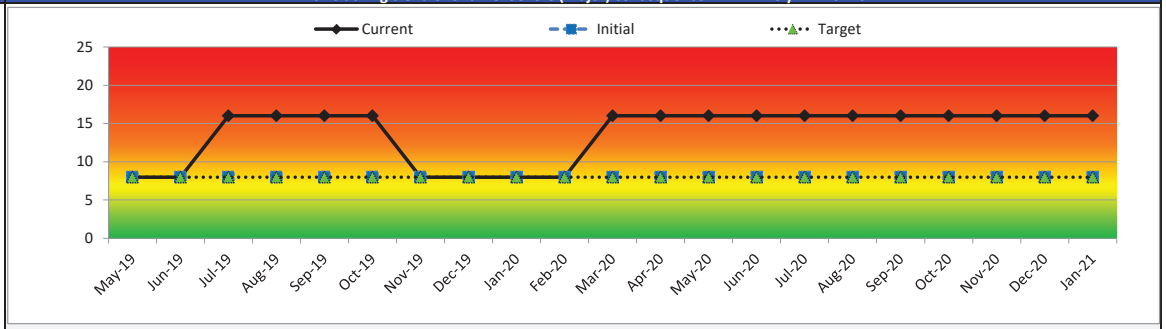
Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

* The heatmap demonstrates the current local risks that relate to or underpin the management of this strategic risk.

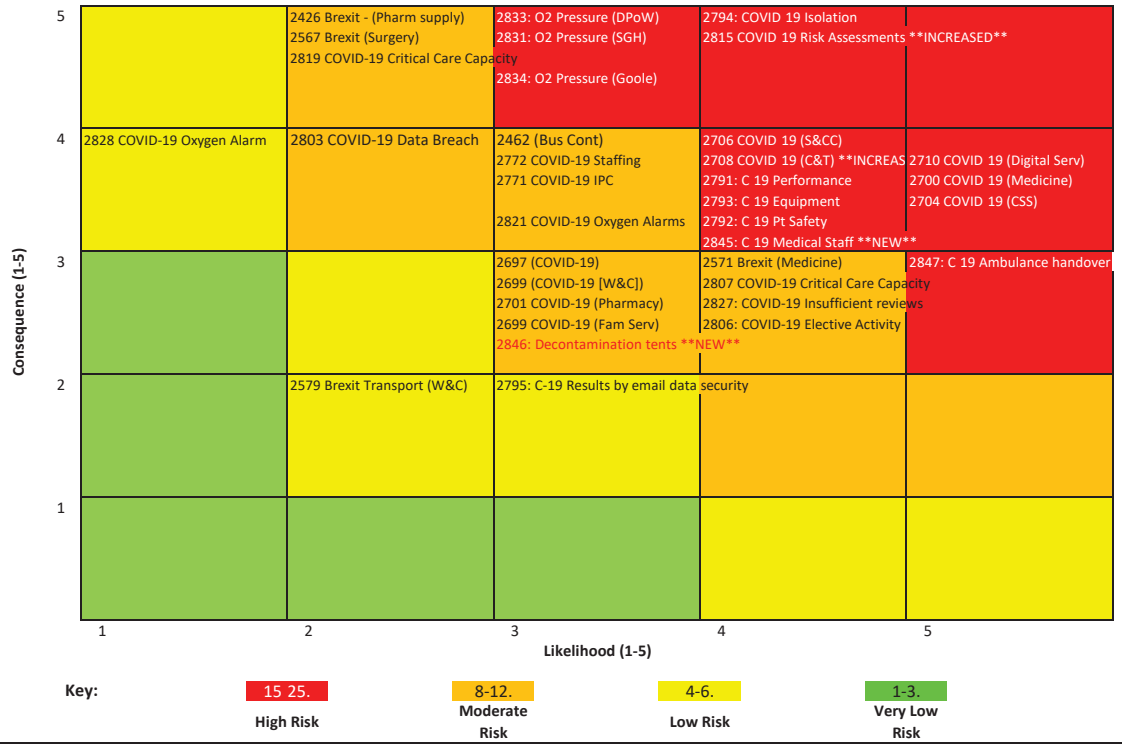
Changes this month:

* **NEW** 2845: Risk to Medical Staffing due to COVID 19 [Medicine] (Risk rating: 16; C4xL4)
* **NEW** 2847: Ambulance Handover Delays (Risk rating: 15; C3xL5)
* 2815: COVID Risk Assessments and risk to workforce (RR: 20; C5xL4) [Risk Rating INCREASED from 12 to 20, Jan 2021]
* 2822: Oxygen Alarms not Functioning Correctly on Ward 25 (RR: 12; C4xL3) [Risk removed from RR, Jan 2021]
* 2760: Misc: Consultant Pharmacist - Antimicrobials [CSS] (RR: 10; C2xL5) [Risk removed from RR, Jan 2021]
* **NEW** 2846: Decontamination Tents - Emergency Departments. (Risk rating: 9; C3xL3)
* 2708: Covid-19 (Community & Therapies) (RR: 16; C4xL4) [Risk Rating INCREASED from 12 to 16, Jan 2021]
* 2798: Swabbing Sites Trust Wide (RR: 9; C3xL3) [Risk removed from RR, Jan 2021]
* 2833: Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - DPoW (RR: 15; C5xL3)

Risk tracking trend over time: Severe (Major) consequence: 4 x 4: Likely RR of 16



Linked Corporate or High Level Risk Rating HEATMAP:



STRATEGIC OBJECTIVE	1 TO G IVE GREAT CARE						
Risk to Strategic Objective:	3) Adverse impact of external events (i.e. Britain's exit from the European Union; Pandemic) on business continuity and the delivery of core services.		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Shaun Stacey Trust Management Board Audit, Risk and Governance		**Date added:** **Last updated**	01-May-19 12-Jan-21
Consequences of Risk Materialising:	* Inability to provide core service functions; * Medicines and medical supplies with a short shelf life could become short in supply; * Shortage of radiopharmaceuticals would impact adversely on diagnostics and cancer care; * Increased demand on Trust services as a result of a pandemic and risks to the Trust's workforce; * Inability to deliver medical treatments, devices due to pandemic impact on estate or workforce resulting in a requirement to minimise contact or use personal protect equipment at all times.		A g d h h p g h k b g				Trend RAG Rating: AMBER
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**		**Assurance / Oversight Group**
Pandemic: Issue 1: Overall Executive and Operational Leadership and planning	COO is the lead Executive Director; with other Executives taking allocated lead roles on related issues. Operational leads in place and virtual Incident Coordination Centre established; Divisional business specific risks being identified and scoped out with feedback to the Emergency Preparedness team for central collation and publishing on the Hub site; Twice daily operations meetings, daily strategic planning / management meeting and daily Executive meeting overseeing Trust response. Generic mailbox is receiving daily updates/guidance/requests for returns and these are logged for action/assurance; Visiting arrangements changed and implemented. Red/Green/Yellow A and Yellow B zones implemented to mitigate against infection spread; Trust linking in with EPRR regional teams and Humber Local Resilience Forum; Winter planning group established during July 2020; Consultant Antimicrobial Pharmacist has been appointed and commenced work within the Trust, Dec 20. Consultant Microbiologist working as Covid-19 Microbiology lead and supporting Clinical Reference Group and Covid Strategic Planning Meeting.	*Assurance data:* None. *Assurance sources:* (1) **Positive:** The Trust's response to the pandemic during wave 1 and wave 2 has tested capabilities and provided assurance that the management of the pandemic has been appropriate. (2) **Negative:** Approximately 25% of transmission rates in hospital.	Risks of Covid-19 and Flu impact on business continuity in view of limited isolation facilities. Exposure of positive Covid-19 cases in Yellow zones is reducing capacity of beds/bays because of exposure. Winter pressures impacting on capacity of Yellow B/Red areas. Demand on Trust services is greater than what was expected. New variant has a higher transmission rate between 50-70% more transmissible.		Redi Rooms providing temporary and portable isolation facilities have been deployed with 30 in place across the Trust. Progress made. Monitor during wave 2. Review in February 2021. Recent purchase of Cubiscreens and fitted to a number of wards across the 2 main sites along with additional acrylic screens fitted in some locations, review in February 2021. Working to keep Goole as a green site to maintain elective surgical activity, review in February 2021. Rapid testing available in January 2021 enabling 24/7 access. New hardware being installed. Aim to have the ability to undertake rapid swab testing in ECC before the patient is transferred to a ward or discharge plans made. Discharge to Assess initiative launched with support from National ECIST team. [See Quality Section of the BAF: SAFER for more details on pilot and ECIST work] Not achieved full rollout yet. Systems and process being established. Review in February 2021. Lateral flow staff testing established and processes becoming embedded, review in February 2021.	A A A A A A	
Pandemic: Issue 2: Trust Staff	POE Executive Director leading on HR Guidance and duty of care aspect of Trust response to Covid-19; Communications team issuing regular updates to Trust staff; Covid-19 Hub site enabling communication with staff and responding to FAQs; Increased VPN/network access and arrangements made to enable larger scale remote working for staff; Increased staff testing available and has demonstrated sufficient capacity to meet demand during the pandemic; Staff swabbing ongoing, now business as usual, in line with national guidance; Staff screening and symptomatic staff self-isolating in line with national guidance; Staff identified as being in an at risk group have been provided with risk assessment tool to support line managers take appropriate action to support and mitigate the risk and understand wellbeing needs of staff; Facemask go live for all Trust staff in all areas from the 16 June 2020, and face coverings required of patients and visitors; Covid-19 workplace risk assessment in use to assess and determine 'Covid Secure' locations using HSE templates and ongoing monitoring i.e. shielding staff coming back into the workplace; Social distancing	*Assurance data:* None. *Assurance sources:* (1) **Negative:** 90% of all staff have had risk assessments completed. Deadline: 30 September 2020.	All staff requiring a risk assessment and wellbeing review with their line manager. Longevity of the incident and its management can impact on staff resilience. Staff shortages faced as a result of the pandemic or other absences risks business continuity.	Gap in assurance 1: Staff risk assessments required remain outstanding.	Strategic Planning Group overseeing. 90% completed to date (Dec 20). Majority of not yet risk assessed staff are bank and agency staff members. Increased the number of reusable FFP3 masks from 500 to >1500 for vulnerable staff, review in February 2021. Regular communication promoting mental health support available to staff. Further provisions to be made available in Jan/Feb 2021. Redeployment hub established to enable non-clinical staff to be redeployed to support provision of direct clinical care / quality of care. Not fully mitigating to date. Review in February 2021.	A A G R	Trust Management Board / Trust Board
Pandemic: Issue 3: Equipment availability, allocation, training and advice **Pandemic: Issue 4:** Staffing of extended ICU facilities (inc. different staffing models) **Pandemic: Issue 5:** Development of facilities (including greater ICU capacity) and options around bringing other facilities into use	Nominated Executive Directors leading on specific aspects of Trust response to Covid-19, with overall lead executive. Non-Executive Director also supporting focus on; Daily stock checks completed by procurement and returned to the centre. Regional PPE cell established with links to the LRF and daily regional discussions; Mutual Aid group meets daily to review PPE needs of organisations and supports in cases of shortage; National/regional arrangements in place to order/loan additional equipment with daily updates received. Due to previous shortages of Haemofiltration consumables, to meet the demands of patients during pandemic, regular stock updates and returns are in place with regular feedback; Purchase of equipment during wave 1 to reduce reliance on disposable PPE equipment (i.e. 20 respirator hoods; 500 reusable half masks); Risk assessment completed for options appraisal if fit testing not able to be completed due to a lack of consumables. External support provided to the Trust with additional fit test trainers; Red/Green/Yellow A and Yellow B zones have been implemented to support to mitigate infection spread with latest PHE guidance being used to guide staff in these zones and dependant on clinical procedures/investigations being undertaken what PPE is required; Critical care facilities have been expanded using Theatres with red/green zones. Critical care facilities were sufficient during wave 1 of the pandemic, ICU/ITU now have capacity for Covid-19 patients and sufficient isolation facilities to meet demand; Ongoing management of available machines with escalation to regional/national loan arrangements, ongoing as business as usual activity. High flow oxygen capacity planning involving critical care teams and Estates teams in place and supporting ensure safe and sustainable use of oxygen. Increased staff training and competency to operate anaesthetic machines following large scale training programme mobilisation; Public Health England (PHE) guidance followed by the Trust relating to all PPE issues arising from the Covid-19 pandemic. There are no current national or local shortages of PPE; Clinical Reference Group established to support with clinical decision making during phase 1 and to support planning for future phases of the pandemic; Clinical Ethics Group established to support in clinical decision making linked to surges and available equipment; Board routes log available to support covid decisions	*Assurance data:* None. *Assurance sources:* (1) **Positive:** No significant concerns with regard to equipment availability has been identified during wave 1 and 2 of the pandemic response. (2) **Positive:** Public Health England and HSE guidance followed during wave 1 of the pandemic and will continue during wave 2. (3) **Positive:** To date, the Trust has not reached a point where availability of equipment has required external escalation. Ventilators accessed as part of national approach of increasing capacity. To date there have been no significant issues with PPE / Equipment. (4) **Negative:** Major incident declared, November 2020 linked to capacity of oxygen and higher acuity of patients. (5) **Positive:** CAS alert received and action required undertaken and completed. Dec 20.	Planning for winter: risks of Covid-19 and Flu impact on business continuity especially in respect of SGH with increased prevalence and limited isolation facilities. Lack of point of care testing to support management of Covid / Flu during the winter season. Risk to business continuity if pathology analysers become un-operational for any period of time. Lack of internal testing capacity is reducing our ability to also test staff on a regular basis to identify asymptomatic staff. This is also likely to be a contributory factor in the spread of COVID to patients and staff. Increased demand seen on oxygen requirements for patients with higher levels of acuity during wave 2 stretching available oxygen supply capacity to Red/Yellow areas.		Rapid testing available in January 2021 enabling 24/7 access. New hardware being installed. Aim to have the ability to undertake rapid swab testing in ECC before the patient is transferred to a ward or discharge plans made. Analyser in Boston available to support business continuity should any analysers become un-operational for a period of time. Review in February 2021. New mass testing planned by the Dept of Health should help to alleviate this concern, rollout date/Trust plans for rollout to be confirmed when further information available. New oxygen system manifold that will help support pressures in the system being installed. Review in February 2021. Debrief of the major incident undertaken during December and an associated action plan to be developed to improve management of oxygen capacity, review in February 2021. E&F team to include within E&F strategy an increase in oxygen capacity to respiratory wards. Timescales to be confirmed, review in February 2021.	A A R A A A	
Pandemic: Issue 6: Phase 3 response	Restored elective activity with risk prevention interventions and in place (social distancing; screen people before procedure; taping of floors etc.); Risk assessment processes related to Covid-19 (at risk staff, workplace to assess for Covid-secure locations) in place; Social distancing steps taken within Trust premises, with reminder signage and estates work in place; Deviation from National Guidance reviewed and agreed by Clinical Reference Group to prevent higher number of patient initiated cancellations / NEW NICE guidance; Interpretation and implementation of national guidance to support recovery, ongoing;	*Assurance data:* (1) **Positive:** Infection Prevention Control Board Assurance Framework (BAF): 2/62 RAG rated as Red; 7/62 RAG rated as Amber, June 2020. *Assurance sources:* IPC Board Assurance Framework;		New Covid-19 interventions guidance received. Some potential organisational gaps against guidance relating to ventilation.	Reminders to staff to ensure during winter that windows are opened slightly to enable ventilation and air flow. Ongoing communications plans. Review in February 2021.	A	
Brexit: Issue 1: Impact on the timely access to medicines. Reduced access to general sales medicines could increase patients accessing urgent care services for support with normally self-managed conditions.	EU Exit group re-established with subject matter experts. NLAG to run as a concurrent incident alongside Covid-19 incident response. Plans have been put in place nationally to mitigate against any potential supply disruptions. The message continues to be that we should not be stockpiling locally and we should report any shortages through the usual routes.	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.					Trust Board
Brexit: Issue 2: Impact on the timely access to medical devices.	Plans have been put in place nationally to mitigate against any potential supply disruptions. The message continues to be that we should not be stockpiling locally and we should report any shortages through the usual routes.						
Brexit: Issue 3: Impact on the timely access to non-medical consumables.	Plans have been put in place nationally to mitigate against any potential supply disruptions. The message continues to be that we should not be stockpiling locally and we should report any shortages through the usual routes.	Business continuity plans revised and updated in connection with 'Brexit'.					
Brexit: Issue 4: Financial risk from non-UK patients becoming chargeable as the Trust leaves the EU Single Market.	Visitors from the EU accessing healthcare: Short-term visitors to the UK who are not covered by the new UK-EU agreement on reciprocal healthcare, including former UK residents, may be charged for NHS treatment. Those visiting for six months or more will be charged as part of their visa application, but some member states have agreed to reimburse this.				Communication to remind staff to ask every patient on every visit 'How long they have lived in the UK?' and pay particular note to the entry date. If this is after 1 February 2021 immediate referral to the Overseas Team. Review in February 2021.	G	
Brexit: Issue 5: EU Data sharing	Continue to handle data in the same way as the agreement allows for the continued free flow of personal data from the EU/EEA to the UK until an adequacy decision is adopted.						

RAG RATING KEY:		
	G	Green: Fully assured that proaress is beina made in mitiaatina issues. impactina on strateaic risk.
	A	Amber: Partially assured. proaress is beina made in mitiaatina the issues.
	R	Red: Not assured: limited signs of progress being made to mitigate issues leading to increased risk.

Strategic Objective: 2. TO BE A GOOD EMPLOYER

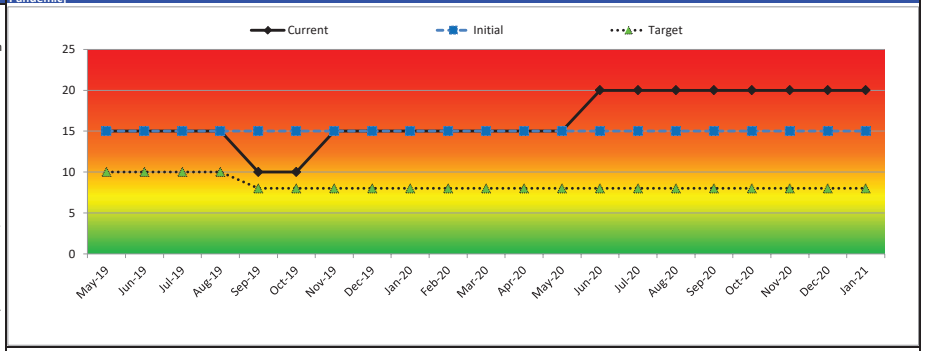
Risk to Strategic Objective: 4) Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and longer term

Risk Description: The risk of having insufficient staff or staff who are not suitably trained which could prevent the Trust providing care to its patients, lead to poor care outcomes which could adversely affect actual care quality as well as damage the Trust's reputation.

Monthly Executive Highlight Report:

* HIGH RISK rating, remains at 20. Recruitment pipeline has lead to a steady reduction in the nurse vacancy rate with new staff from overseas able to join the Trust. Nurse vacancies have recently increased during November from 158 in October to 179 in November. Medical and Dental vacancy rate has increased slightly in November to 108.70 from 107.92. Risk remains high as a result of the extremely challenging operational pressures which could lead to an increased turnover rate and difficulties with retention. Other mitigating actions being explored including uplift agreed for bank staff and additional HCA recruitment to the bank to support filling vacancies.
* Trust successful in receiving NHSI/E funding to recruit Organisational Development (OD) practitioners. Successful in obtaining funds to recruit for additional OD post and HR posts. These posts will support focus on retention of staff through the engagement agenda (outlined in People Strategy) as well as supporting more effective HR helpdesk function to support staff who are struggling better.
* The Trust have been focussing on risk assessing all staff and ensuring staff wellbeing during the pandemic. To date 7424 risk assessments have been completed, with 722 outstanding. Looking to agree at Board level the appropriate risk stratification actions for those staff scoring a risk above 6 and who wish to remain working. Shielding letters are being issued during November. The risk to the workforce is not fully understood.
* A Trust wide launch of the Trust's People Strategy has been paused as a result of the second wave of the pandemic. This links with requirements of NHS People Plan.
* Development completed of live dashboard data with mandatory training performance by division / discipline to support more focus on mandatory training performance.

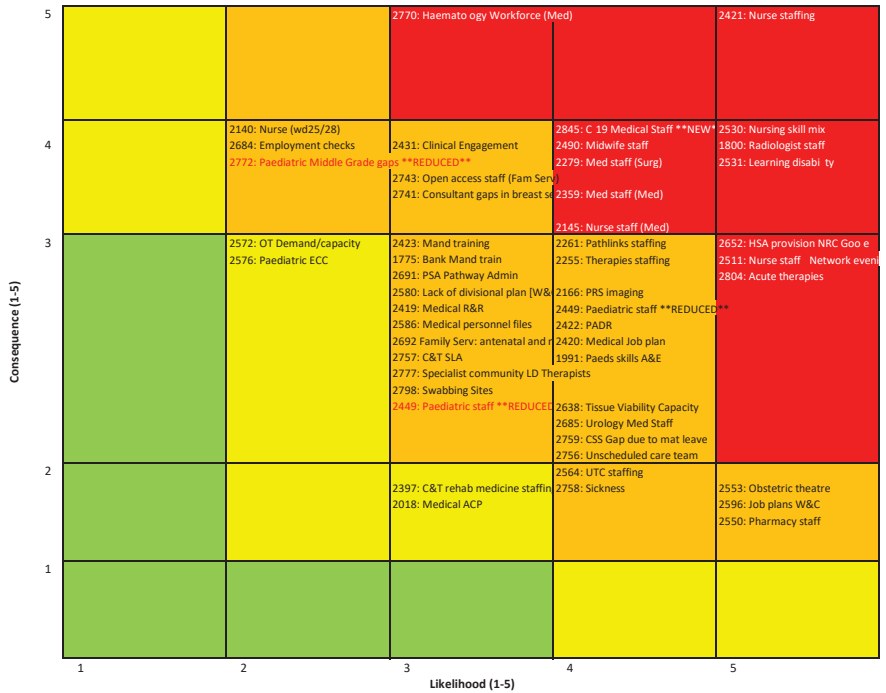
Risk tracking trend over time: Catastrophic consequence: 5 x 4: Likely RR of 20 [Target risk rating: not able to project during the Trust s incident response to the Pandemic]



Monthly Executive Highlight Report: Plans for next month:

* Scope out the processes required with Hull to for the deployment of a vaccination for Covid-19. Flu vaccinations are now open to all staff following deployment to front line staff.
* There is a challenge for how to roll out increased use of asymptomatic Covid-19 testing and how to co-ordinate as an Organisation.

Linked Corporate or High Level Risk Rating HEATMAP:



Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

* The heatmap demonstrates the current local risks that relate to or underpin the management of this strategic risk. There are a large number of underpinning or related risks captured on divisional and directorate risk registers. See appendix for the full list. There are some changes since last month:

CHANGES SINCE LAST MONTH:

* **NEW** 2845: Risk to Medical Staffing due to COVID 19 [Medicine] (Risk rating: 16; C4xL4)
*
2772: Paediatric Middle Grade Gaps linked to Covid-19 (RR: 8; C4xL2) [Risk Rating REDUCED from 12 to 8, Jan 2021]
* 2449: Paediatric staffing (not meeting national guidance) W&C (risk rating: 9; C3xL3) [Risk Rating Reduced from 12 to 9, Jan 2021]
* ~~2817: No Therapy cover within the Intermediate Care Service (RR: 15; C3xL5)~~ [Risk closed on RR, Jan 2021]
* ~~2189: Admin W/F in Pink Rose Suite Surgery (RR: 12; C3xL4)~~ [Risk closed on RR, Jan 2021]

STRATEGIC OBJECTIVE	2. TO BE A GOOD EMPLOYER						
Risk to Strategic Objective:	4) Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and longer term		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Claire Low PAM / POE SMT Workforce Committee		**Date added:** **Last updated:**	05-May-19 12-Jan-21
Consequences of Risk Materialising:	* Inability to safely provide services to the local population; * Unable to cover key posts within the Trust due to a lack of succession planning / future talent identification;			**Assurance Rating:**		**Current RAG Rating:**	
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**	**Current RAG Rating:**	**Assurance / Oversight Group**
Mandatory training & PADR	Monthly reporting to management teams (Triumvirates / Heads of dept. / HR Business Partners). Access to e-learning and a standard PADR template. TMB approval of revised targets for both PADR and Mandatory Training (Core and Role specific). HRBP supporting and working with each directorate to focus on specific gaps. More reliance on non-face to face training during the pandemic i.e. booklet/smaller groups/on line training. Cleansing of ESR data provides improved quality of workforce data providing integrated data systems that now join workforce and finance data. Report on mandatory training / PADRs (linked to 'must do') - CQC monthly reports to Workforce Committee and Trust Management Board. Development completed of live dashboard data with mandatory training performance by division / discipline to support more focus on mandatory training performance.	*Assurance data:* (1) **Positive:** Core Mandatory Training rate (Trust): Oct 20: 91% (vs. target of 90%). (2) **Negative:** PADR (Trust) Oct 20: 82% (vs. target of 95%) (3) **Negative:** Role Specific Mandatory Training rate (Trust): Oct 20: 81% (vs. target of 85%). *Assurance sources:* *PAM monitoring as part of Workforce focus;* *Workforce committee reviews key data;* *Review completed to evaluate the level of mandatory training required and determined appropriate.*	Releasing staff (in particular those in front line departments) to attend mandatory training. E-learning platform not user friendly. New dashboard launched on ESR and improvements continue with national updates.	Gap in assurance 1 and 2: Core mandatory training and PADR targets not being met in frontline services. Resuscitation Training rate for site specific. Advanced resuscitation training courses required for A & E postponed due to pandemic Gap in assurance 1: A gap in availability of KPIs to support measuring progress against staffing and morale improvement projects.	Staff/managers to undertake PADR using virtual means, with performance being reported to PRWG. Monitoring undertaken by Triumvirates and HRBPs. March 2021. NHSE/I support to developing collaborative approach working with other Trusts to maximise attendance opportunities on courses where faculty attend site to provide training - when able post-Covid which includes general resuscitation and EPALS. Current review of resuscitation training to be undertaken system-wide. Delayed as a result of pandemic wave 2. November 2020.	R	Workforce Committee; PRWG
Recruitment / Workforce Planning	People Strategy (includes Leadership and Management plan) in place. Operational plan (5 year planning) includes workforce and outlines plan for transformational role development with ICS. Review of holistic requirements of the Humber Coast and Vale workforce requirements, led by People Lead - HCV ICS. POE central talent acquisition team in post and supporting with hard to recruit to vacancies. HR Business Partners from central team supporting divisions/directorates. Additional funding awarded and mobilised to enable a focus on key operational HR backlogs from interim HR professionals (commenced Feb 2020). Workforce planner and support in post. ESR data cleanse completed to support continued roll out of manager ESR which will eventually support improved PADR and Mandatory Training rates. International Recruitment recommenced now restrictions lifted from Government controls. Recruitment for Director of People completed - start date 1 January 2021. Joint International Recruitment being concerned within the ICS.	*Assurance data:* (1) **No assurance data:** Key staffing data. (2) **Negative:** Nov 20: 178.94 (30.62% vacancy factor); Oct 20: 158 WTE (9.59% vacancy factor). *(Budgeted establishment increased 31 WTE in month);* (3) **Negative:** Nov 20: 108.70 (14.91% vacancy factor); Oct 20: 107.92 WTE (14.88% Medical and Dental Vacancies) (Improvement on August: 110 WTE or 15.2%). *(Budgeted establishment increased 4 WTE in month);* **EXTERNAL ASSURANCE:** (Int) **Negative:** Audit Yorkshire internal audit: Medical Staff Personnel Files: Low Assurance, Q1 2019. *Assurance sources:* *External assurance from NHSI that time taken to recruit is good compared to peers;* *Advert to recruitment timescales.*	Mentoring training needs for future workforce planning activities. Triumvirates and HRBPs skilled to plan for the future workforce in line with internal strategy. People Lead - HCV ICS, review to be undertaken. HRBP integrated local workforce meetings with HRBP have recommenced. High risk of increased turnover as a result of covid pressures. Potential for higher than normal level retirements due to covid pressures. Short term absences will also increase as a result of the virus and related mental health impacts of the working environment. 3rd Covid-19 spike impacts now being felt with regards staffing. Recruitment process and retention of information within staff personnel files. Substantive HRD successfully appointed. Review of critical POE function / launch of strategy not yet able to be completed.	Gap in assurance 2 and 3: Staffing vacancies remain and could be exacerbated by affects of pandemic on workforce (i.e. burnout and early retirement). Increase in nursing establishments. Gap in assurance: External Assurance: Low level of assurance from Q1 internal Audit into medical staff personnel files	Manager self service project to provide increased line manager oversight of core training and will include electronic PADR, ongoing. Full rollout to commence January 2021. Supporting staff to shield for the 2nd occasion now throughout the pandemic. This is proving to be very emotionally taxing for individuals concerned. HR advice issued to managers to support members of staff through isolated period. Continue to undertake staff risk assessments linked to Covid-19. 650 assessment outstanding - the majority of these are bank staff. Options now been considered to alternative approaches to reduce this number further in line with national advice. New business case with options appraisal. MD and HRD to review. On-hold whilst managing covid response as a result of redeployment of resources. HRD now in post, review underway	A R A A A	Workforce Committee
Retention / Turnover	Employee benefits package better understood by workforce (Total Reward Statement). Recruitment and Retention Strategy abandoned with retention forming a core element of the 'culture' Work stream within the NLaG People Strategy. Successful NHSI Special Measures funding for 2 OD practitioners, commenced in post to 31 March 2021, to support retention and engagement agenda (outlined in People Strategy). Interactive KPI and SMART objectives tool to measure retention under development. Currently managed using SPC charts and cascaded to HRBPs. Dashboard delayed to new year. Measured in Senior Management Team in POE. Retire and Return workshops in place.	*Assurance sources:* Retention rates are market leading amongst peers and continue to improve; Monthly staffing report to Workforce Committee. Monthly staffing report to JNCC.	Evaluation of staff leavers reveals 34% avoidable leavers retire, 30% leave for career progression, 25% relocate and 7% leave for work life balance reasons.	POE dashboard in draft format.	Trust's People strategy approved. HR Team reviewing strategy and developing Trust wide launch. Delayed due to Covid-19 2nd wave. Review in January 2021. 2 OD practitioners, commenced in post to 31 March 2021, to support retention and engagement agenda (outlined in People Strategy). A review of Retire/Return practices underway Q3 20. Flexible working/carers passport review and launch Q3/Q4 and review scheduled for talent management/leadership development in Q3/Q4 20. 69% to be finalised by November 2020. Exit Questionnaire process under review to increase uptake of leavers. Delayed due to pandemic, rescheduled to Q4, 20/21. Staff Benefits review to be undertaken 2021/22 with Total Reward Statement forming core element. Review in January 2021.	R A A A A A	
Increasing establishment and approval/costs of overseas recruitment	Outcome of nursing establishment review agreed and increase agreed for phased implementation. Increased establishment agreed - phase 2 has been funded.	*Assurance sources:* *Staffing report outlining vacancy rates.*	Increased establishment agreed (to be phased in) - recruitment activities required.	Adverse impact on nursing vacancy rates whilst recruitment underway. Failure to convert the 50 overseas nursing recruits.	Overseas nurses pipeline agreed, Visa restrictions lifted, delays enabling staff to sit their English language test could have significant impact. Review in January 2021. Two successful bids submitted for additional funding to facilitate overseas nursing recruitment. 20 nurses commenced November 2020, further 20 commencing December 2020, additional 60 planned up to Oct 2021 possible due to additional successful funding. Review in January 2021.	R A	Workforce Committee
Future Talent Management	Working with schools/local education regarding future employment options and supporting careers fairs. Internal Transfer panel to support flexible internal movements to support retention (limited to nursing staff on a pilot). Effective Roster Committee established to review system gaps and maximisation of system resource. Operational Deployment Centre to improve flexibility of employment working with MD/CN and COO. Lead appointed. Bank, E-Rostering, Rota Co-ordinators and Medical Staffing Managers centralised within the Operational Deployment Centre with budgets aligned. Nursing Recruitment and Retention Strategy now in place which supports staff with increased flexibility. Director of People working with ICS for future workforce (right people, right time, right skills).	*Assurance sources:* *Assurance from retention reported as part of Use of Resources;* *Educational and Leadership pathway work, aligned to People Strategy.* *Alignment with NHS People Plan.* *Monthly case reviews of HRBPs.*	Better understanding of future staffing needs/talent management needed. Capacity of HRBPs work roles and responsibilities and consultations.		HRBP to support divisions planning future staffing needs as part of Divisional engagement plans, develop a wide variety of apprenticeships, by March 2021. Trust's People strategy approved. HR Team reviewing strategy and developing Trust wide launch. Delayed due to Covid-19 2nd wave. Review in January 2021. Continuation and building on career confidence programme launched in September to pause due to wave 2 of pandemic. Launch of kick-start scheme once governmental approval confirmed. On-hold to be reviewed Feb 2021.	A R A	Workforce Committee

RAG RATING KEY:	
G	Green: Fully assured that progress is being made in mitigating issues, impacting on strategic risk.
A	Amber: Partially assured, progress is being made in mitigating the issues.
R	Red: Not assured: limited signs of progress being made to mitigate issues leading to increased risk.

Strategic Objective:	**2. TO BE A GOOD EMPLOYER**
Risk to Strategic Objective:	5) Ineffective staff engagement and ownership of Trust agenda affects morale and failure to change and improve the culture
Risk Description:	Ineffective staff engagement in the Trust's agenda risks delivery of the Trust's strategic objectives by adversely affecting the ability to retain staff, reduce sickness absences and improve morale.

Monthly Executive Highlight Report:

* Good progress has been made with mandatory training and PADR rates, with a deep dive pending into areas specifically falling below target.
* A Trust wide launch of the Trust's People Strategy has been paused as a result of the second wave of the pandemic. This links with requirements of NHS People Plan.
* The Trust continues with various platforms of communication to support engagement.
* Trust successful in receiving NHSI/E funding to recruit Organisational Development (OD) practitioners. Successful in obtaining funds to recruit for additional OD post and HR posts. These posts will support focus on retention of staff through the engagement agenda (outlined in People Strategy) as well as supporting more effective HR helpdesk function to support staff who are struggling better. Associate Director for Culture appointed as a secondment to support increased focus.
* The Trust continues with various platforms of communication to support engagement.
* A substantive Director of People and Organisational Effectiveness has been appointed and will take up post in January 2021.
* National Staff Survey released, current uptake is 31% vs. 38% UK average.

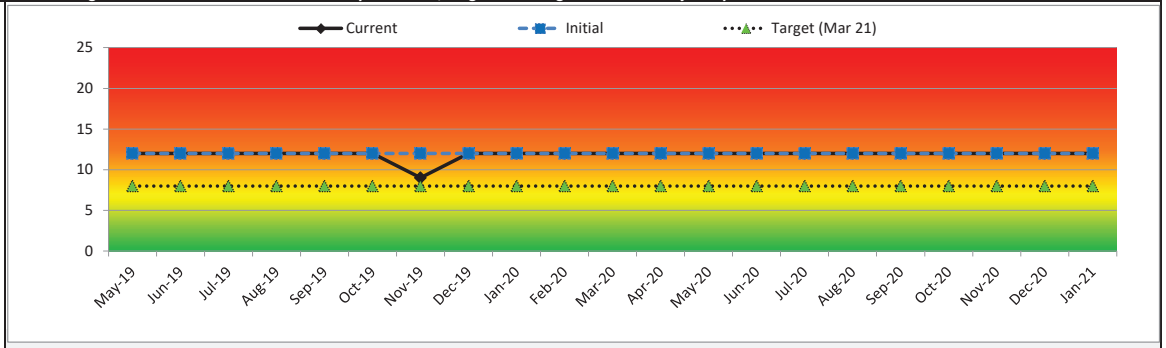
Monthly Executive Highlight Report: Plans for next month:

* Support ongoing workstreams to support retention and engagement with staff at a difficult time.

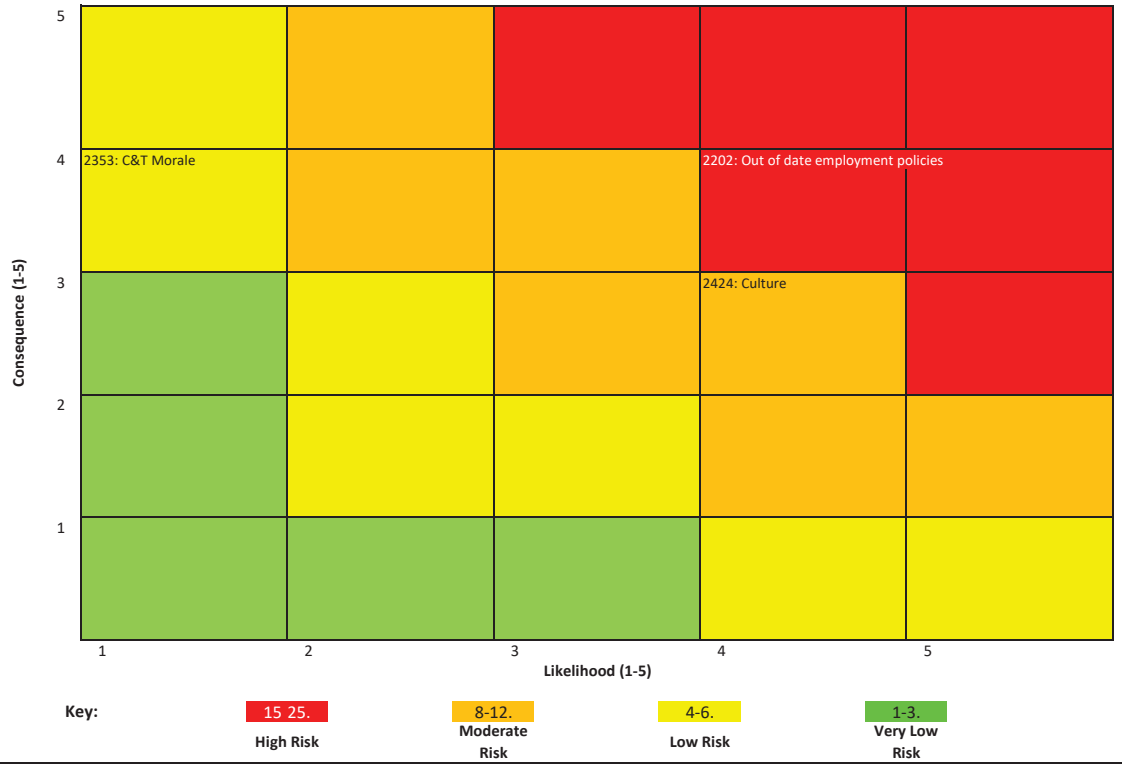
Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

* The heatmap demonstrates the current local risks that relate to or underpin the management of this strategic risk. There are no further risks identified this month or any changes to existing risks.

Risk tracking trend over time: Moderate 3 x 4 Likely RR of 12; Target risk rating achievement trajectory: March 2021.



Linked Corporate or High Level Risk Rating HEATMAP:



STRATEGIC OBJECTIVE	2 TO BE A GOOD EMPLOYER							
Risk to Strategic Objective:	5) Lack of staff engagement and ownership of Trust agenda affecting morale and failure to change and improve the culture		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Claire Low POE SMT / Workforce Committee Workforce Committee			**Date added:** 01-May-19 **Last updated:** 12-Jan-21	
Consequences of Risk Materialising:	* Failure to retain staff; * Higher sickness levels; * Poor morale.		**Assurance ha he ssues mpac ng on h s r sk are be ng managed**				Trend RAG Rating: AMBER	
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**		**Assurance / Oversight Group**	
Uncertainty / apathy from staff resulting from poor consultations, pockets of bullying and lack of speaking up arrangements in the past. Working to demonstrate improvements in the Trust's approach to these issues.	NLAG People Strategy. NHS People Plan. Communications to staff from Chief Executive, Executive Directors, Social Media, NLAG Hub. Pride and Respect Programme relaunched as a virtual training session. Incorporated into the Trust Strategic framework, NLAG People Strategy and Recruitment Processes. HR Business Partners and OD Practitioners working with divisions to implement plans for further improvement on the back of the NHS Staff Survey and feeding back to the central team specific issues. Pride and Respect and FTSU has been amended for Induction purposes - face-to-face and online video. Review of FTSU Strategy is going through ratification process. Health and well being programme has had significant investment including the launch of Care for Each Other workstream, VIVUP and Remploy.	*Assurance data:* (1) **Positive:** 3376 (39.7%) staff attended Pride and Respect training, April 2020. (1) **Positive:** 80 Pride and Respect champions, April 2020. (2) **Positive:** 105 staff supported by Trust mediation service with a 92.6% success rate, April 2020. (3) **No assurance data:** Lack of clarity on KPIs for workforce data. (3) **No assurance data:** There is a lack of outcome data from mediation sessions to demonstrate current actions are targeted and fit for purpose. BI system to provide data for assurance by December 2020. (4) **No assurance as yet:** National Staff Survey released, current uptake is 31% vs. 38% UK average. (4) **No assurance data:** The 2020 National Staff Survey issued in October 2020. Results normally available during the early part of the following year. (5) **No assurance as yet:** Staff preferences for engagement to be better understood. **EXTERNAL ASSURANCE:** (Ext) **Positive:** Audit Yorkshire internal audit: Freedom to Speak Up: Significant Assurance, Q3 2019. **EXTERNAL ASSURANCE:** (Ext) **Positive:** Audit Yorkshire internal audit: Equality and Diversity (Inclusion): Significant Assurance, Q3 2019.	Existing staff who have not yet had Pride and Respect training.		Pride and Respect, Freedom to Speak Up Guardian and Health and Well-Being champions to be integrated into one role to better promote campaigns across the Trust. Delayed, review in January 21.	A	Workforce Committee; POE SMT	
				Gap in assurance 3: A gap in availability of KPIs to support measuring progress against staffing and morale improvement projects.	Development of BI linked dashboards to provide assurance on progress against key metrics to support measurement of People Strategy. Delayed, review in January 2021.	A		
					Staff Morale Barometer (Engagement, Value and HWB focused) to be launched Q1 2021/22 and conducted quarterly thereafter To adopt staff survey scores to allow for comparison. To be housed on Staff App. Results to be evaluated using SPC methodology for statistical analysis.	A		
				Gap in assurance 3: Deep dive into data available from mediation not available to understand themes and examine embedded culture issues.	As part of Pride and Respect re-launch incorporate deep dive into mediation data to understand themes and ensure these are included as part of the action planned, December 2020.	A		
				Gap in assurance 5: Staff engagement preferences to be explored.	Staff Engagement plans from 2019/20 to be reviewed to identify progress. Staff focus groups regarding preferences for methods of staff engagement to be held Q4 2020/21 and Q1 2021/22, revised engagement plans to be constructed and enacted.	A		
Perceptions that Trust policy regarding recruitment and selection not always followed / adhered to.	Establishment control process now embedded to support delivery of Trust's finance objective and assurance provided via Internal Audit. Recruitment and Selection training package developed HR Helpdesk and Ask Peter Platforms for Staff raising concerns.	**EXTERNAL ASSURANCE:** (Ext) **Positive:** Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020. *Assurance sources:* *Annual staff survey results;* *Progress with Trust priorities report to Trust Board;* *People Strategy KPIs reported to Workforce Committee.*	NLAG People Strategy incorporates Leadership Development working in partnership with NHSI to develop appropriate training.		Support from NHSE/I in pulling together a competency framework to identify gaps in leadership skills and support leadership development approach. Review in December 2020.	A	Workforce Committee	
Reliance on interim / acting arrangements for senior leadership positions.	Establishment Control Process for approval of Senior Leadership vacancies. Formal process for interim appointments. Appointment of Trust Secretary, Director of Strategic Development and Chief Information Officer. Remuneration and Terms of Service Committee oversees recruitment process. Recruitment underway for Director of People.	Remunerations and Terms of Service Committee. Annual Report - declaration of senior appointment and remuneration.				G	Workforce Committee	
Lack of staff training opportunities.	Apprenticeship Levy. NLAG People Strategy NHS People Plan	*Assurance sources:* *KPIs to Workforce Committee.* *Highlight Report to Workforce Committee.*		KPI Dashboard in development.	KPIs to be finalised by November 2020.	G	Workforce Committee	
Medical engagement has been a challenge.	Findings from MES survey discussed with senior clinicians and mangers at time out session during November to identify gaps and necessary actions needed. Joint weekly consultant committee (HCC & MAC). Good clinical engagement through the Covid-19 pandemic with support to the Clinical Reference Group and the Ethics Committee. Good communication and engagement during the pandemic linked to assessment of staff in high risk categories. Medical Director led engagement sessions (inc. Consultant committees; 'ward walks'; Clinical Leads forum; Divisional Clinical Directors) ongoing. Collaborative engagement with CCG colleagues, forum established which is supporting closer working and development of transformational changes.	*Assurance data:* (1) **Positive:** Higher fill rate (to date, for August rotation) from deanery than previous years for at 92.9%, June 2020. (2) **Positive:** MES survey in 2019 demonstrated improvements when compared with the 2017 survey, 2019. *Assurance sources:* *Improvements identified from the Medical Engagement Survey.*	Ongoing work required in improving further Medical Engagement.		MES Strategy to focus on 3 key areas: (1) developing trust, (2) improving communication and (3) empowering clinicians. Strategy to be published in November 2020.	A	Workforce Committee	

RAG RATING KEY:	
G	Green: Fully assured that progress is being made in mitigating issues, impacting on strategic risk.
A	Amber: Partially assured, progress is being made in mitigating the issues.
R	Red: Not assured: limited signs of progress being made to mitigate issues leading to increased risk.

Strategic Objective:	**3. TO LIVE WITHIN OUR MEANS**
Risk to Strategic Objective:	6) Finance risk, specifically: (a) Not achieving the control target total agreed with NHS Improvement for the Trust and failure to achieve the overall system target; (b) Risk of non-delivery of the long term financial plan to produce a balanced financial position, working in conjunction with everyone else to achieve a system balance.
Risk Description:	Failure to deliver financial improvement plans, lack of support to the Trust and System and the risk of regulatory action and intervention.

Monthly Executive Highlight Report:

* The Impact of Covid 19 has resulted in a suspension of all planning and contracting within the NHS. As a result there has been no agreed activity plans and contracts with commissioners. There has also been no agreed financial plan with NHSI.
* The Trust has been (during the first 6 months of 20/21) receiving a monthly top-up payment to ensure the Trust breaks even. This top-up payment has included any reimbursement for Covid-19 expenditure.
* The risk rating was reduced from 15 (5x3) to 12 (4x3) given the fact that the top up payments being made to the Trust should ensure a break even position.
* For months 7-12 a control target has now been set for the Humber and the Trust as part of the Humber. The Trust have developed a plan which is considered achievable which includes Covid-19. There may need to be additional costs associated with quality which may threaten the plan but these are being worked through. There may also need to be investment in waiting list improvement which could add additional cost pressures.
* Whilst arrangements for months 7-12 are clear, post-Covid with associated recovery plans may present further risks. There is a significant uncertainty as to the financial framework for 2021/22. At this time, whilst awaiting clarification, the risk for 21/22 cannot be quantified.
* Awaiting release of planning guidance, may not be received until Q1 2021/22.

Monthly Executive Highlight Report: Plans for next month:

* Revisit phase 3 activity assumptions.
* Process in place to contain Covid-19 within budgeted envelope.
* Confirm Trust response to CQC including dialogue with commissioners.
* Start to take a measured view of larger Trust position.

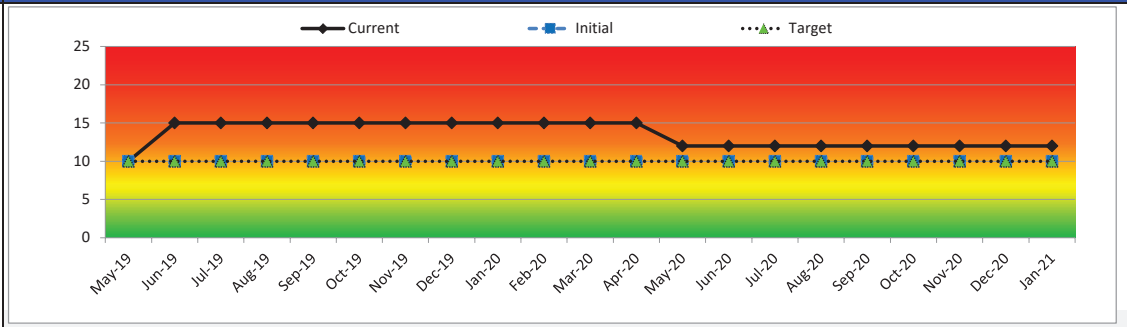
Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

* The heatmap demonstrates the current local risks that relate to or underpin the management of this strategic risk.

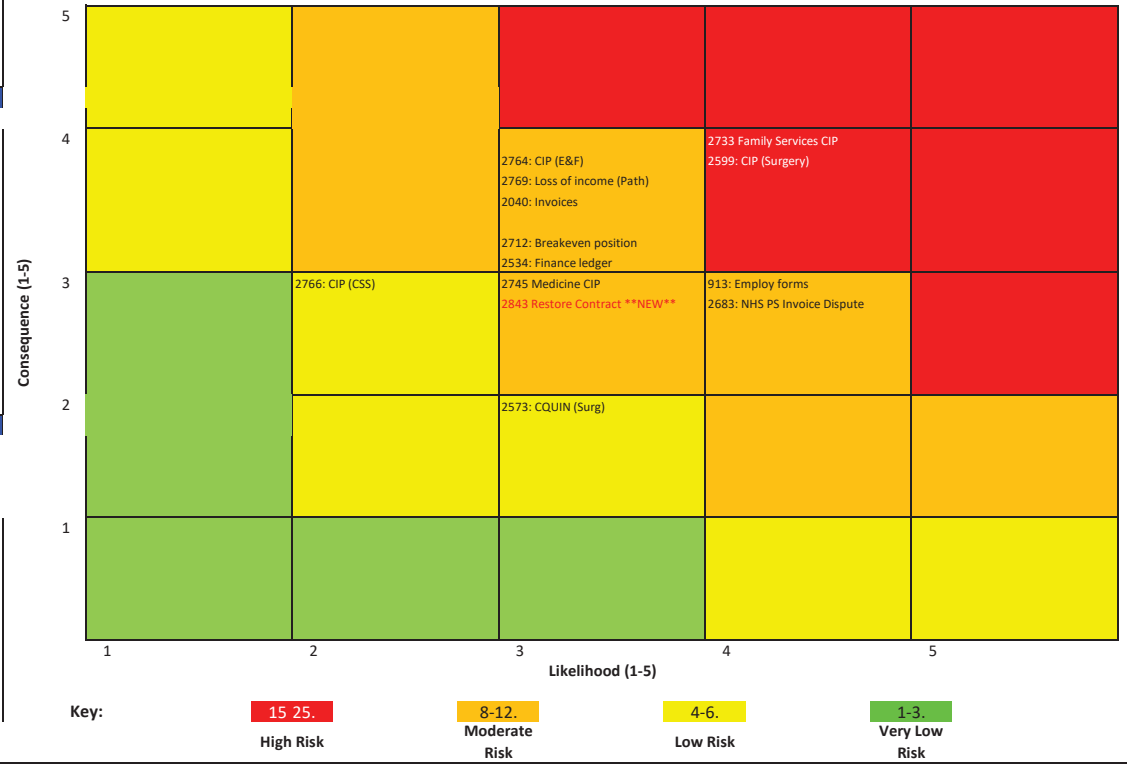
CHANGES SINCE LAST MONTH:

* **NEW** 2843: Restore Contract – rolling contract from October 2020 – Financial risk (Risk rating: 9; C3xL3)

Risk tracking trend over time: Severe (Major) consequence: 4 x 3: Possible RR of 12 [Target risk rating achievement to be set].



Linked Corporate or High Level Risk Rating HEATMAP:



STRATEGIC OBJECTIVE	3 TO LIVE WITH IN OUR MEANS						
Risk to Strategic Objective:	6) Finance risk, specifically: (a) Not achieving the control target total agreed with NHS Improvement for the Trust and failure to achieve the overall system target; (b) Risk of non-delivery of the long term financial plan to produce a balanced financial position, working in conjunction with everyone else to achieve a system balance.			**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Lee Bond Performance Improvement Meeting (PIM), Finance Review Group (FRP) Finance & Performance Committee	**Date added:** 01-May-19 **Last updated:** 07-Jan-21	
Consequences of Risk Materialising:	* Potential lack of support to the system, regulatory action and inability to exit quality and financial special measures; * Lack of longer term sustainability.				**Assurance that the issues impacting on the risk are being managed**		Trend RAG Rating: AMBER
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**		**Assurance / Oversight Group**
Issue 1: For months 7-12 the Trust has a new control total to achieve.	System of financial governance controls including SFIs and scheme of delegation overseen by Audit, Risk and Governance Committee. Oversight governance assurance through Audit, Risk & Governance backed up by internal audit and external audit. Clear system of finance performance reporting to management, Finance & Performance and Trust Board and PRIM.	*Assurance data:* **EXTERNAL ASSURANCE:** (Ext) **Significant Assurance:** Audit Yorkshire internal audit: Core Financial Controls (GL, Board Reporting, Payroll): Significant Assurance, Q3/Q4 2019. **EXTERNAL ASSURANCE:** (Ext) **Significant Assurance:** Audit Yorkshire internal audit: Clinical Coding / Activity Recording: Significant Assurance, Q2 2019. **EXTERNAL ASSURANCE:** (Ext) **Significant Assurance:** Audit Yorkshire internal audit: National Cost Collection: Significant Assurance, Q2 2019. **EXTERNAL ASSURANCE:** (Ext) **Significant Assurance:** Audit Yorkshire internal audit: Radiologists – Additional Payments: Significant Assurance, Q1 2019. (1) **Negative:** Lack of certainty as a result of not being able to fully plan. *Assurance sources:* Audit, Risk and Governance Committee (with feeds from Counter Fraud and Internal Audit plans); Finance and Performance Committee; Board oversight.		Gap on the CIP plan. Lack of assurance we can adequately manage risks arising from Trust response to Covid-19.		A	Trust Board, Finance & Performance Committee
Issue 2: Impact of Covid-19 Pandemic	Covid-19 oversight/monitoring and governance processes supporting Trust ongoing management of the pandemic. Daily strategic planning meeting that ensures confirm and challenge of financial expenditure in relation to Covid-19. Links to Executive Team daily meeting. Financial expenditure process reviewed by Executive Team on a daily basis. Financial impact of covid-19 following for the first 6 months of 2020/21 supported by top up payments being made to the Trust ensuring a break even position.	*Assurance data:* (1) **Positive:** Month 7 and 8 performance. *Assurance sources:* Assurance from NHSE/I that Covid-19 related spend will be covered centrally.		Management time focussed on response and management of Covid-19 pandemic and therefore a lack of time to focus on Business as Usual functions. Clarity received regarding financial arrangements and requirements for month 7 onwards. Ongoing focus and review.	Monitoring new guidance as it is released, ongoing.	A	Trust Board, Trust Management Board, Finance & Performance Committee
Issue 3: CIP / Financial Improvement Plan	Delivery support and monitoring of CIP through Improvement team. Monthly CIP report produced with management accounts feeding in. Individual divisional plans (CIP) in place with divisional leads established. Divisional Finance Improvement and CIP meetings have been established with divisional leads which is reviewing CIP performance, frequency dependant on delivery. CIP on PIM meeting agenda (including medical and nurse staff expenditure). Ongoing divisional / directorate meetings taking place to continue to develop CIP scheme ideas. Ongoing; step up/step down as needed. National benchmarking and productivity data constantly reviewed to identify CIP schemes. Ongoing. Oversight via TMB and Finance and Performance Committee.	*Assurance data:* (1) **Limited Assurance:** Summary CIP position by Workstream; **2020/21 Forecast**: August 2020 Report (month 3) Forecast for 20/21: RAG Rated RED [Report to F&P]. (1) **Limited Assurance:** Summary CIP position by Division: **2020/21 Forecast:** August 2020 Report (month 3) Forecast for 20/21: RAG Rated RED [Report to F&P]. **EXTERNAL ASSURANCE:** (Ext) **Significant Assurance:** Audit Yorkshire internal audit: Q&A process: Significant assurance. *Assurance sources:* Detailed reporting and progress reports to meeting structure; Monthly reporting to Finance and Performance Committee; Assurance: delivered on 2019/20 CIP schemes; Regional office suggested the Trust as an exemplar example for approach taken to CIP.	Although we have identified savings these will be difficult to deliver because of Covid 19.	Gap in assurance 1: The Trust is working up a CIP plan of £10.4m.	Develop a process to undertake deep dives into specialties to determine productivity and efficiency, end of October 2020.	R	Finance & Performance Committee, Finance Recovery Board.
Issue 4: Long term underlying financial sustainability.	Engagement with ICS on system wide planning Engagement with Humber Acute Services review to redesign fragile and vulnerable service pathways at both a system and sub system level Engagement with other partners to capitalise on the benefits from system service transformation.	*Assurance data:* ***None*** *Assurance sources:* ICS Executive Oversight Group Monthly Assurance Review; HASR Programme Assurance Group; NLAG Clinical Strategy/Plan Implementation Board.	System plans may not address individual organisational sustainability Longer term sustainability dealing with significant challenges: HASR; CIP Delivery and Estate. No clarity yet on the financial framework for 2021/22. NHS finances not yet clarified as part of Government spending review.	Plans may not focus on individual organisational sustainability and may seek to only deliver system wide control total Not able to plan effectively / understand the scale of the risk.	HASR Fragile and vulnerable services programme to deliver substantive change in pathways which deliver operational efficiency, improve quality and outcomes and support recruitment of staff 5 year plan, interim clinical plan and Trust recovery Plan Await further information and clarity on financial expectations for the NHS and the Trust, review in January 2021.	R A R	Trust Interim Clinical Plan Board HASR Programme Board Trust Management Board Trust Board Trust Interim Clinical Plan Board Trust Board, Finance & Performance Committee and TMB.
RAG RATING KEY:	G A R	Green: Fully assured that progress is being made in mitigating issues. impacting on strategic risk. Amber: Partially assured. progress is being made in mitigating the issues. Red: Not assured: limited signs of progress being made to mitigate issues leading to increased risk.					

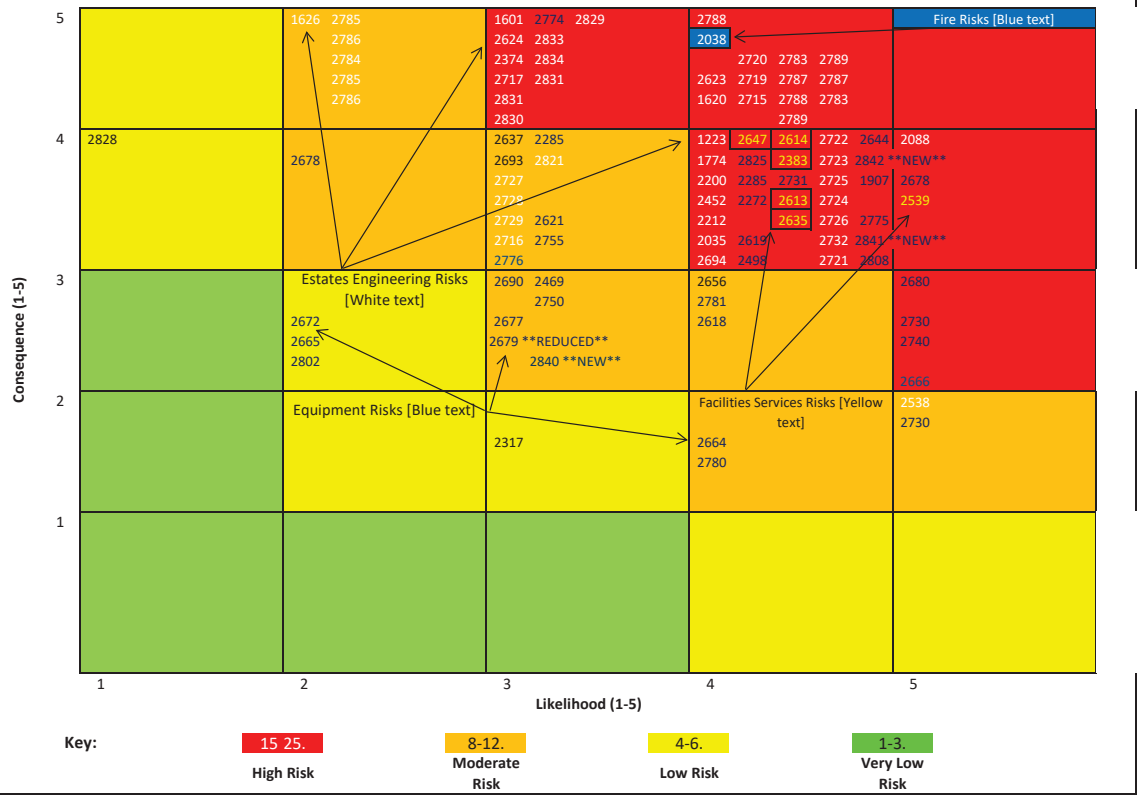
Strategic Objective:	**4. TO WORK MORE COLLABORATIVELY**
Risk to Strategic Objective:	7) Risk of failure of the Trust's infrastructure; specifically: (a) Ageing estate and equipment.
Risk Description:	The risk is the Trust will be unable to deliver care to patients and also lead to enforcement action by regulators.

Monthly Executive Highlight Report:

* BLM and capital schemes continue for 2020/21.
* BLM allocation for 20/21 is set at £1.828m. The current BLM requirement is £97.7m.
* The Trust have been awarded £3.496m Critical Infrastructure risk funding. The intention is to focus on Fire Alarms and Water Infrastructure upgrades.
* AE visits and annual AE audits are completed throughout the year on all specialist engineering services.
* AE visits during October were HV/LV.
* Internal audit programme embedded within E&F.
* Informal ward walks have been deferred and are due to recommence with nursing at the end of November 20.
* The following 20/21 PAM workshops scheduled for December are SS7 Transport/Car Parking, P4 Car Parking and Access.

Risk tracking trend over time: Severe (Major) consequence: 4 x 5: Certain RR of 20

Linked Corporate or High Level Risk Rating HEATMAP:



Monthly Executive Highlight Report: Plans for next month:

* BLM and capital schemes continue for 2020/21.
* BLM allocation for 20/21 is set at £1.828m. The current BLM requirement is £97.7m.
* AE audits continue throughout 2020/21.
* The following PAM workshops are scheduled to take place in January; SS8 Pest Control, SS4 Infection Control, SS5 Linen & Laundry, E4 SDMP, SH18 Safe and Suitable Non NLaG Premises, SH19 Contract Management, F1 Efficiency Performance Management and F2 Improvement Efficiency, F3 Refurb & Land Mgt and F4 Finance.

Underpinning Risks: Executive Summary (For full list of underpinning risks - see Section 3 Appendix)

* The heatmap demonstrates the current local risks that relate to or underpin the management of this strategic risk.

CHANGES SINCE LAST MONTH:

Estates Engineering risks:

* 2822: Oxygen Alarms not Functioning Correctly on Ward 25 (RR: 12; C4xL3) [Risk removed from RR, Jan 2021]
* 2813: Replacement of Forklift (RR: 15; C3xL5) [Risk removed from RR, Jan 2021]
* 2833: Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - DPoW (RR: 15; C5xL3)
* 2834: Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Goole (RR: 15; C5xL3)
* 2831: Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - SGH (RR: 15; C5xL3)

Equipment risks:

* **NEW** 2842: Fields Machine SGH/GDH [Ophthalmology] (Risk rating: 16; C4xL4)
* 2825: Canon CF1 Digital Retina Fundus Camera not functioning (RR: 16; C4xL4)
* **NEW** 2841: Nidek AR-310A Autofractor [Ophthalmology] (Risk rating: 16; C4xL4)

STRATEGIC OBJECTIVE:	4. TO WORK MORE COLLABORATIVELY						
Risk to Strategic Objective:	7) Risk of failure of the Trust's infrastructure; specifically: (a) Ageing estate and equipment.		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Jug Johal Estates & Facilities Governance Group Finance & Performance Committee		**Date added:** 01-May-19 **Last updated:** 17-Dec-20	
Consequences of Risk Materialising:	* Risk of harm to staff, patients and visitors; * Regulatory action and adverse effect on Trust's reputation.			**Assurance that the issues impacting on this risk are being managed:**			Trend RAG Rating: AMBER
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**		**Assurance / Oversight Group**
Asbestos	Remedial inspections carried out annually	External audit in June 18. Policy, procedures and staff training in place	No electronic asbestos register	No external AE services	Use electronic asbestos register	G	E&F Governance group
Electrical services - Low Voltage - Infrastructure is aging and in poor material condition	5 year fixed wiring and test in place. Annual service contract in place for generators. Thermal monitoring of switch gear.	Annual external AE audit. Policy, procedures and staff training in place	No funding to replace infrastructure	None	Secure funding to upgrade/replace infrastructure and equipment	R	E&F Governance group
Electrical services - High Voltage - Site capacity and ongoing investment	Monitoring of site usage. Monitoring of infrastructure and 5 yearly compliance maintenance completed. Estates included in capital equipment projects.	Annual external AE audit. Policy, procedures and staff training in place.	None	None	None	G	E&F Governance group
Fire Compliance - All infrastructure and equipment in poor material state, including fire ring main, alarm system, detectors, compartmentation	Limited capital investment in detector head replacement and clinical schemes	External audit conducted by HFRS covering all sites on a 5 year rolling programme. Policy, procedures and staff training in place	No funding to replace infrastructure	None	Secure funding to upgrade/replace infrastructure and equipment	R	E&F Governance group
Lifts - critical lifts failing	Maintenance contract in place. Reactionary adhoc repairs complete	Annual external AE audit. Policy, procedures and staff training in place. Insurance contract in place	No funding to replace infrastructure	None	Secure funding to upgrade/replace infrastructure and equipment	A	E&F Governance group
Medical Gas Piped Services - Infrastructure and equipment is aging and in poor material condition	Reactionary adhoc repairs complete	Annual external AE audit. Policy, procedures and staff training in place.	No funding to replace infrastructure	None	Secure funding to upgrade/replace infrastructure and equipment	R	E&F Governance group
Pressure Systems - infrastructure and equipment is in poor material condition	Reactionary adhoc repairs complete	Annual external AE audit. Policy, procedures and staff training in place. Insurance contract in place	No funding to replace infrastructure	AE only in place one year, policy and procedures need updating	Secure funding to upgrade/replace infrastructure and equipment. Update policy and procedures	G	E&F Governance group
Heating Ventilation and Air Conditioning systems - majority of infrastructure in poor material state	Maintenance contract in place. Reactionary adhoc repairs complete. Annual inspection and testing carried out on critical equipment including laminar flow	Annual external AE audit. Policy, procedures and staff training in place	No funding to replace infrastructure	None	Secure funding to upgrade/replace infrastructure and equipment	R	E&F Governance group
Water systems - Infrastructure and associated equipment is in poor material condition	Flushing routine of LUO with electronic monitoring. Random and planned water sampling. Use of Silver/copper ionisation systems. Adhoc remedial works as required	Annual external AE audit. Policy, procedures and staff training in place	No funding to replace infrastructure	None	Secure funding to upgrade/replace infrastructure and equipment	R	E&F Governance group
Building infrastructure - fabric of the buildings is deteriorating affecting other engineering services (electrical supplies) with roofs collapsing/failing to cause damage and water ingress	Adhoc repairs completed as required	Internal inspections completed	No funding to replace infrastructure or equipment.	None	Secure funding to upgrade infrastructure	R	E&F Governance group
Facilities infrastructure and equipment - ward kitchens domestic and fitted in 2010, they are in poor material condition and need replacement. Facilities equipment needs replacing, including tugs, dishwashers and ovens	Capital equipment group replaces the most do equipment items on an annual basis. Adhoc repairs and maintenance contracts on infrastructure and equipment	External inspections by EHO. Internal inspections by Facilities teams, IPC and environmental audits	No funding to replace infrastructure or equipment. No equipment replacement plan	None	Secure funding to upgrade/replace infrastructure and equipment. Create an equipment replacement plan	G	E&F Governance group
Ligature risks posed from the estate (EFA Safety Alert).	No estates controls in place	No estates assurance in place	None	None	Staff led individualised risk assessment of patient and environment risk, supported by Specialist Mental Health Practitioner. Work being undertaken to complete ligature free rooms in both ED departments, to revisit gap analysis and brief Q&S committee, Jan 2021.	R	E&F Governance group; Quality Governance Group

RAG RATING KEY:		
	G	Green: Fully assured that progress is being made in mitigating issues, impacting on strategic risk.
	A	Amber: Partially assured, progress is being made in mitigating the issues.
	R	Red: Not assured; limited signs of progress being made to mitigate issues leading to increased risk.

Strategic Objective:	**4. TO WORK MORE COLLABORATIVELY**
Risk to Strategic Objective:	7) Risk of failure of the Trust's infrastructure; specifically: (b) Longer term estates sustainability.
Risk Description:	The risk is that insufficient backlog maintenance funding will impact on the delivery of care to patients and also lead to enforcement.

Monthly Executive Highlight Report:

* Numerous capital bids have been submitted to address the Trust's ageing infrastructure, including IPC, winter planning, CIR/Critical Care and AAU/ED.
* The Trust has been awarded £3.496m critical infrastructure risk funding. This will be used to commence Fire Alarm system replacement and water infrastructure upgrades at DPoW.
* £1.4m Critical Care funding has been approved for HDU improvements (£1.2m SGH & £0.2m DPoW).
* 6 Facet survey reports have been reviewed, the figure for the Trust is £97.7m.
* GDH boiler house replacement scheme underway. 50% funding from BEIS project. Due to complete May 21.
* AE visits and annual AE audits are completed throughout the year on all specialist engineering services.
* Internal audit programme embedded within E&F.
* The Trust are out to tender for the Trust wide Energy Performance Contract for the Investment Grade Audit (IGA), with a deadline date of 26.11.20. Evaluation panel 08 December 20. Trust Management Board 04 January 21. Award IGA January 21.
* Green Plan (SDMP) presented at E&F Governance 22.10.20, Trust Management Board, 07.12.20 and Trust Board 04.02.21.
* Trust Estates Strategy is currently under review. Due to be approved by the end of the year.
* Refurbishment/replacement of Xray Facility at GDH Room 1 is underway.

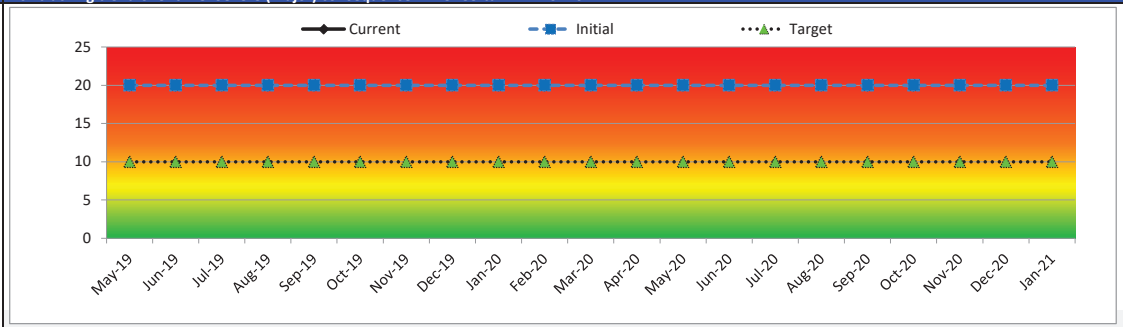
Monthly Executive Highlight Report: Plans for next month:

* During January an internal audit of SS4 Cleanliness - Domestic Services is scheduled to take place.
* Trust Estates Strategy under review. Due to be approved by the end of the year.

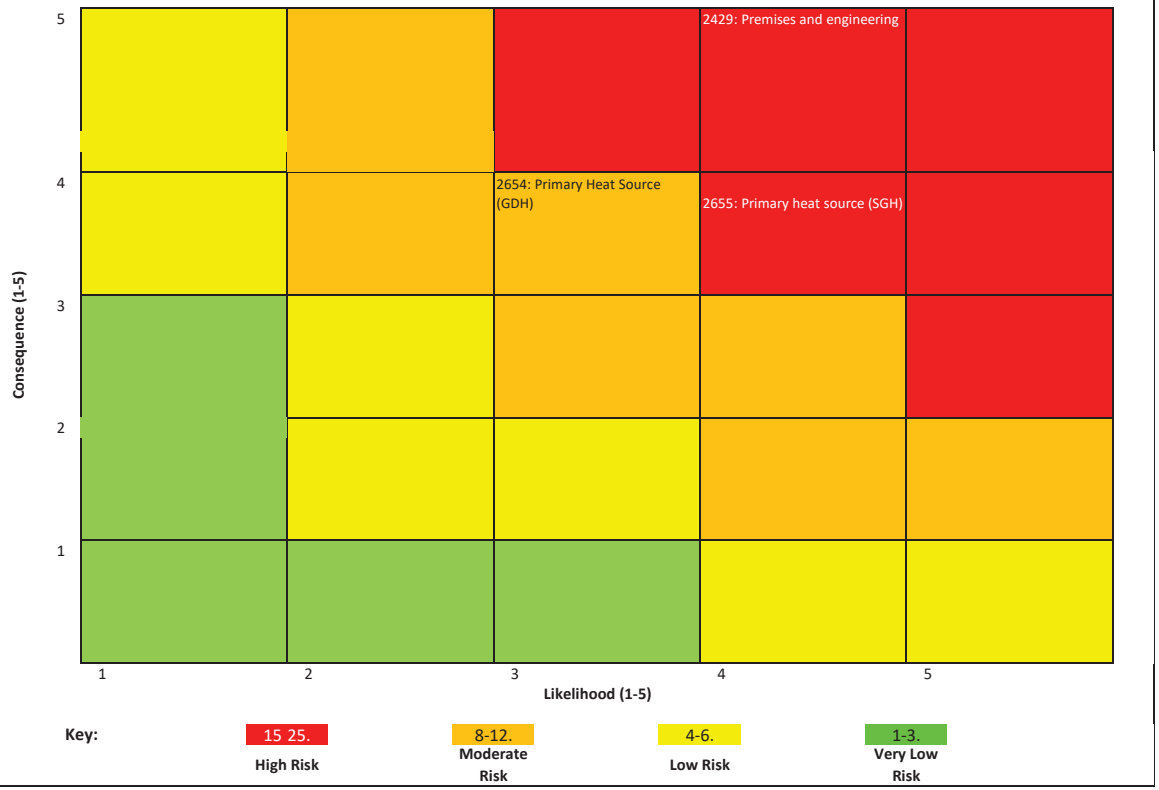
Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

* There are no significant changes requiring in month that relate to the underpinning directorate risks. For a full list refer to appendix; section 3.

Risk tracking trend over time: Severe (Major) consequence: 4 x 5: Certain RR of 20



Linked Corporate or High Level Risk Rating HEATMAP:



STRATEGIC OBJECTIVE:	4. TO WORK MORE COLLABORATIVELY						
Risk to Strategic Objective:	7) Risk of failure of the Trust's infrastructure; specifically: (b) Longer term estates sustainability.		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Jug Johal Estates & Facilities Governance Group Finance & Performance Committee		**Date added:** 01-May-19 **Last updated:** 17-Dec-20	
Consequences of Risk Materialising:	* Risk of harm to staff, patients and visitors; * Regulatory action and adverse effect on Trust's reputation; * Lack of longer term sustainability.			**Assurance that the issues impacting on this risk are being managed:**			Trend RAG Rating: AMBER
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**		**Assurance / Oversight Group**
Sustainability of current estate	External AE audits. HFRS inspections. Policy and procedures. Staff training. Action plan monitoring. Insurance and external verification testing.	Model Hospital benchmark. ERIC. PAM	Capital funding to reduce/eliminate risk	None	To secure capital funds to reduce/eliminate risk	G	E&F Governance Group
Level of BLM allocation 20/21: £1.828m	6 Facet survey, AE audits, Insurance and external verification testing	Model Hospital benchmark. ERIC. PAM	Capital funding to reduce/eliminate risk	None	To secure capital funds to reduce/eliminate risk	R	E&F Governance Group
Energy Centre at SGH - 25 year ESCO contract expired 2 years ago with ENGIE. Primary heat source for the hospital, failure would result in loss of heating and hot water on entire site	ENGIE complete adhoc repairs, funded via the Trust. Annual maintenance and insurance inspections.	Monitoring by ENGIE	No engineering solution to replace steam boilers. No funding source identified	None	Awaiting feasibility study from HUTH sustainability team. Complete detailed design on preferred replacement engineering solution and identify funding source. Business case to be produced to provide options on procurement route and funding.	A	E&F Governance Group
Energy Centre at Goole - Coal fired boilers providing primary heat source on hospital site, failure would result in possible loss of heat source dependent on external temperatures, one gas fired boiler on site.	Extensive maintenance program and adhoc repairs	Monitoring by NLaG in-house engineering team	No engineering solution to replace steam boilers. No funding source identified	None	Awaiting feasibility study from HUTH sustainability team. Complete detailed design on preferred replacement engineering solution and identify funding source. Working with Dept of Business, Energy and Industrial Strategy and Managing Energy Partners to produce a business case that provides options on procurement route and funding.	R	E&F Governance Group

RAG RATING KEY:		
	G	Green: Fully assured that progress is being made in mitigating issues, impacting on strategic risk.
	A	Amber: Partially assured, progress is being made in mitigating the issues.
	R	Red: Not assured; limited signs of progress being made to mitigate issues leading to increased risk.

Strategic Objective:	**4. TO WORK MORE COLLABORATIVELY**
Risk to Strategic Objective:	7) Risk of failure of the Trust's infrastructure; specifically: (c) IT / Digital Strategy / Cyber Security.
Risk Description:	The risk of failure in the Trust's infrastructure would impact on the organisation's ability to undertake its business as usual resulting from a loss of access to digital information and also the risk to data security.

Monthly Executive Highlight Report:

* The Trust submitted the 19/20 Data Security Protection Toolkit return on the 30th September 2020. Due to the impact of COVID-19 a number of actions were put on hold. An improvement plan has been developed and agreed by both the Trust's Senior Information Risk Owner and NHS Digital. Until all actions are completed the Trust's toolkit compliance status is one of '19/20 Standards Not Fully Met (Plan Agreed)'.
* 20/21 Data Security Protection Toolkit was due to be launched mid-October 2020, with a submission date of the end of March 2021. However the toolkit will now be launched mid November 2020, with an extended submission date of 30 June 2021.
* Completed Digital Strategy due for presentation at Digital Services Governance Group in November 20, Digital Strategy Board December 20 and to Trust Board in January 21.
* The IT data Security Manager has commenced in post.
* IT Service Management System - Currently working with procurement to consider inclusion in Digital Aspirant Funding.
* Serious incident investigations are ongoing into the inappropriate access of digital records by staff. HR investigation now complete, however HR appeals process remains ongoing.
* Risk 2495 - WebV Server Warranty Renewal: Awaiting servers being configured for our use.

* Trust committed to HIMSS Maturity Assessment of digital infrastructure which will be undertaken over the next couple of months.
* The Trust have commissioned a consultancy company to scope a rollout plan for Microsoft N365 and remove unsupported Microsoft Office 2010 from computers.

Monthly Executive Highlight Report: Plans for next month:

* Ongoing capital planning and prioritisation is occurring through the Digital Strategy Board and Capital Investment Board.
* Meetings ongoing between NLAG and HUTH to agree prioritisation over Digital Aspirant Funding.

* SGH next generation firewalls installed. DPoW to be scheduled for January 2021 (HSCN connections).

* Working with Ops around current processes linked to short notice ward reconfiguration and the impact on IT devices and infrastructure.

Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

* The heatmap demonstrates the current local risks that relate to or underpin the management of this strategic risk.

CHANGES SINCE LAST MONTH:

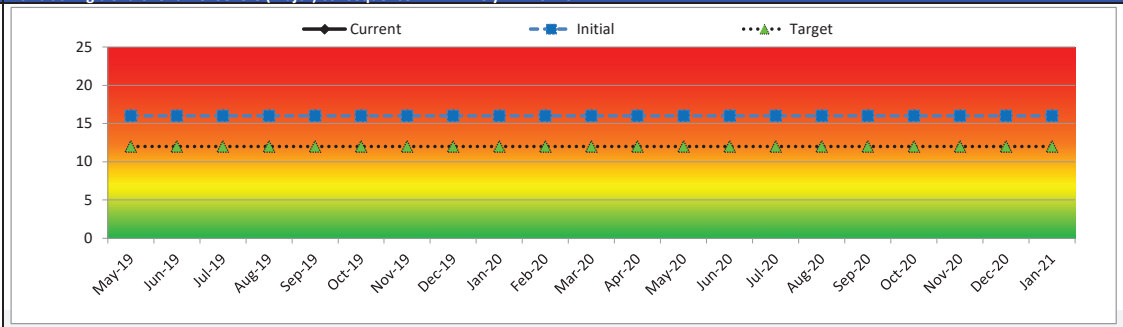
Cyber Security:

* 2461: Need for qualified IT Security Officer for Data Security Toolkit (RR: 20; C4xL5) [Risk removed from RR, Jan 2021]
* 2753: Viewpoint fetal database need to upgrade system to be compatible with other systems in the Trust for sharing of patient data infl (RR: 16; C4xL4) [Risk Rating INCREASED from 9 to 16, Jan 2021]

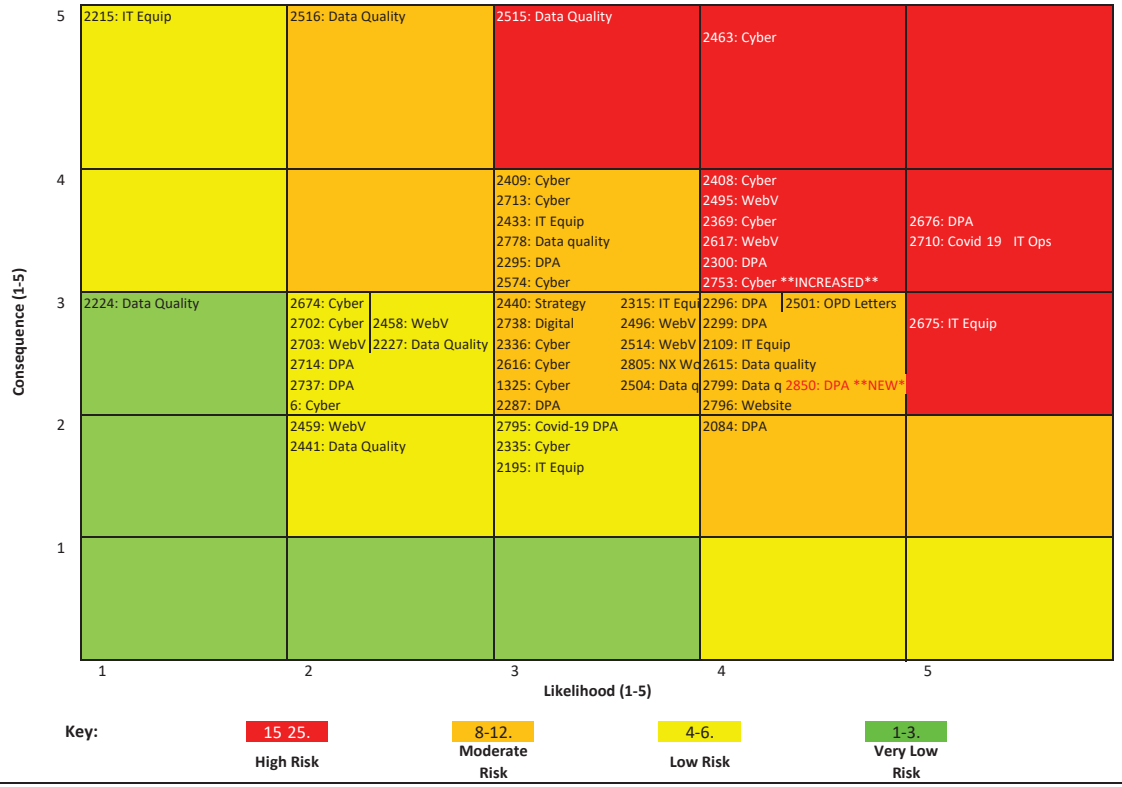
Risks of non-compliance with the Data Protection Act:

* 2300: Insufficient processes in place to ensure records management /quality against national guidance (risk rating: 16; C4xL4) [Risk rating INCREASED from 8 to 16, Nov 20]
* **NEW** 2850: Information Governance Risk from Quality Assurance Team Working Remotely (Risk rating: 9; C3xL3)
* 2803: Swabbing - Risk of Data Breach (RR: 8; C4xL2) [Risk removed from RR, Jan 2021]

Risk tracking trend over time: Severe (Major) consequence: 4 x 4: Likely RR of 16



Linked Corporate or High Level Risk Rating HEATMAP:



STRATEGIC OBJECTIVE:	4 TO WORK MORE COLLABORAT VELY						
Risk to Strategic Objective:	7) Risk of failure of the Trust's infrastructure; specifically: (c) IT / Digital Strategy / Cyber Security.		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Shauna McMahon WebV, IT & Information Governance Group Finance & Performance Committee		**Date added:** 01-May-19 **Last updated:** 17-Dec-20	
Consequences of Risk Materialising:	Data security breaches, regulatory action and a loss of public confidence in the Trust damaging its reputation; Not meet national digital strategy timescales, risk of running dual paper and electronic systems and risks to patient safety and the Trust's sustainability.		**Assurance that the ssues mpact ng on th s r sk are be ng managed:**				Trend RAG Rating: AMBER
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**		**Assurance / Oversight Group**
Lack of adequate controls to defend against a cyber attack; risk of a cyber attack as a result of increased prevalence world-wide	Board approval of cyber security procurement. Anti-virus, malware scanners, firewalls etc. in place. Security Operations Centre (SOC) Service 24/7 Remote Monitoring. Cyber security incident management contract. CareTower; Business continuity plans in place. Annual Penetration Testing. Patching policy approved and now in place. Vulnerability Posture Assessments completed monthly by NHS Digital.	Security Operations Centre (SOC) Service 24/7 Remote monitoring. Qualified IT Data Security Manager in post.		Refreshed posture assessment needed	Undertake refreshed posture assessment once implementation of cyber procurement completed, 2020/21.	G	IG Steering Group; Digital Services Governance Group; Digital Strategy Board
			Implementation of board approved cyber security procurement (ongoing).		Complete procurement of cyber security arrangements and implement, 2020/21.		
Risk on non-compliance with the Data Protection Act 2018	Data Security & Protection toolkit submissions; Substantive Data Protection Officer in post; IG Steering group oversees DSP toolkit improvement plan; Web V, IT & Information Governance Group. IG Administrator now in post creating additional capacity into the IG team.	NHSD approved Trust DSP improvement plan; Audit Yorkshire Internal Audit of DSP: Significant assurance; DSP Toolkit submitted 30 September 2020. **EXTERNAL ASSURANCE:** (Ext) **Limited Assurance:** Audit Yorkshire internal audit: Data Security and Protection Toolkit: Limited Assurance, Q3 2019. **EXTERNAL ASSURANCE:** (Ext) **Significant Assurance:** Audit Yorkshire internal audit: GDPR Compliance (cfwd 18/19): Significant Assurance, Q1 2019.	Staff training not meeting national target (95%).	Improvement actions from DSP Toolkit currently being worked through.	Continue to focus on mandatory training compliance, ongoing.	A	IG Steering Group; Digital Services Governance Group; Digital Strategy Board
			New DSP toolkit mapping of leads delivering and resource required into work programme.		Map new DSP requirements to work programme.		
Shortage of IT equipment to support the Trust achieve its objectives	Rationalising current available IT equipment to ensure shared out Capital. Capital monies available. COVID specific budget funding available.	Tech shop process support ordering and approval by lead directors	Inadequate resource available resulting in a shortfall of equipment;		Digital Delivery Plan vs. risks overseen by Digital Strategy Board with links to the forward capital plan and business planning arrangements, ongoing. Digital Aspirant bids to be submitted.	A	IG Steering Group; Digital Services Governance Group; Digital Strategy Board
A lack of strategic direction and engagement in digital projects resulting in a failure to deliver improved and innovative systems of care that could lead to patient safety and financial risks	3 task and finish groups in operation; Digital Strategy Board (DSB) in place; DSB approves requests for digital changes; CIO/CNIO/CCIO post to direct and drive engagement at executive level. CIO appointed. NLAG / NHSI and NHSD review complete.	CIO on Board monitoring engagement and strategy direction. CCIO and CNIO attending senior clinical groups driving engagement	No task and finish groups yet established for key areas where input/engagement is needed i.e. Medicine;		Engagement exercise underway with divisional triumvirates to focus on this area.	R	Digital Strategy Board
			DSB inconsistent attendance/divisional representation which delays decision making;				
			Lack of clarity around the digital strategy and plan.		NHSI support review of efficiency and CIP and review of the plan for the Digital Strategy Board/associated task and finish groups, ongoing.	A	
			Official CCIO/CNIO not in place.		Digital Strategy drafted and awaiting Board approval. CCIO/CNIO to be recruited.	A	
Trust's PAS system and data quality issues adversely impacting on business decision making.		Limited assurance reporting is available for some data sources. **EXTERNAL ASSURANCE:** (Ext) **Significant Assurance:** Audit Yorkshire internal audit: Clinical Coding / Activity Recording: Significant Assurance, Q2 2019.	Independent validation of data is not in place; Lack of integration on some systems effects data quality from being improved by single input source which prevents duplication; True enterprise data management not available.		Undertaking data assurance validation with 3rd party provider.	A	Finance & Performance Committee
					Procurement of data warehouse tools or solutions will be linked into outcomes from a BI review. Completion date; Nov 20.	A	
					2021 accounts for PAS review/procuring new PAS Jan 21-Dec 21.	A	
RAG RATING KEY:	G	Green: Fully assured that progress is being made in mitigating issues, impacting on strategic risk.					
	A	Amber: Partially assured, progress is being made in mitigating the issues.					
	R	Red: Not assured; limited signs of progress being made to mitigate issues leading to increased risk.					

Strategic Objective:	**4. TO WORK MORE COLLABORATIVELY**
Risk to Strategic Objective:	8) Inability to pursue a clear organisational strategy that staff and stakeholders are aware of and support
Risk Description:	The risk of not having a strategy which reflects the requirements to deliver improved outcomes at an ICS, Humber and Trust/local level will mean that we cannot influence the ICS strategy and that our operating models may not deliver organisational and financial sustainability and improved patient outcomes. Our strategy underpinned by an agreed Trust Clinical Strategy / Plan will enable us to prioritise our workforce, training and development, research and innovation and finance and capital investment plans. Ensuring that we are accountable for delivery of our planned outcomes.

Monthly Executive Highlight Report:

* Trust is an active participant in ICS, Humber Acute Services and Acute Collaborative Planning.
* Trust has an agreed capital investment plan which has delivered significant in year capital funding to support changes in emergency care and diagnostics.
* Trust is engaged with local authority and academic partners in developing capital bids for SGH and DPoW.

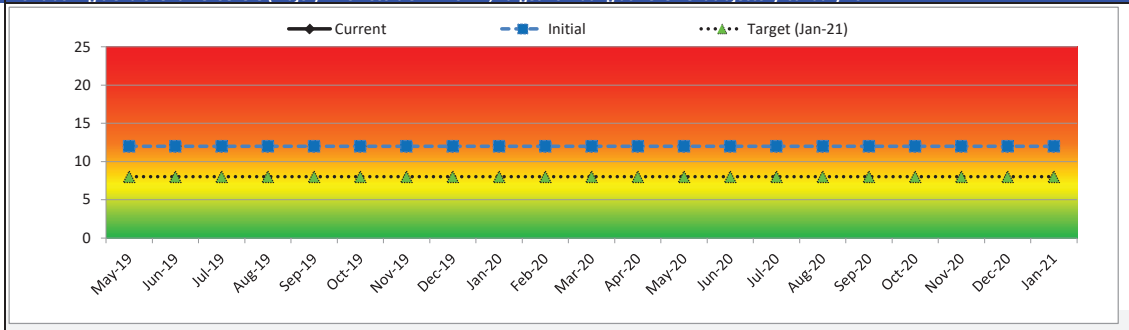
Monthly Executive Highlight Report: Plans for next month:

* Trust is engaged with HASR programme on implementing revised governance structures for delivery of interim clinical plan (ICP).
* More detailed review of strategic capital risk relative to NHSE/DHSC feedback on funding sources.
* Map Trust clinical strategy to emerging system strategies/plans.

Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

* See appendix for a full list of underpinning divisional risks already on the risk register. These are summarised within the Heatmap referenced to the risk register ID number.

Risk tracking trend over time: Severe (Major) 4 x 3 Possible RR of 12; Target risk rating achievement trajectory: January 2021.



Linked Corporate or High Level Risk Rating HEATMAP:

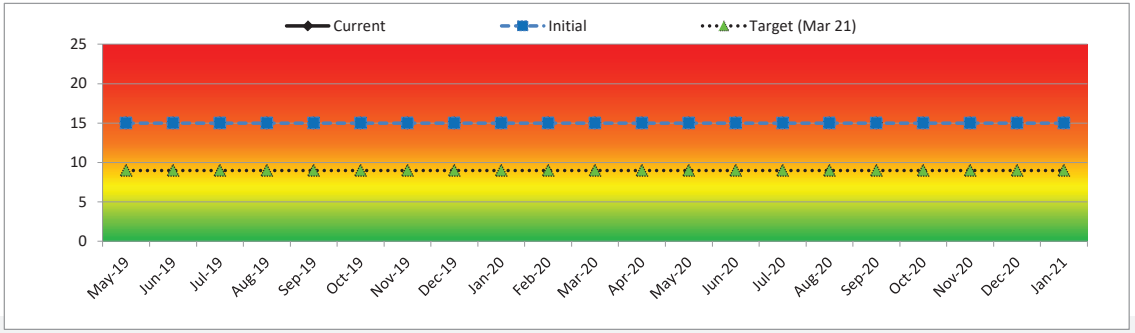
STRATEGIC OBJECTIVE:	4. TO WORK MORE COLLABORATIVELY						
Risk to Strategic Objective:	8) Inability to pursue a clear organisational strategy that staff and stakeholders are aware of an support		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Peter Reading & Ivan McConnell Trust Board; TMB; Finance and Performance Trust Board - reporting on a 6-monthly basis		**Date added:** 01-May-19 **Last updated:** 08-Jan-21	
Consequences of Risk Materialising:	* Failure to develop aligned system wide strategies and plans which support long term sustainability and improved patient outcomes * Lack of evidence based decision making; * Prevents changes being made which are aligned to organisational and system priorities; * Undermines the confidence and morale of staff; * Reduced ability to attract staff * Poor relationships with stakeholders * inability to implement change to deliver agreed strategic priorities.			**Assurance that the issues impacting on this risk are being managed:**			Trend RAG Rating: AMBER
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**		**Assurance / Oversight Group**
Evolving ICS Governance and Assurance coupled with the need to have an agreed Humber wide Recovery Plan set within the constraints of Covid 19.	NHS Long Term Plan; ICS Long Term Plan; ICS Leadership Group; Humber Acute Services Executive Oversight Group; Humber - Elective/Non Elective and Out of Hospital Strategic Group (Recovery); Wave 4 ICS Capital Committee; NLAG Recovery Board.	*Assurance data:* (1) **Positive:** Local agreement of Phase 3 plan completed. Forwarded to ICS. *Assurance sources:* *ICS Governance;* *Humber Sub System Governance;* *NLAG Recovery Board Reporting;* *Capital Investment Board (CIB).*	Time available for engagement of executives, clinical/non-clinical leaders and teams in capital and service developments (i.e. AAU). Wider system engagement in Clinical Strategy development during Covid 19. Attendance at Programme Boards and Clinical Sign Off of Proposed Plans and Implementation Plans, engagement and decision making at Divisional level.		Remote sign off - if not available, ongoing. Identification and approval for appropriate management time within existing consultant management Pas (Clinical Leads) to review, approach to be agreed with COO/DCDs, review in December 2020.	A	Trust Board; Trust Management Board; Finance and Performance Committee
Ensuring effective Executive and Non Executive engagement within ICS, Humber sub system and LRFs within NE and N Lincolnshire	Executive, NED and Board time to build relationships to encourage NHS Improvement / NHS England to foster alignment between the Trust and its system partners.	*Assurance data:* (1) **Positive:** Effective internal engagement obtained in the consultation and agreement of Phase 3 plan. *Assurance sources:* *Attendance at ICS and Humber Executive Boards.*	NED engagement in planning Local Authority, primary care and community service engagement/feedback Attendance at System Programme Boards.		Agreed ICS and Humber work plan with NED/Local Authority involvement Agreed Capital Investment Strategy to deliver system wide and Trust priorities with NED/Local Authority involvement	A	Trust Board; Trust Management Board; Finance and Performance Committee
Inability to agree assumptions at an ICS and Humber level which allow the development of the Trusts underpinning Strategies	Agreed System and Trust work plan to develop required Strategies and Plans Agreed system wide planning and recovery assumptions Agreed funding and contracting frameworks Executive, NED and Board time to build relationships to encourage NHS Improvement / NHS England to foster alignment between the Trust and its system partners.	*Assurance data:* (1) **Positive:** Significant work undertaken with ICS and Humber to inform integrated planning and governance structures, available. *Assurance sources:* *Programme plan agreed and resourced to deliver each underpinning strategy and plan with regular reviews by Programme Boards.*	Lack of ICS and Humber work plan and agreed dependency map for workforce, ICT, finance and estates.	<u>Gap in assurance 1:</u> Lack of integrated plan and governance structure.	Project and Programme Plans to be developed, with formal sign off required for each.	A	Trust Board
RAG RATING KEY:	G	Green: Fully assured that progress is being made in mitigating issues, impacting on strategic risk.					
	A	Amber: Partially assured, progress is being made in mitigating the issues.					
	R	Red: Not assured; limited signs of progress being made to mitigate issues leading to increased risk.					

Strategic Objective:	**4. TO WORK MORE COLLABORATIVELY**
Risk to Strategic Objective:	9) Lack of an integrated ICS, Humber and Trust clinical strategy which delivers long term system, service and organisational sustainability including the ability to attract inward investment
Risk Description:	The risk of not having an integrated clinical strategy for the ICS, Humber, Trust/Local level will limit the Trusts ability to deliver its strategic, workforce, finance and investment strategies impacting on the delivery of improved clinical outcomes

Monthly Executive Highlight Report:

* HAS Interim Clinical Plan approved at TMB 14/7/20 and Finance and Performance Committee on the 29/7/20. Non-Executive Director Briefing held on the 5 August 2020.
* Major capital investment programme initiated within ICS re HIP3 submission of EOI and also STP Wave 4 by Dec 2020 - reviewing alternative funding models. Programme Board has been established.
* NLaG Draft Clinical Strategy 2020-24 engagement commenced. Draft version tabled at Trust Management Board. ICP was approved at on 14/7/20.
* Submission of phase 3 planning.
* HASR Programme 2 re-launched for Urgent & Emergency Care (U&EC) and Maternity/Paediatrics (M&P). SRO's and Transformation Leads in place. Clinically led workshops completed for both U&EC and M&P to assess options to be modelled. Workshops held in September to inform the next stages of modelling the options leading to Pre-consultation business case due by March 2021. High level output is required to inform the Strategic Outline Case for major capital investment due in December 2020.
* HASR Programme 1 (Interim Clinical Plan), Programme 2 (Longer term proposals), Programme 3 (major capital) briefings provided at TMB 21/9/20 and Council of Governors 15/10/20.
* Divisional strategies reviewed and referenced into the Draft Clinical Strategy ensuring these are appropriate post Covid-19.
* Engagement with HAS during Covid19. Core team of SROs and CCG leads developed work plan. Capital programme for 2020 has been approved.
* HASR Governance and timescales approved through Executive Oversight. U&EC and M&P data cycles 1 and 2 complete and presented to Clinical Design Group.

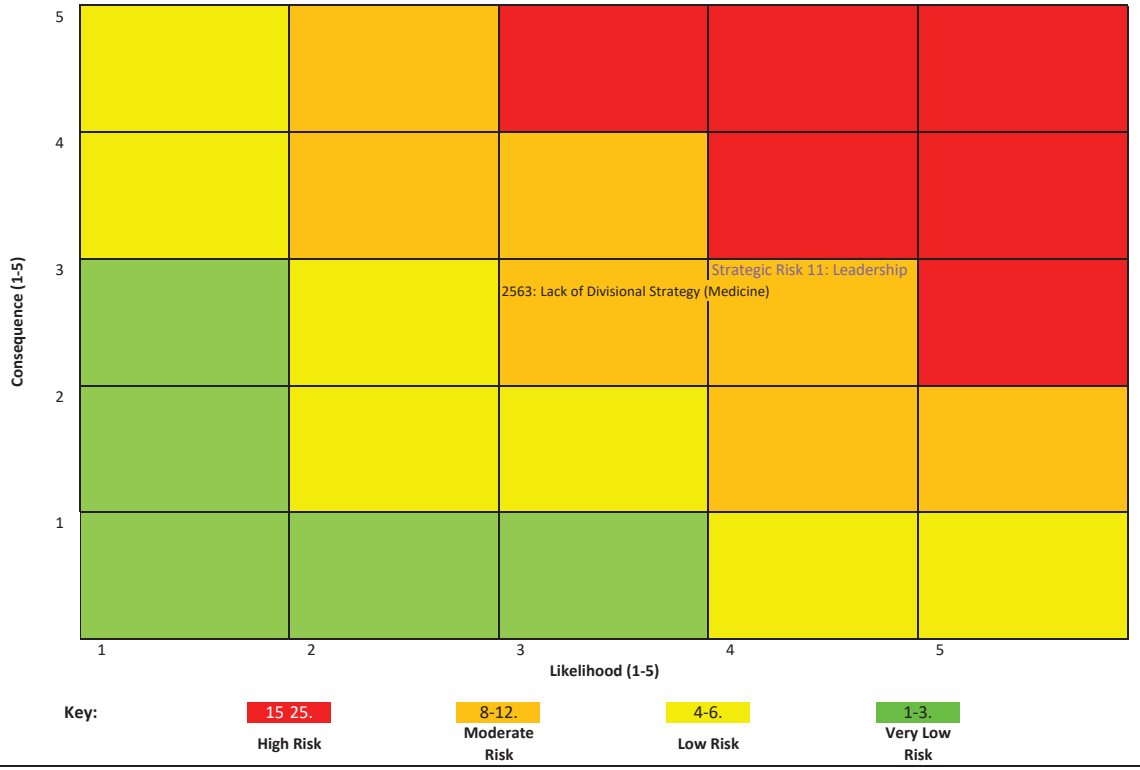
Risk tracking trend over time: Catastrophic 5 x 3 Possible RR of 15; Target risk rating achievement trajectory: March 2021.



Monthly Executive Highlight Report: Plans for next month:

* Post Covid recovery planning continues to be undertaken in line with National Guidance.
* Identification of potential investment requirements during initial development of interim Clinical Plan - commenced with clinical teams and options for improvement.
* To ensure that Phase 3 recovery plan aligns to Strategic initiatives and drives work on long term plan e.g. diagnostics.
* NLAG Clinical Strategy continues to be developed in partnership with Executives, Divisional Teams and Corporate.
* HASR U&EC and M&P cycle 1 evaluation of options – further workshops scheduled January 21.
* Communication and engagement trust wide and external stakeholders for draft Clinical Strategy and progress on the HASR.
* Final Clinical Strategy 2020-24 is due for Trust Board approval on 2 February 21 – engagement and briefings will continue throughout January including wider stakeholders and HealthWatch.

Linked Corporate or High Level Risk Rating HEATMAP:



Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

* See appendix for a full list of underpinning divisional risks already on the risk register. These are summarised within the Heatmap referenced to the risk register ID number.

Changes in month:

* 2563: Lack of divisional strategy [Medicine] (RR: 9; C3xL3) [Risk removed from RR, Jan 2021]

STRATEGIC OBJECTIVE:	4. TO WORK MORE COLLABORATIVELY						
Risk to Strategic Objective:	9) Lack of an integrated ICS, Humber and Trust clinical strategy which delivers long term system, service and organisationally sustainability including the ability to attract inward investment		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Ivan McConnell Trust Board; TMB; Finance and Performance Trust Board - reporting on a 6-monthly basis		**Date added:** 01-May-19 **Last updated:** 08-Jan-21	
Consequences of Risk Materialising:	* Ineffective decision making; * Prevents changes being made aligned to organisational priorities; * Undermines the confidence and morale of staff; * Poor relationship with key stakeholders;	* Reduced ability to attract staff; * Failure to address issues highlighted in Fragile Services may result in poor performance and patient outcomes.	**Assurance that the issues impacting on this risk are being managed:**				Trend RAG Rating: AMBER
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**		**Assurance / Oversight Group**
Trust Clinical Strategy 2020-24 does not align to future ICS, Humber and local priorities for delivery	Agreed ICS, Humber and Trust priorities and planning assumptions; Agreed Trust work plan which identifies key dependencies and risks at ICS, and Humber level.	*Assurance data:* (1) **Positive:** The Clinical Strategy is drafted and going through the engagement process. Discussed at August TMB and September Trust Board and presented to NEDS meeting in October. Further internal and external engagement to take place with staff, commissioners and NEDs and Governors. *Assurance sources:* *Humber Programme*	Availability of clinical staff to design and develop plans.		Remote approvals of proposals when required	A	Trust Board; Trust Management Board; Finance and Performance Committee
			CCGs, Local Authority and wider Trust finance, contracting, performance, informatics engagement		CCG and Regulatory engagement during engagement/briefing process (Oct/Nov) 20)		
			Non attendance at Boards				
				Gap in assurance 1: Internal sign off not yet completed.	Final approval due at February 2021 Trust Board.		
Risk of fragile services deteriorating further	Progress with the interim clinical plan with Humber. Business as Usual operational management with appropriate escalation processes in place.	*Assurance data:* (1) **Positive:** HAS Interim Clinical plan agreed and supported. *Assurance sources:* *HAS Executive Oversight Group;* *Performance monitored through PRIMS with appropriate escalation.*	Governance of clinical engagement and sign off for proposed plans	Attendance at Project Boards, delivery groups and continuity of clinical staff engagement.	Ensure support service engagement in options development and planning, March 2021.	A	Trust Management Board
				Finance, estates, capital, workforce and ICT engagement	Identification of appropriate deputies from clinical and non teams, March 2021.		
Governance arrangements for HCV programme 1 - 3	New Director Humber Acute Services in post, with senior role within NLAG; also qualified as a portfolio manager; Executive Oversight Group already established; Accountable officer for the Humber; Programme SROs in place; Risk registers in place for individual projects underway;	*Assurance data:* None. *Assurance sources:* Assurance Process agree and in place: 3 weekly meetings in place with NHSE/I and assurance checkpoints formerly included in the revised Governance structure and programmed into the timelines.	Governance arrangements require review	Risks from 3 programmes could be more clearly defined and captured within HCV programme or via individual organisational risk registers. There is a plan in place to close this gap.	Recommendations to Executive Oversight Group on 9 December, on revised Governance Framework for 3 programmes.	A	Trust Board
					Agreement reached, to formally describe linkages: Strengthened project risk registers will capture key risks and prevent duplication on local risk registers (NB: May be some overlap on key risks at specialty level).	A	
					Strengthened Project Management Team (PMO) to be established to support capture of project details including risks, December 2020.	A	
			Clinical Leadership of programme 1 could be strengthened.	To define hosting of clinical services to support planning.	Strengthened Clinical Leadership to be approved and established, Executive Oversight Group, 9 December 2020.	A	
				Programme 2 extends to February 2021	Establish plans for a two year work programme to cover up to March 2022, agree in December 2020.	A	
Programme 3: Risk: No strategic capital investment identified	Options appraisal underway regarding capital funding for both North Lincolnshire and North East Lincolnshire.	*Assurance data:* None.	Approach to options appraisal needs approval	Define the process across multiple organisations to consider options available around capital funding.	Approval from Executive Oversight Group from HCV (reporting to Partnership Board) to investigate options and commit to develop formal options framework (all options link to strategic outline case). Start work in December, work up by March 2021.	A	Trust Board

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	R	Red: Not assured; limited signs of progress being made to mitigate issues leading to increased risk.

Strategic Objective: **4. TO WORK MORE COLLABORATIVELY**

Risk to Strategic Objective: 10) The risk of ineffective relationships with stakeholders

Risk Description: As a public sector organisation, the Trust is accountable as an organisation to many different stakeholders, including the public. It is critical therefore to develop and maintain effective relationships with stakeholders. Failure to do so effectively results in the risk to the Trust's reputation and risks achievement of strategic objectives.

Monthly Executive Highlight Report:

* Continued weekly briefings provided to local MPs regarding the Trust's handling of Coronavirus pandemic.
* Senior Executives continue to engage with colleagues in external organisations at PLACE and ICS level.
* Trust's Director of Strategic Development heavily involved in HASR; Chief Operating Officer meets regularly with senior colleagues.

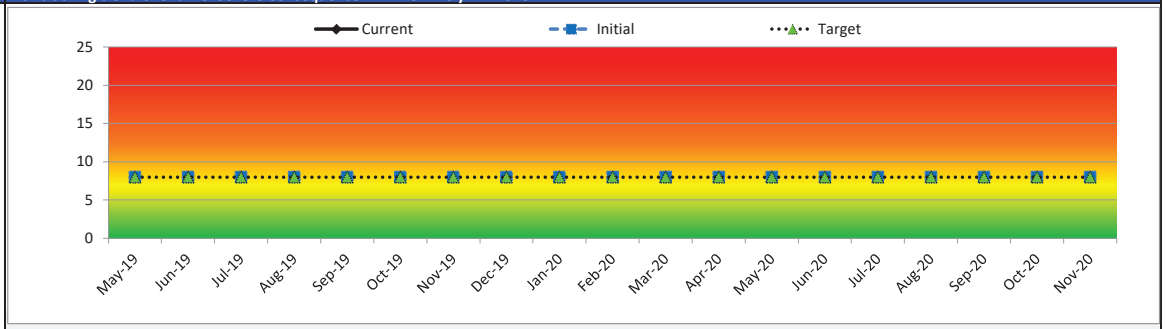
Monthly Executive Highlight Report: Plans for next month:

* Continue ongoing engagement activities with stakeholders.

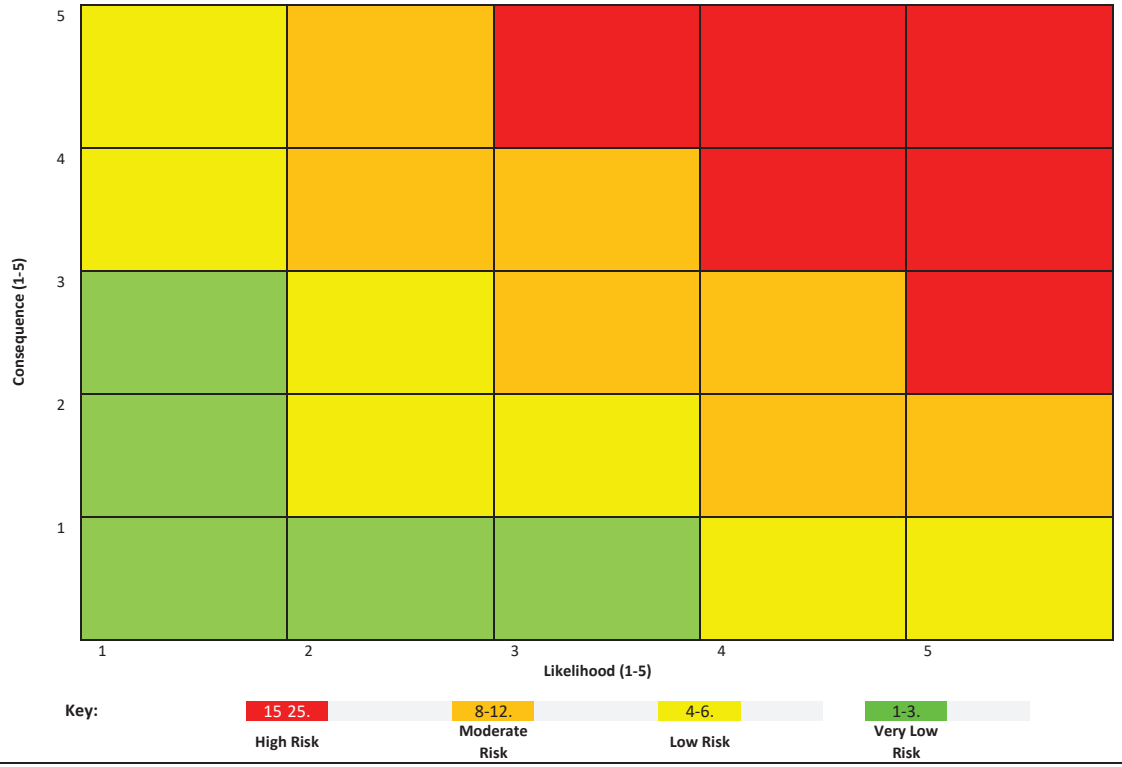
Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

* There are no linked corporate or high level risks that underpin this strategic risk.

Risk tracking trend over time: Severe Consequence: 4 x 2: Unlikely RR of 8



Linked Corporate or High Level Risk Rating HEATMAP:



STRATEGIC OBJECTIVE:	4. TO WORK MORE COLLABORATIVELY					
Risk to Strategic Objective:	10) The risk of ineffective relationships with stakeholders		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Peter Reading Trust Board Trust Board	**Date added:** 01-May-19 **Last updated:** 11-Dec-20	
Consequences of Risk Materialising:	* 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.			**Assurance that the issues impacting on this risk are being managed:**		Trend RAG Rating: GREEN
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**	**Assurance / Oversight Group**
There is a large number of stakeholders that NHS/Public organisations need to effectively work alongside and that hold to account the organisation.	There are currently no formal controls, however the CEO, Executive and Non-Executive Directors are working effectively to manage and build relationships with stakeholders, as a result the risk rating is low/meeting target set. Stakeholder map developed and considered by Trust Board.	*Assurance data:* *None.* *Assurance sources:* *Commentaries received from stakeholders provides the Trust with assurance that effective relationships with stakeholders have been established.*	6 Areas identified from stakeholder mapping where additional focus is required.		Board review of stakeholder map and agreement of 6 areas where additional focus is required, Trust Board/CEO, held in January 2020; further discussion planned with Trust Board, January 2021 (deferred as a result of the Trust's incident response to wave 2).	G Trust Board
Area of additional focus 1: New MPs - following the General Election;	New arrangements and relationships developed.	*Assurance data:* *None.* *Assurance sources:* *Positive relationships and feedback from Covid-19 collaborative relationship/working;* *Proactive engagement work with MPs following General Election, developing well.*				
Area of additional focus 2: Local CCGs;	Close working relationships between Executive teams.	*Assurance data:* *None.* *Assurance sources:* *Continued evidence of effective relationships;* *Very productive discussions with CCG leaders regarding relationships with primary care and clinical pathways.*				
Area of additional focus 3: National leaders in the NHS (NHSE/I and ministerial);		*Assurance data:* *None.* *Assurance sources:* *CEO meeting with CEO (Amanda Pritchard) of NHS Improvement;* *Chair meeting with Chief Inspector of Hospitals.*				
Area of additional focus 4: GPs and PCNs;		*Assurance data:* *None.* *Assurance sources:* *Agreement with Meridian PCN regarding collaborative arrangements.* *Assurance of relationship with GPs and PCNs.*				
Area of additional focus 5: Patient and voluntary groups;						
Area of additional focus 6: Humber Coast and Vale (HCV) and ICPs in NL and NEL.						
Ensuring that the CEO, Executive and Non-Executive Directors have sufficient capacity to prioritise effective stakeholder relationship development.	Executive directors have structures in place to enable effective support arrangements in place to enable them to have capacity to perform their duties, including working collaboratively with stakeholders. 1:1 arrangements between Executive Directors and the CEO to identify any capacity challenges. 1:1 arrangements between Non-Executive Directors and the Chair to identify any capacity challenges.	Absence of negative feedback regard the Trust's lack of engagement.	Opportunity for closer working relationships between the Trust and stakeholders in greater Lincolnshire.		Head of Contracting and Chief Operating Officer (COO) working with Lincolnshire, Ongoing. Regular operational action between Executives and counterparts at HUFT regarding key issues. Real progress being made. Time intensive for Executives. Ongoing.	
Opportunity for closer working relationships between the Trust and councillors in Local Authorities.	Attended NEL / NL Health Scrutiny Panel and ongoing development of working relationship. Meeting held with ERoY.					

RAG RATING KEY:		
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Strategic Objective:	**5. TO PROVIDE STRONG LEADERSHIP**
Risk to Strategic Objective:	11) Risk of insufficient investment and development of the Trust's leadership (including clinical leadership) - capacity and capability
Risk Description:	Effective leadership is fundamental for any organisation to achieve their strategic objectives. Inadequate leadership therefore puts at risk the delivery of the Trust's strategic objectives.

Monthly Executive Highlight Report:

* Assurance and Governance requirements in Wave 2 of Covid-19 continue in place as clarified by Trust Chair to enable focus on operational pressures.
* Trust Board met publically on 1 December 2020; Quality & Safety Committee due to meet on the 23 December 2020.
* Management of national incident continues, overseen by the Trust's two Senior Responsible Officers the Chief Operating Officer and the Chief Nurse.
* Trust Chair, vice Chair, Chief Executive Officer and Trust Secretary met and agreed an approach for board development under the Well Led framework during 2021/22.
* Newly appointed Director of People and Divisional General Manager for Clinical Support Services Division commence within the Trust during January 2021.

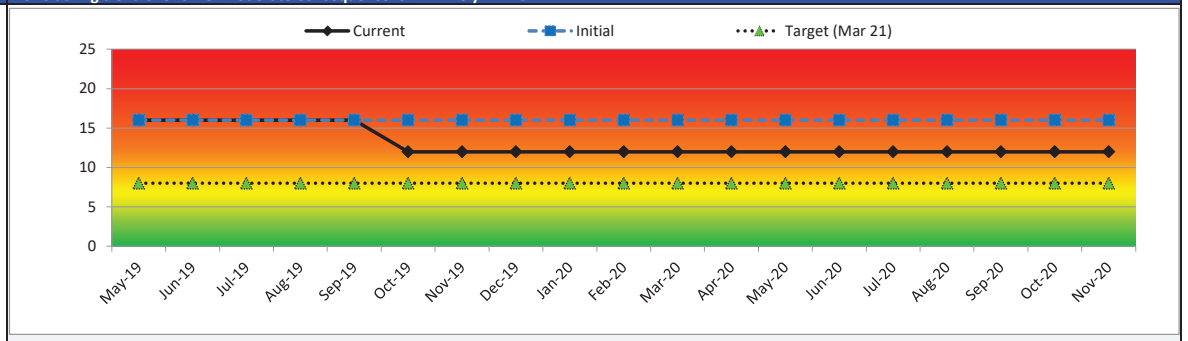
Monthly Executive Highlight Report: Plans for next month:

* Chief Information Officer to start in October 2020.

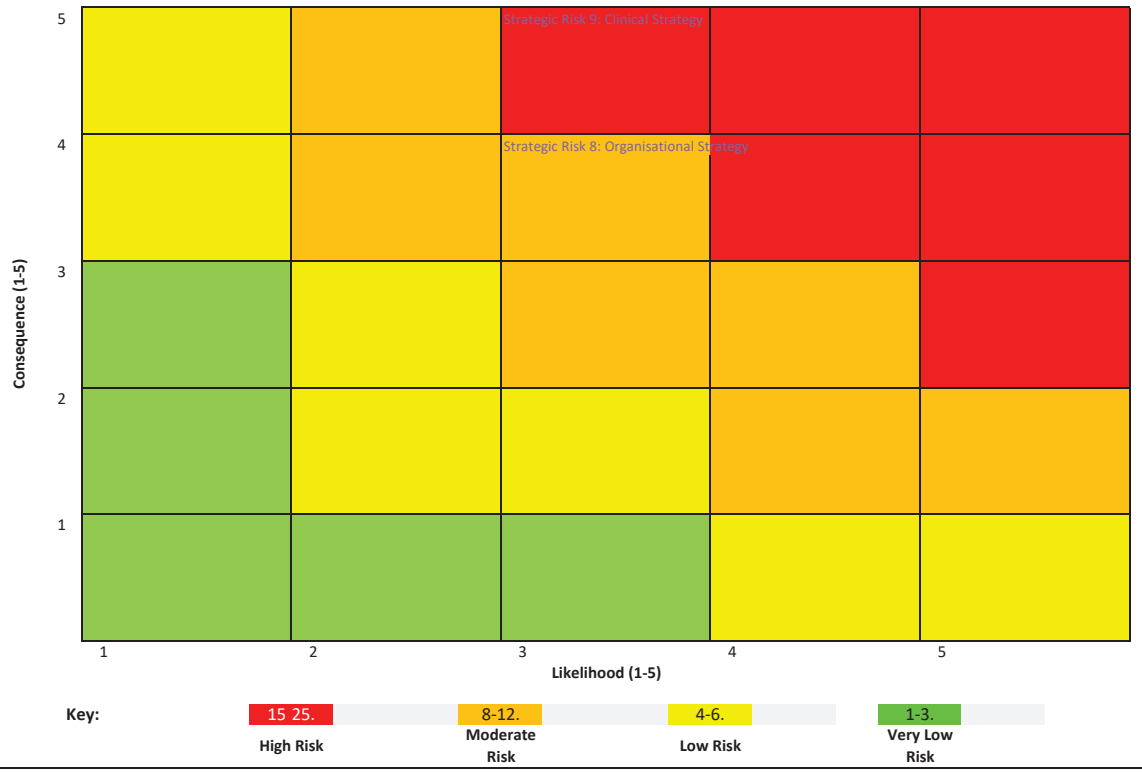
Underpinning Risks: Executive Summary (For full list of underpinning risks see Section 3 Appendix)

* See linked strategic risks in the heatmap and listed in section 3, the appendix.

Risk tracking trend over time: Moderate Consequence: 3 x 4: Likely RR of 12



Linked Corporate or High Level Risk Rating HEATMAP:



STRATEGIC OBJECTIVE:	5. TO PROVIDE SKILLED LEADERSHIP						
Risk to Strategic Objective:	11) Risk of insufficient investment and development of the Trust's leadership (including clinical leadership) - capacity and capability		**Lead Executive:** **Oversight Group:** **Assurance Committee:**	Peter Reading Trust Board Workforce Committee		**Date added:** 01-May-19 **Last updated:** 11-Dec-20	
Consequences of Risk Materialising:	* Non-delivery of the Trust's strategic objectives; * Continued quality/financial special measures status; * CQC well-led domain of 'inadequate'.			**Assurance that the issues impacting on this risk are being managed:**			Trend RAG Rating: AMBER
Issues:	**Controls:**	**Assurance:**	**GAPS in Controls:**	**GAPS in assurance:**	**Actions required to improve:**		**Assurance / Oversight Group**
Evidence that Trust leadership arrangements still need to be strengthened to improve further to a CQC rating of Good for 'well led' and the Trust being within both quality and finance special measures.	Agreed 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. Increased focus on communication with the Trust's senior leaders to ensure they are aware of key developments and to support effective decision making and communication within their teams. Informal leadership development strategy has resulted in strengthening of organisational structures. NHSI Well Led Framework has been used to support the Trust reflect and self-assess. Deloitte's Board Leadership development sessions to refine leadership qualities at Board level. Strengthening of PRIMS arrangements. 36 Clinical Leads appointed and in post. Formal leadership development strategy approved by Board. Focus on PADR compliance levels via PRIM as part of the Trust's focus on Performance improvement.	Regular reporting to Trust Board. Workforce committee has been re-established and is now meeting monthly. Latest NHS Staff Survey demonstrated some improvements, whilst recognising further improvement work is underway still. Medical engagement scale results available which demonstrate improvement from previous survey results. CQC report, February 2020.	PADR compliance shortfall of target set.		Continued focus on PADR compliance levels via PRIM, a key control to focus on performance improvement.	A	Workforce Committee; PRIM
There is a low level of medical engagement and there are opportunities for improved leadership within nursing, operational management and financial management.				CQC Re-inspection of Well Led Framework and Trust ratings. Trust remains in Quality Special Measures. Financial improvements needed.	Elaine Criddle (NHSI), Jo James (NHSI) and Tracey Granger (NHS E Regional Intensive Support Director) undertaking some close work across the Trust and the Northern Lincolnshire system, ongoing. Continued transition from improvement to Business as Usual to develop and embed sustainable change, 3 years, 2021/22.	A	Trust Board
There is a need for leaders to develop new leadership skills within an NHS that is now much more geared towards collaboration and working together.	Formal leadership development strategy approved by Board.		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.		No additional funding available. To mitigate this gap through continued focus on supporting leaders working within wider systems.	A	Workforce Committee

RAG RATING KEY:		
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	A	Amber: Partially assured, progress is being made in mitigating the issues.
	R	Red: Not assured; limited signs of progress being made to mitigate issues leading to increased risk.

Section 3: Appendix: Full list of underpinning divisional/directorate risks underpinning strategic risks.

Strategic Risk 1: PERFORMANCE: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

(a) Cancer 62 day target:

* 2838: CT Colonoscopy Backlog, Waiting Times and Capacity (RR: 20; C5xL4)
* 2592: Cancer waiting / 62 day target [Surgery] (risk rating: 16; C4xL4)
* 2791: COVID 19 Performance including RTT and Cancer (RR: 16; C4xL4)
* **NEW** 2849: Quality Surveillance (Formerly Peer Review) for Cancer Services and NHS Spec Comm (Risk rating: 12; C3xL4)
* 2160: Risks of non-delivery of constitutional performance: Histology (RR: 12; C3xL4) [Risk rating reduced from 15 to 12, Sept 20]
* 2261: Risks of non-delivery of constitutional performance: Histology (RR: 12; C3xL4)
* 2743: Open Access - Single Staff Service (Fam Serv - Cancer Performance) (risk rating: 12; C4xL3)
* 2448: Failure to reach cancer targets [Gynae] (risk rating: 12; C4xL3)
* 2008: Diagnostic PTLs meeting the cancer standards (risk rating: 12; C4xL3)
* 2244: Risk to Overall Performance: Cancer Performance Target 62 day (RR: 12; C4xL3)
* 2569: Failure to meet cancer targets [Medicine] (risk rating: 12; C3xL4)
* 2601: National Bowel Cancer Audit: 18 Month Stoma outlier (RR: 8; C4xL2) [Risk rating reduced from 12 to 8, Jul 20]
* 2650: Lung Cancer QSIS submission 2019. Gaps in compliance [Medicine] (RR: 12; C3xL4)
* 2605: National Lung Cancer Outlier Alert [Medicine] (RR: 12; C3xL4)
* 2282: Haematology Oncology Pharmacy Screen [CSS] (RR: 12; C3xL4)
* 2524: Delay of CT reports for oncology patients (risk rating: 9; C3xL3)
* ~~2310: Haemato-Oncology Peer Review: Risk of haemato-Oncology [Medicine] (RR: 12; C4xL3)~~ [Risk removed from RR, Feb 2020]

(b) A&E target:

* 2562: Failure to meet constitutional targets in A&E (Risk rating: 20; C4xL5) [Risk Rating INCREASED from 16 to 20, Jan 2021]
* **NEW** 2847: Ambulance Handover Delays (Risk rating: 15; C3xL5)
* 1991: Working with Children - A&E Staff (Risk rating: 12; C3xL4)
* 2561: Reduction in the average length of stay (Risk rating: 9; C3xL3)
* 2564: Risk to A&E performance from UTC medical staffing gaps (RR: 8; C2xL4) [Risk rating reduced to 8 from 16, Feb 2020]
* 2576: Paediatric medical support pathway for ECC (Risk rating: 6; C3xL2) [Risk rating reduced to 6 from 15, Feb 2020]

(c) RTT - 18 weeks target:

* 2515: Accuracy of Data of Business Decision Making (risk rating: 15; C5xL3) [Risk rating reduced from 20 to 15, Sept 20]
* 2826: Delayed or missing internal referrals - Surgery (RR: 16; C4xL4)
* 2048: Instability of ENT service (risk rating: 16; C4xL4)
* 2347: Risk to Overall Performance: Overdue Follow-ups (RR: 15; C5xL3) [Risk Rating reduced from 16 to 15, Nov 20]
* 1851: Shortfall in capacity with the Ophthalmology service (risk rating: 15; C3xL5)
* 2746: Urology CNS Accommodation DPOW (Surgery RTT Performance) (risk rating: 12; C3xL4)
* 2118: Overdue Follow Up Colorectal Patients (risk rating: 8; C4xL2) [Risk Rating Decreased from 12 to 8, Jan 2021]
* 2401: Clinical Harm Review Process (risk rating: 12; C4xL3)
* 2245: Non compliance with RTT incomplete target (risk rating: 16; C4xL4) [Risk rating INCREASED from 12 to 16, June 2020]
* **NEW** 2816: High waiting lists Podiatry NEL (34 weeks) (RR: 12; C3xL4)
* **NEW** 2806: Risk to cancelation of elective activity (RR: 12; C3xL4)
* **NEW** 2840: Cyclodiode Machine [Ophthalmology] (Risk rating: 9; C3xL3)
* 2801: Cath Lab Closure SGH (RR: 12; C4xL3) [Risk Rating INCREASED from 6 to 12, Jan 2021]
* 2400: Capacity & Demand (risk rating: 6; C4xL3) [Risk Rating INCREASED from 6 to 12, Nov 2020]
* 2583: Risk to 18w target due to long waiters and overdue pt f/u (RR: 8; C2xL4) [Risk INCREASED from 6 to 8, Dec 20]
* 2698: Capacity and Demand [W&C] (RR: 8; C4xL2)

(d) Diagnostics:

* 1800: Shortage of Radiologists (RR: 20; C4xL5)
* 1631: MRI Equipment - Philips Intera 1.5T Achieva DPoW (risk rating: 20; C4xL5)
* 2646: Replacement of Xray room 1 at Goole (risk rating: 16; C4 x L4) [Risk Rating reduced from 20 to 16, Apr 2020]
* 2499: SGH Main MRI Scanner Capacity and Waiting Lists (risk rating: 15; C3xL5)
* ~~2307: Shortage of Radiographers (RR: 4; C2xL2) [Risk Rating reduced from 12 to 4, July 2020]~~ [Risk removed from RR, Sept 20]
* 2522: One CT Scanner at DPoW (risk rating: 12; C4xL3)
* 2141: Nuclear Medicine Reporting Software (risk rating: 12; C3xL4)
* 2750: SGH CT scanner past end of 7 year life (RR: 9; C3xL3) [Risk rating INCREASED from to 9 from 8, Sept 20]
* 2755: SGH MRI scanner past end of 7 year life (RR: 12; C4xL3) [Risk rating INCREASED from 8 to 12, Sept 20]

Strategic Risk 2: QUALITY: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK: [updated: 16/12/20]

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

* 2838: CT Colonoscopy Backlog, Waiting Times and Capacity (RR: 20; C5xL4)
* 2515: Accuracy of Data of Business Decision Making (risk rating: 15; C5xL3) [Risk rating reduced from 20 to 15, Sept 20]
* 2773: Clinical Harm [CSS] (RR: 12; C4xL3) [Risk rating reduced from 20 to 12, Sept 20]
* 2048: Instability of ENT service (risk rating: 16; C4xL4)
* 2826: Delayed or missing internal referrals - Surgery (RR: 16; C4xL4)
* 2347: Risk to Overall Performance: Overdue Follow-ups (RR: 15; C5xL3) [Risk Rating reduced from 16 to 15, Nov 20]
* 2245: Non compliance with RTT incomplete target (risk rating: 16; C4xL4) [Risk rating INCREASED from 12 to 16, June 2020]
* 2770: Lack of workforce to run Haematology Services (Medicine) (RR: 15; C5xL3)
* 1851: Shortfall in capacity with the Ophthalmology service (risk rating: 15; C3xL5)
* 2806: Risk to cancelation of elective activity (RR: 12; C3xL4)
* 2746: Urology CNS Accommodation DPOW (Surgery RTT Performance) (risk rating: 12; C3xL4)
* 2118: Overdue Follow Up Colorectal Patients (risk rating: 8; C4xL2) [Risk Rating Decreased from 12 to 8, Jan 2021]
* 2401: Clinical Harm Review Process (risk rating: 12; C4xL3)
* 2698: Capacity and Demand [W&C] (RR: 8; C4xL2)
* 2400: Capacity & Demand (risk rating: 6; C4xL3) [Risk Rating INCREASED from 6 to 12, Nov 2020]
* 2583: Risk to 18w target due to long waiters and overdue pt f/u (RR: 8; C2xL4) [Risk INCREASED from 6 to 8, Dec 20]

(2). Quality Priority 2: Clinical Effectiveness: Reduce mortality rates and strengthen end of life care;

* 2418: Mortality Performance (risk rating: 10; C5xL2) [Risk Rating reduced from 15 to 10, Sept 20]
* 2744: Mortality: Specific Focus on End of Life (risk rating: 20; C5xL4)
* 2653 Ceilings of care and advance care planning [C&T] (risk rating: 8; C4xL2) [Risk Rating Reduced from 12 to 8, Jan 2021]
* 2761: Quality Priority 2: Goole District Hospital Mortuary [Fam Serv] (RR: 16; C4xL4) [Risk rating reduced from 20 to 16, Sept 20]
* 2531 Inequitable provision of an Acute Hospital Learning Disability Liaison Nurse at Scunthorpe (risk rating: 20; C4xL5) [Risk INCREASED from 15 to 20, Jul 20]
* 2765: Lack of availability of ultrasound scans appointments required to assess fetal wellbeing (RR: 16; C4xL4)
* 2782: Perinatal Mortality Review Tool (PMRT) historic backlog of cases (RR: 12; C3xL4)
* 2797: Backlog number of Mortality reviews requiring review and theming (RR: 8; C4xL2) [Risk Rating Reduced from 12 to 8, Jan 2021]
* 2827: Risk of insufficient Mortality Reviews due to COVID-19 wave #2 (RR: 12; C3xL4)
* 2597 NELA outlier alert for mortality (risk rating: 12; C4xL3)
* 2811: End of Life - Surgery Division (RR: 8; C4xL2)
* 2434 CQC Mortality Review: Heart Valve Disorders (risk rating 12; C4xL3) [Risk rating INCREASED from 8 to 12, Nov 20]
* 2602 NHFD outlier alert for mortality (risk rating: 8; C4xL2)
* ~~2751: Quality Priority 2: Audit of Documentation and decisions of DNACPR [C&T] (RR: 8; C2xL4)~~ [Risk Removed from RR, July 20]
* ~~2598 Lack of timely mortality SJR reviews [Surgery] (risk rating: 6; C2xL3) [Risk rating reduced from 12 to 6, June 2020]~~ [Risk Removed from RR, July 20]
* 2111 Lack of 7-day services for palliative care at SGH (risk rating: 6; C2xL3)
* 2714: Off Site Mortality Case Note Review (risk rating: 6; C3xL2)
* 2800: Risk of deteriorating patients not being identified and escalated appropriately (ED) (RR: 15; C5xL3)
* 2388 Risk of deteriorating patients not being escalated [Medicine] (RR: 15; C5xL3)
* 2390 Risk of deteriorating patients not being escalated [Paediatrics] (RR: 10; C5xL2) [Risk reduced from 15 to 10, Oct 20]
* 2308 The risk of deteriorating patients not being escalated (RR: 12; C4xL3)
* 2671 CTG Archiving [Maternity] (risk rating: 12; C3xL4)
* 2389 Risk of deteriorating patients not being escalated [Surgery] (RR: 10; C5xL2) [Risk Rating reduced from 12 to 10, July 2020]
* 2582 Care of critically ill children (risk rating: 12; C4xL3) [Risk Rating reduced from 16 to 12, May 2020]
* 2669 Lack of high observation machine on the antenatal/postnatal ward [Maternity] (risk rating: 9; C3xL3)
* 2393 Risk of deteriorating patients not being escalated [Maternity] (RR: 6; C3xL2)
* 2576 Paediatric medical support pathway to ECC (risk rating: 6; C3xL2) [Risk Rating reduced from 15 to 6, Mar 2020]
* 2661 Maternity Datascopes [Maternity] (risk rating: 6; C3xL2) [Risk Rating reduced from 20 to 6, Feb 2020]
* 2672 Paediatric Ventilator [W&C] (risk rating: 6; C3xL2)

(3). Quality Priority 3: Patient Safety: Improve the management of diabetes;

* 2812 DKA / Diabetes Management in ECC. (RR: 9; C3xL3)
* ~~2537 Diabetes Nurse Specialist vacancy (risk rating: 9; C3xL3)~~ [Risk Removed from RR, July 20]

(4). Quality Priority 4: Patient Experience & Clinical Effectiveness: Improve the effectiveness of cancer pathways focussing on time to diagnosis;

* 1800 Shortage in radiologists (risk rating 20; C4xL5)
* 2592 Cancer waiting / performance against 62 day target (risk rating 16; C4xL4)
* 2160 Delays in biopsy reporting (risk rating 12; C3xL4) [Risk rating reduced from 15 to 12, Sept 20]
* 2210 Failure to meet 6 week target for CT / MRI (risk rating 15; C3xL5)
* **NEW** 2849: Quality Surveillance (Formerly Peer Review) for Cancer Services and NHS Spec Comm (Risk rating: 12; C3xL4)
* 2814 Lack of a Clinical Lead for Cancer of Unknown Primary (CUP) - Medicine Division (RR: 12; C3xL4)
* 2244 Divisional delay in cancer pathways risk (risk rating: 12; C4xL3)
* 2261 Delays in biopsy reporting (risk rating 12; C3xL4)
* 2448: Failure to reach cancer targets (risk rating: 12; C4xL3)
* 2008: Diagnostic PTLs meeting the cancer standards (risk rating: 12; C4xL3)
* 2569: Failure to meet cancer targets [Medicine] (risk rating: 12; C3xL4)
* 2763: Quality Priority 4: Delay in cancer diagnosis, follow-up and treatment due to COVID-19 [Fam Serv] (RR: 12; C3xL4)
* 2745: Quality Priority 4: Risk to cancer diagnostic performance for endoscopy due to pre procedure isolation / screening requirements for these exams. [CSS] (RR: 9; C3xL3) [Risk Rating reduced from 12 to 9, July 2020]
* 2601: National Bowel Cancer Audit: 18 Month Stoma outlier (RR: 8; C4xL2) [Risk rating reduced from 12 to 8]
* 2650: Lung Cancer QSIS submission 2019. Gaps in compliance [Medicine] (RR: 12; C3xL4)
* 2605: National Lung Cancer Outlier Alert [Medicine] (RR: 12; C3xL4)
* 2282: Haematology Oncology Pharmacy Screen [CSS] (RR: 12; C3xL4)
* 2743: Open Access - Single Staff Service (Fam Serv - Cancer Performance) (risk rating: 12; C4xL3)
* 2524: Delay of CT reports for oncology patients (risk rating: 9; C3xL3)
* ~~2310: Haemato-Oncology Peer Review: Risk of haemato-Oncology [Medicine] (RR: 12; C4xL3)~~ [Risk removed from RR, Feb 2020]

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

* 2566: 7DS risk [Surgery] (risk rating: 12; C4xL3)
* 2620: 7DS risk - Medical Directors Office (risk rating: 16; C4xL4) [Risk rating INCREASED from 12 to 16]
* 2673: Implementation of 7 Day Services [Medicine] (RR: 12; C4xL3)
* 2640: 7DS risk [CSS] (risk rating: 6; C3xL2)

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

* 2659: Management of formal complaints and Pals within Trust Timescales [Chief Nurse] (RR: 15; C3xL5) [Risk Rating INCREASED from 12 to 15, June 2020]
* 2681: Divisional Complaints Backlog [Medicine] (RR: 12; C3xL4)

(7). Clinical Service Concern (CSC): Ophthalmology:

* **NEW** 2841: Nidek AR-310A Autofractor [Ophthalmology] (Risk rating: 16; C4xL4)
* 2839: A Scan AXIS II (Opthalmology Equipment) (RR: 16; C4xL4)

* 2776: Ophthalmology Pentacam (RR: 12; C4xL3) [Risk rating reduced from 16 to 12, Nov 20]
* CSC: 2347 Failure to review patients in specified timescales (risk rating 15; C5xL3) [Risk Rating reduced from 16 to 15, Nov 20]
* 2775: IOL Master Biometry Machine - Aging Equipment (RR: 16; C4xL4)
* CSC: 1851 Shortfall in Ophthalmology (risk rating 15; C3xL5)
* 2774: Aging OCT Machines (RR: 15; C5xL3)
* CSC: 2186 Space in Ophthalmology outpatients (risk rating 12; C4xL3)
* **NEW** 2840: Cyclodiode Machine [Ophthalmology] (Risk rating: 9; C3xL3)

(8). Clinical Service Concern (CSC): Care of the Paediatric Patient in the Emergency Department:

* 2832: Risk of Deteriorating Paediatric Patients not Escalated Appropriately (RR: 12; C4xL3)
* 1991: Working with Children - A&E Staff (Risk rating: 12; C3xL4)
* 2812 DKA / Diabetes Management in ECC. (RR: 9; C3xL3)
* 2576: Paediatric medical support pathway for ECC (Risk rating: 6; C3xL2) [Risk rating reduced to 6 from 15, Feb 2020]
* 2449: Paediatric staffing (not meeting national guidance) W&C (risk rating: 9; C3xL3) [Risk Rating Reduced from 12 to 9, Jan 2021]

(9). Miscellanious Quality Related:

* 2794: Inability to segregate patients in ED and in ward environments due to lack of isolation facilities (RR: 20; C5xL4)
* 2823: Lack of a MCA/LPS Lead for the Trust (RR: 16; C4xL4)
* 2809: Potential delayed and omitted doses (RR: 16; C4xL4)
* 2793: COVID 19 Equipment (RR: 16; C4xL4)
* 2792: COVID 19 Patient Safety (RR: 16; C4xL4)
* **NEW** 2847: Ambulance Handover Delays (Risk rating: 15; C3xL5)
* ~~2748: Misc: Restrictive bed capacity on Rainforest Ward due to the closure of the PAU which was co-located to ECC due to COVID-19 [Fam Serv] (RR: 12; C3xL4) [Risk Rating reduced from 20 to 12, July 2020]~~ [Risk removed from RR, Jan 2021]
* 2779: Risk of harm to patients due to inability from orthotic provider (Taycare) to produce orthoses (RR: 8; C4xL2) [Risk rating reduced from 12 to 8, Oct 20]
* 2595: Lack of a Local Quality Dashboard – displaying quality indicators (risk rating: 16; C3xL5) [Risk Rating Reduced from 16 to 15, Jan 2021]
* 2157: Obstetric Theatre (risk rating: 15; C3xL5)
* ~~2705: Interuption of High Flow Nasal Oxygen during transfer (RR: 12; C4xL3)~~ [Risk removed from RR, July 2020]
* JAG Accreditation Linked: 2694: Failure to meet JAG Recommendations in housing enema room within clinical area [CSS] (RR: 16; C4xL4)
* 2765: Misc: Lack of availability of ultrasound scans appointments required to assess fetal wellbeing [Fam Serv] (RR: 16; C4xL4)
* 2771: IPC: Infection Prevention & Control: Lack of closed cubicles within ECC (RR: 12; C4xL3) [Risk rating reduced from 16 to 12, Sept 20]
* **NEW** 2851: Non Compliance with NICE Guidance [Medicine] (Risk rating: 12; C3xL4)
* 2820: CQC improvement plan (RR: 12; C3xL4)
* 2824: EPMA - Not implemented in Emergency Departments (RR: 12; C3xL4)
* 2752: Misc: Audit Viewing Room – Access [Med Dir] (RR: 9; C3xL3) [Risk rating reduced from 12 to 9, Nov 20]
* CQC Linked: 2549: Assessment of ligature points within the Medicine Division [Medicine] (RR: 10; C5xL2)
* ~~2760: Misc: Consultant Pharmacist - Antimicrobials [CSS] (RR: 10; C2xL5)~~ [Risk removed from RR, Jan 2021]
* **NEW** 2844: Paracetamol Prescribing Risk [Medicine] (Risk rating: 9; C3xL3)
* **NEW** 2848: Paracetamol Prescribing Risk [Surgery] (Risk rating: 9; C3xL3)
* 2810: Antimicrobial Overuse - Medicine (RR: 9; C3xL3)
* 2818: Lack of adherence to the Anti-Microbial Policy (RR: 9; C3xL3)
* CQC Linked: 2707: Resus training provision (RR: 9; C3xL3)
* ~~2762: Misc: Non compliance with the Falsified Medicines Directive (FMD) [CSS] (RR: 9; C3xL3)~~ [Risk removed from RR, Jan 2021]
* CQC Linked: 2687: Syringe Driver Training Compliance [C&TS] (RR: 9; C3xL3)
* 2790: Lack of failsafe and pathways for Newborn and Infant Physical Examination (NIPE) (RR: 9; C3xL3)
* 2600 Omitted doses (risk rating: 9; C3xL3)
* 2801: Cath Lab Closure SGH (RR: 12; C4xL3) [Risk INCREASED from 6 to 12, Dec 20]
* CQC Linked: 2663: Lack of Ligature Free Rooms within Paediatric Wards [W&C] (RR: 4; C4xL1) [Risk Rating reduced from 8 to 4, July 2020]
* 2768: Re-audit of Maternity Documentation (Limited assurance) (RR: 6; C2xL3)
* Patient Safety Alert Linked: 2742: Breast Implant associated lymphoma (BIA ALCL) (RR: 4; C4xL1)
* 2410: IPC: Infection Prevention & Control: Hygiene Code (RR: 16; C4xL4) [Risk Rating INCREASED from 8 to 16, Sept 20]
* 2350: Misc: Lack of capacity and loss of overnight provision within the SPA service to meet the demand required (RR: 15; C3xL5)

Strategic Risk 3: Adverse impact of external events (i.e. Britain's exit from the European Union; Pandemic) on business continuity and the delivery of safe care: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

* 2794: Inability to segregate patients in ED and in ward environments due to lack of isolation facilities (RR: 20; C5xL4)
* **NEW** 2845: Risk to Medical Staffing due to COVID 19 [Medicine] (Risk rating: 16; C4xL4)
* 2791: COVID 19 Performance including RTT and Cancer (RR: 16; C4xL4)
* 2793: COVID 19 Equipment (RR: 16; C4xL4)
* 2792: COVID 19 Patient Safety (RR: 16; C4xL4)
* **NEW** 2847: Ambulance Handover Delays (Risk rating: 15; C3xL5)
* 2462: Supply of radiopharmaceuticals and nuclear medicine 'cold kits' (risk rating: 12, C4xL3)
* 2567 Brexit [Surgery] (risk rating: 10; C5xL2) [Risk Rating reduced from 12 to 10, July 2020]
* 2571 Transport arrangements linked to Brexit [Medicine] (RR: 12; C3xL4)
* 2771: IPC: Infection Prevention & Control: Lack of closed cubicles within ECC (RR: 12; C4xL3) [Risk rating reduced from 16 to 12, Sept 20]
* 2772: Paediatric Middle Grade Gaps linked to Covid-19 (RR: 12; C4xL3)
* 2815: COVID Risk Assessments and risk to workforce (RR: 20; C5xL4) [Risk Rating INCREASED from 12 to 20, Jan 2021]
* 2821: Oxygen Alarms not Functioning Correctly on Ward 22/23/24 (RR: 12; C4xL3)
* ~~2822: Oxygen Alarms not Functioning Correctly on Ward 25 (RR: 12; C4xL3)~~ [Risk removed from RR, Jan 2021]
* 2807: Critical care capacity during covid 19 (RR: 12; C3xL4)
* 2827: Risk of insufficient Mortality Reviews due to COVID-19 wave #2 (RR: 12; C3xL4)
* 2806: Risk to cancelation of elective activity (RR: 12; C3xL4)
* 2579 Transport arrangements linked to Brexit [W&C] (RR: 4; C2xL2) [Risk Rating reduced from 12 to 4, Apr 2020]

* 2426: Business continuity (risk rating: 10; C5xL2)
* ~~2760: Misc: Consultant Pharmacist - Antimicrobials [CSS] (RR: 10; C2xL5)~~ [Risk removed from RR, Jan 2021]
* 2819: Critical Care Capacity due to Covid 19 (RR: 10; C5xL2)
* **NEW** 2846: Decontamination Tents - Emergency Departments. (Risk rating: 9; C3xL3)
* 2697: Risk to frontline staff - exposure to COVID 19 (RR: 9; C3xL3)
* 2699: COVID 19 impact on W&C (RR: 9; C3xL3)
* ~~330: Risk of lack of preparedness for coping with major incident (risk rating: 6; C3xL2)~~ [Risk removed from RR, July 2020]
* ~~2688: Risk to clinical services due to impact on transport arrangements following Britain's exit from the EU (C&T) (RR: 6; C3xL2)~~ [Risk removed from RR, July 2020]
* 2708: Covid-19 (Community & Therapies) (RR: 16; C4xL4) [Risk Rating INCREASED from 12 to 16, Jan 2021]
* 2710: COVID-19 Pandemic: Risk to IT Operations Service (Digital Services) (RR: 20; C4xL5)
* 2700: Impact on Divisional Businees Plan / Service Delivery due to COVID 19 (Medicine) (RR: 20; C4xL5)
* 2704: Risks arising as a result of Covid-19 Pandemic (CSS) (RR: 20; C4xL5)
* 2706: COVID 19 Pandemic (Surg & CC) (RR: 16; C4xL4)
* ~~2705: Interuption of High Flow Nasal Oxygen during transfer (RR: 12; C4xL3)~~ [Risk removed from RR, July 2020]
* ~~2798: Swabbing Sites Trust Wide (RR: 9; C3xL3)~~ [Risk removed from RR, Jan 2021]
* 2701: Covid 19 - Pharmacy perspective (CSS) (RR: 9; C3xL3)
* 2699: Covid-19 - all sites (Family services) (RR: 9; C3xL3)
* 2803: Swabbing - Risk of Data Breach (RR: 8; C4xL2)
* 2795: Transmission of COVID-19 Antibody results by email (RR: 6; C2xL3)
* 2714: Off Site Mortality Case Note Review (risk rating: 6; C3xL2)
* 2828: Oxygen Alarms not Functioning Correctly on Ward 26 (RR: 4; C4xL1)

Strategic Risk 4: SKILLED STAFF: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

Medical Staffing Risks:

* 1800: Shortage of Radiologists CSS (risk rating: 20; C4xL5)
* **NEW** 2845: Risk to Medical Staffing due to COVID 19 [Medicine] (Risk rating: 16; C4xL4)
* 2359: Doctor vacancies in Medicine (risk rating 16; C4xL4)
* 2279: Risk to Overall Performance: Medical Workforce in Surgery (RR: 16; C4xL4)
* 2770: Lack of workforce to run Haematology Services (Medicine) (RR: 15; C5xL3)
* 2685: Urology medical staffing shortfall (risk rating: 12; C3xL4) [Risk Rating reduced from 15 to 12, June 2020]
* 2772: Paediatric Middle Grade Gaps linked to Covid-19 (RR: 8; C4xL2) [Risk Rating REDUCED from 12 to 8, Jan 2021]
* 2741: Depleted Consultant Workforce Breast Service (Fam Serv) (risk rating: 12; C4xL3)
* 2419: Medical staff Recruitment and retention (risk rating: 9; C3xL3) [Risk Rating reduced from 12 to 9, July 2020]
* 2420: Medical staff job planning (risk rating: 12; C3xL4)
* 2261: Histology Reporting due to staffing CSS (risk rating: 12; C3xL4)
* 2018: Lack of substantive Acute Care Physicians [Medicine] (risk rating 6; C2xL3) [Risk rating reduced from 10 to 6, Nov 20]
* 2596 Job plans in W&C (risk rating: 10; C2xL5)
* 2564: Risk to A&E perf from UTC medical staffing gaps Medicine (RR: 8; C2xL4) [Risk Rating reduced from 16 to 8, Feb 2020]
* 2449: Paediatric staffing (not meeting national guidance) W&C (risk rating: 9; C3xL3) [Risk Rating Reduced from 12 to 9, Jan 2021]

Nursing Staffing Risks:

* 2421: Nurse Staffing (risk rating: 25; C5xL5)
* 2530: Poor registered nursing skill mix on wards (risk rating: 20, C4xL5) [Risk Rating reduced from 25 to 20, July 2020]
* 2511: Registered Nurse cover in the Network Evening Service (RR: 15; C3xL5)
* 2140: Registered Nurse Vacancy Position Ward 25 and 28 Surgery (RR: 8; C4xL2) [Risk reduced from 16 to 8, Jul 20]
* 2145: Nurse Staffing and Vacancy Position Medicine (risk rating: 16; C4xL4) [Risk Rating Reduced from 20 to 16, Jul 2020]
* 2490: Midwifery Staffing W&C (risk rating: 16; C4xL4)
* ~~2537 Diabetes Nurse Specialist vacancy Medicine (risk rating: 9; C3xL3)~~ [Risk removed from RR, July 2020]
* ~~2479: CNS Staffing Levels Medicine (risk rating: 15; C3xL5)~~ [Risk removed from RR, Feb 2020]
* 2531 Inequitable provision of an Acute Hospital Learning Disability Liaison Nurse at Scunthorpe (risk rating: 20; C4xL5) [Risk rating INCREASED from 15 to 20]
* 2692: Potential failure to achieve antenatal and newborn screening KPIs (RR: 9; C3xL3)

Other Staffing Risks:

* ~~2163: Estates Workforce Shortfall E&F (risk rating: 16; C4xL4)~~ [Risk removed from RR, Sept 20]
* 2035: Equality Act 2010 compliance (risk rating: 16; C4xL4)
* 2804: Impact of increased workload with implementing D2A on Acute Therapies (RR: 15; C3xL5)
* ~~2817: No Therapy cover within the Intermediate Care Service (RR: 15; C3xL5)~~ [Risk closed on RR, Jan 2021]
* 2652: HSA provision on NRC (RR: 15; C3xL5)
* 2638: Tissue Viability Team Capacity (risk rating: 12; C3xL4) [Risk rating reduced from 15 to 12, Jul 20]
* 2691: PSA Pathway Admin Support (RR: 9; C3xL3) [Risk rating reduced from 15 to 9, Sept 20]
* 2743: Open Access - Single Staff Service (Fam Serv - Cancer Performance) (risk rating: 12; C4xL3)
* ~~2189: Admin W/F in Pink Rose Suite Surgery (RR: 12; C3xL4)~~ [Risk closed on RR, Jan 2021]
* 2166: Breast care: Imaging team W/F in Pink Rose Suite Surgery (RR: 12; C3xL4)
* 2255: Staffing issues in Nutrition and Dietetics C&T (risk rating 12; C3xL4)
* ~~2356: Community & Therapy staff sickness C&T (risk rating 12; C3xL4)~~ [Risk removed from RR, July 2020]
* ~~2519: Community & Therapies physiotherapy staffing (RR 12; C3xL4)~~ [Risk removed from RR, Jul 2020]
* 2759: Gap in staffing due to 1 year maternity leave not covered - 37.5hrs [CSS] (RR: 12; C3xL4)
* 2756: Reduced therapy cover due to maternity leave within the Unscheduled Care Team (RR: 12; C3xL4)
* 2553 Obstetric theatre staffing model for mat services W&C (RR: 10; C2xL5)
* 2550 Pharmacy staffing (risk rating: 10; C2xL5)
* 2798: Swabbing Sites Trust Wide (RR: 9; C3xL3)
* ~~2696: Limited Neuro Rehab Therapy provision to provide rehabilitation to the unit (RR: 9; C3xL3)~~ [Risk removed from RR, May 2020]
* 2777: Lack of provision of specialist community LD therapists in NL (RR: 9; C3xL3)
* 2580 Lack of divisional workforce plan in W&C (risk rating: 9; C3xL3)
* 2757: Risk to staffing due to ambiguities of current discussions re: SLA ceasing and who might be involved in this [C&T] (RR: 9; C3xL3)
* ~~2581 Lack of leadership/succession plan in W&C (risk rating: 9; C3xL3)~~ [Risk removed from RR, Jul 2020]

* 2758: Low staffing levels due to short and long term sickness (RR: 8; C2xL4)
* 2576: Paediatric Medical Support Pathway for ECC (risk rating: 6; C3xL2) [Risk Rating reduced from 15 to 6, Feb 2020]
* ~~2352: Vacancies and Recruitment - Acute Therapy Staff NEL C&T (RR: 6; C2xL3)~~ [Risk removed from RR, May 2020]
* 2397: Rehab Medicine staffing C&T (risk rating: 6; C2xL3)
* 2572 Occupational Therapy Capacity and Demand [C&T] (risk rating: 6; C3xL2) [Risk Rating Decreased from 9 to 6, Mar 2020]
* ~~2100: Theatre staffing Surgery (risk rating: 6; C2xL3)~~ [Risk removed from RR, July 2020]
* ~~2689: Low staffing levels and high waiting times within the MSK Service (RR: 6; C3xL2)~~ [Risk removed from RR, Sept 20]
* ~~2492: 60 hour labour ward cover W&C (risk rating 16; C4xL4)~~ [Risk removed from RR, Feb 2020]

Training and Appraisals:

* 2422: Leadership & Management: Annual Appraisal (risk rating: 12; C3xL4)
* 1991: Working with Children - A&E Staff [Medicine] (Risk rating: 12; C3xL4)
* 2423: Leadership & Management: Mandatory Training (risk rating: 9; Cx3xL3)
* 1775: Bank Staff - Mandatory training (risk rating: 9; C3xL3)

Clinical Engagement:

* ~~2682: Working lives of our trainee doctors (risk rating: 12; C4xL3) [Risk Rating reduced from 16 to 12, May 2020]~~ [Risk removed from RR, Nov 20]
* 2431: Clinical Engagement (risk rating: 12; C4xL3)

Recruitment / Personnel Files:

* 2684: Compliance with employment check standards for private patient professionals (risk rating: 8; C4xL2) [Risk Rating reduced from 12 to 8, Apr 2020]
* 2586: Medical Personnel Files storage arrangements (risk rating: 9; C3xL3)

Strategic Risk 5: STAFF ENGAGEMENT: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

* 2202: Failure to review and agree a number of out of date employment policies (risk rating: 16; C4xL4)
* 2424: Organisational Culture, Systems and Processes (RR: 12; C3xL4) [Risk Rating reduced from 20 to 12]
* 2353: Staff Morale - Community and Therapies Services (risk rating: 4; C4xL1) [Risk Rating reduced from 6 to 4, Sept 20]

Strategic Risk 6: FINANCE: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

* 2712: Achieve 2020/21 breakeven position as agreed with NHSi (risk rating: 12; C4xL3) [Risk rating reduced from 16 to 12, Nov 20]
* 2040: Delay in payment of invoices (risk rating: 12; C4xL3) [Risk rating reduced from 16 to 12, Nov 20]
* 2534: Tender for new financial ledger (risk rating: 12; C4xL3) [Risk rating reduced from 16 to 12, Nov 20]
* ~~2535: Loss of income if Trust does not achieve the 2019/20 deficit as agreed with NHSI (risk rating: 16; C4xL4)~~ [Risk removed from RR, June 2020]
* 2769: Potential Loss of Income (LiSH Sexual Health) (Path Links) (RR: 12; C4xL3)
* 913: Late Submission of Termination of Employment Forms (risk rating: 12; C3xL4)
* **NEW** 2843: Restore Contract – rolling contract from October 2020 – Financial risk (Risk rating: 9; C3xL3)

CIP Savings:

* 2733: Risk of not achieving 2020/2021 CIP target of £1.19m [Family Services] (risk rating: 16; C4xL4)
* ~~2577: Risk of not achieving CIP target (W&C) (RR: 16; C4xL4)~~ [Risk removed from RR, June 2020]
* 2599: Unable to meet CIP deliver (Surgery) (RR: 16; C4xL4)
* ~~2526: Delivery of 2019/20 CIP (Community & Therapies) (risk rating: 15; C3xL5) [Risk rating INCREASED from 12 (C4xL3) to 15, Mar 2020]~~ [Risk removed from RR, May 202
* ~~2560: Failure to meet agreed CIP (Medicine) (RR: 12; C3xL4)~~ [Risk removed from RR, May 2020]
* 2764: Failure to deliver CIP for 20/21 [E&F] (RR: 12; C4xL3)
* 2745: Delivery of Medicine CIP for financial year 2020/21 (risk rating: 9; C3xL3)
* 2766: Financial Risks of not achieving the Cost Improvement Plan (CSS) (RR: 6; C3xL2)
* ~~2543: Risk of not achieving CIP plan (CSS) (RR: 2; C2xL1) [Risk rating reduced from 12 (C4xL3) to 2, Mar 2020]~~ [Risk removed from RR, Jul 2020]
* ~~2508: Risk of not achieving CIP (Medical Directors Office) [Reduced] (risk rating: 9; C3xL3)~~ [Risk removed from RR, Mar 2020]

CQUIN linked risks:

* 2573: CQUIN Performance risk (Surgery) (RR: 6; C2xL3)

Other financial risks:

* ~~2541: Risk if fines for non-disclosure (risk rating: 6; C3xL2) [Risk rating decreased from 9 to 6, June 2020]~~ [Risk removed from RR, July 2020]
* 2683: NHS PS dispute over Invoices (risk rating: 12; C3xL4)

Strategic Risk 7a: ESTATES AND EQUIPMENT: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

Estates Engineering risks:

* 2783: Medical Gas Pipeline System outlet and plant - Replacement Vacuum Pumps (RR: 20; C5xL4)
* 2788: Low Voltage Electrical Infrastructure (DPoW) (RR: 20; C5xL4)
* 2789: Low Voltage Electrical Infrastructure (GDH) (RR: 20; C5xL4)
* 2787: Low Voltage Electrical Infrastructure (SGH) (RR: 20; C5xL4)
* 2720: Water Safety Compliance: Cold water storage (Goole) (risk rating: 20; C5xL4)
* 2719: Water Safety Compliance: Coronation block (risk rating: 20; C5xL4)
* 2715: Water Safety Compliance: Gravity system (DPoW) (risk rating: 20; C5xL4)
* ~~2425: Health & Safety Compliance: Water Safety Compliance (risk rating: 20; C5xL4)~~ [Risk removed from RR, May 2020]
* 2038: Fire Compliance (risk rating: 20; C5xL4)
* ~~2293: Fire Ring Main Deadlegs and Condition Risk (risk rating: 20; C4xL5)~~ [Risk removed from RR, May 2020]
* 2088: Building Management Systems (BMS) Controller failure/upgrade (risk rating: 20; C4xL5)
* 1620: Medical Gas Pipeline System outlet and plant (risk rating: 20; C5xL4)
* ~~2281: Low Voltage Electrical Infrastructure (risk rating: 20; C5xL4)~~ [Risk removed from RR, Sept 20]
* 2623: Failure of windows trust wide (RR: 20; C5xL4)
* 2732: Lack of Authorised Persons (APs) due to AP new starteer and refresher training being postponed/cancelled because of COVID-19 (risk rating: 16; C4xL4)
* 2721: Water Safety Compliance (DPoW): Fire ring main (risk rating: 16; C4xL4)
* 2722: Water Safety Compliance (SGH): Fire ring main (risk rating: 16; C4xL4)
* 2723: Water Safety Compliance (Goole): Fire ring main (risk rating: 16; C4xL4)
* 2725: Water Safety Compliance: Sensor taps (SGH) (risk rating: 16; C4xL4)
* 2724: Water Safety Compliance: Sensor taps (DPoW) (risk rating: 16; C4xL4)
* 2726: Water Safety Compliance: Sensor taps (Goole) (risk rating: 16; C4xL4)
* 1223: Replacement/Repairs of flat roof (risk rating: 16; C4xL4)
* 2200: Door entry/intercom system (risk rating: 16; C4xL4)

* 2212: Nurse Call System (risk rating: 16; C4xL4)
* 1774: Poor condition of Fuel Oil Storage Tanks (SGH) (risk rating: 16; C4xL4)
* 2452: Northside Buildings Roofs (risk rating: 16; C4xL4)
* 2694: Failure to meet JAG Recommendations in housing enema room within clinical area [CSS] (RR: 16; C4xL4)
* 2717: Water Safety Compliance: Silver Copper ionisation (DPoW) (risk rating: 15; C5xL3)
* ~~2718: Water Safety Compliance: Silver Copper ionisation (SGH) (risk rating: 15; C5xL3)~~ [Risk removed from RR, Oct 20]
* 2831: Additional VIE plant to meet demand (RR: 15; C5xL3)
* 2830: Asbestos management - Risk of exposure to asbestos (GDH) (RR: 15; C5xL3)
* 2829: Asbestos management - Risk of exposure to asbestos (SGH) (RR: 15; C5xL3)
* 2374: Medical Air Compressor Plant Replacement – SGH (RR:15; C5xL3)
* 1601: Clock Tower (Northside Development) (risk rating: 15; C5xL3)
* 2624: Pressurised System Safety Valves (RR: 15; C5xL3)
* ~~2813: Replacement of Forklift (RR: 15; C3xL5)~~ [Risk removed from RR, Jan 2021]
* 2821: Oxygen Alarms not Functioning Correctly on Ward 22/23/24 (RR: 12; C4xL3)
* ~~2822: Oxygen Alarms not Functioning Correctly on Ward 25 (RR: 12; C4xL3)~~ [Risk removed from RR, Jan 2021]
* 2727: Water Safety Compliance (DPoW): BMS (risk rating: 12; C4xL3)
* 2728: Water Safety Compliance (SGH): BMS (risk rating: 12; C4xL3)
* 2729: Water Safety Compliance (Goole): BMS (risk rating: 12; C4xL3)
* 2716: Water Safety Compliance: Temperature Monitoring (DPoW) (risk rating: 12; C4xL3)
* 2637: Switch Room Access (Blocked) (RR: 12; C4xL3)
* 2656: Trip Hazard Car Park adjacent to West Arch (RR: 12; C3xL4)
* 2693: Aseptic Air Handling Units - alert system (RR: 12; C4xL3)
* 2784: Call Bell System Failure - A&E (DPoW) (RR: 10; C5xL2)
* 2785: High Voltage electrical infrastructure (DPoW) (RR: 10; C5xL2)
* 2786: High Voltage electrical infrastructure (SGH) (RR: 10; C5xL2)
* 2538: Non Compliant with the Combustion Plant Directive (MCPD) (RR: 10; C2xL5) [Risk reduced from 15 to 10]
* ~~2377: Sterile Pack Bulk Storeroom (risk rating: 20; C5xL4)~~ [Risk removed from RR, Feb 2020]
* 2317: SGH & Pathology Air Tube POD System (risk rating: 6; C2xL3) [Risk rating decreased from 20 to 6, June 2020]
* 2828: Oxygen Alarms not Functioning Correctly on Ward 26 (RR: 4; C4xL1)

Facilities Services risks:

* 2539: Deterioration of the CCTV System leading to loss of functionality (RR 20; C4xL5)
* ~~2381: Scunthorpe Main Kitchen Dishwasher (risk rating: 16; C4xL4)~~ [Risk removed from RR, Mar 2020]
* 2613: Patient Sandwiches Provision (risk rating: 16; C4xL4)
* ~~2383: Hand Wash Sink Configuration SGH Kitchen (risk rating: 16; C4xL4)~~ [Risk removed from RR, Nov 20]
* ~~2481: Cleaning trolleys and equipment (risk rating 16; C4xL4)~~ [Risk removed from RR, May 2020]
* ~~2614: 1 x Pan Dishwasher (risk rating: 16; C4xL4)~~ [Risk removed from RR, Nov 20]
* ~~2547: Multi-cook regen oven (GDH) (risk rating: 16; C4xL4)~~ [Risk removed from RR, June 2020]
* 2635: Patient Beverage & Breakfast Trolley - x44 Units Trustwide (RR: 16; C4xL4)
* 2647: Sound shelter for hearing tests (risk rating: 16; C4xL4)
* ~~2636: Insecure Clinical Waste Bins (RR: 15; C3xL5)~~ [Risk removed from RR, Mar 2020]
* 1626: Asbestos management (risk rating: 10; C5xL2) [Risk rating INCREASED from 5 (C5xL1) to 10, Mar 2020]

Equipment risks:

* 2776: Ophthalmology Pentacam (RR: 12; C4xL3) [Risk rating reduced from 16 to 12, Nov 20]
* ~~2657: Replacement of x20 Endoscopy Patient Monitoring (RR:20; C5xL4)~~ [Risk removed from RR, Apr 2020]
* ~~2735: Patient samples storage fridge – Scunthorpe Microbiology Laboratory (risk rating: 20; C4xL5)~~ [Risk removed from RR, Sept 20]
* ~~2736: Fridge replacement - storage of reagents – Scunthorpe Microbiology Laboratory (risk rating: 20; C4xL5)~~ [Risk removed from RR, Sept 20]
* 2678: Sonosite S Nerve at end of life (RR:8; C4xL2) [Risk Rating reduced from 20 to 8, July 2020]
* 2825: Canon CF1 Digital Retina Fundus Camera not functioning (RR: 16; C4xL4)
* ~~2747: Replacement of Ultrasound Scanner in Special Procedures DPOW (RR: 16; C4xL4)~~ [Risk removed from RR, Oct 20]
* ~~2731: Vacuum Assisted Delivery Machine (risk rating: 16; C4xL4)~~ [Risk removed from RR, Sept 20]
* **NEW** 2842: Fields Machine SGH/GDH [Ophthalmology] (Risk rating: 16; C4xL4)
* **NEW** 2841: Nidek AR-310A Autofractor [Ophthalmology] (Risk rating: 16; C4xL4)
* 2621: Autoclaves (Microbiology) (risk rating: 12; C4xL3) [Risk rating reduced from 16 to 12, Sept 20]
* 2808: Lack of capital funding to support 2020-21 equipment replacement requirements for Clinical Sciences (RR: 16; C4xL4)
* 2285: Bed, Trolley, Couch Replacement Plan (risk rating: 12; C4xL3) [Risk rating reduced from 16 to 12, Nov 20]
* 2272: EHO Compliance with Ward Based Kitchen surfaces and storage areas (risk rating: 16; C4xL4)
* ~~2634: IOL Master- DPOW currently out of contract (risk rating: 16; C4xL3) [Risk reduced from 16 to 12]~~ [Risk removed from RR, Nov 20]
* 2836: Blood Transufsion Fridge (Scunthorpe) (RR: 12; C4xL3)
* 2837: Plasma Freezer (Boston) (RR: 12; C4xL3)
* 2835: Plasma Freezer (Lincoln) (RR: 12; C4xL3)
* 2619: Microscope Replacement (Cellular Pathology) (risk rating: 12; C4xL3) [Risk reduced from 16 to 12]
* 2498: OPT and Cephalostat dental x-ray machine (risk rating: 16; C4xL4)
* ~~2645: Replacement of 1 x Ultrasound Scanner at Goole (risk rating: 16; C4xL4)~~ [Risk removed from RR, Nov 20]
* 2644: Replacement of 1 x Ultrasound Scanner for Vascular (risk rating: 16; C4xL4)
* 2469: Replacement of Endoscopy's Lancer Drying Cabinet (risk rating: 9, C3xL3) [Risk rating reduced from 16 to 9, Sept 20]
* 2775: IOL Master Biometry Machine - Aging Equipment (RR: 16; C4xL4)
* 2781: Microbiology Risk of Analyser Failure (Abbott) (RR: 12; C3xL4) [Risk reduced from 16 to 12, Sept 20]
* 2774: Aging OCT Machines (RR: 15; C5xL3)
* 1907: Replacement of Pharmacy Robot (risk rating 16; C4xL4)
* 2679: Bladder scanners at end of life (RR:9; C3xL3) [Risk Rating Reduced from 15 to 9, Jan 2021]
* 2730: Patient Observation Monitor (risk rating: 10; C2xL5) [Risk reduced from 15 to 10, Oct 20]
* 2740: Aging and fragile equipment for sentinel node biopsy (risk rating: 15; C3xL5)
* ~~2373: Age & Vulnerability of DXC iLab (Apex / Pathology LIMS) (risk rating: 15; C5xL3)~~ [Risk removed from RR, Jul 20]

* ~~2680: MicroMaxx ultrasound - end of life (risk rating: 15; C3xL5)~~ [Risk removed from RR, July 2020]
* 2618: Microtome Cutting Station (Histology) (risk rating: 12; C3xL4) [Risk reduced from 15 to 12, Sept 20]
* **NEW** 2840: Cyclodiode Machine [Ophthalmology] (Risk rating: 9; C3xL3)
* ~~2660: Aging hysteroscopes (RR: 9; C3xL3)~~ [Risk removed from RR, Jan 2021]
* 2677: Cardiology Stress Test System (RR: 9; C3xL3)
* 2666: Extraction Cabinet - Scunthorpe Laboratory (RR: 15; C3xL5) [Risk rating INCREASED from 9 to 15, Nov 20]
* 2690: Osmometer Replacement [CSS, Pathology] (RR: 9; C3xL3)
* 2780: Field of BSV Perimeters not fully functioning (RR: 8; C2xL4)
* 2750: SGH CT scanner past end of 7 year life (RR: 9; C3xL3) [Risk rating INCREASED from 8 to 9, Sept 20]
* 2755: SGH MRI scanner past end of 7 year life (RR: 12; C4xL3) [Risk rating INCREASED from 8 to 12, Sept 20]
* ~~2664: Baby cots (RR: 8; C2xL4)~~ [Risk removed from RR, Sept 20]
* 2802: Balloon Pump out of Compliance - Cath Lab (RR: 6; C3xL2)
* 2665: Aging CTG Machines/Fetal Monitors (RR: 6; C3xL2)
* 2672: Paediatric ventillator (RR: 6; C3xL2)

Strategic Risk 7b: ESTATES SUSTAINABILITY: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

* All specialist engineering risk entered on the register are relevant to this risk
* 2429: Premises and engineering services (risk rating: 20; C5xL4)
* 2655: Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers [Scunthorpe General Hospital] (risk rating: 16; C4xL4)
* 2654: Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers [Goole District Hospital] (risk rating: 12; C4xL3)

Strategic Risk 7c: DIGITAL: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

(a) Cyber Security:

* 2463: Cyber Security Risk - (Windows 10 Implementation) (risk rating: 20; C5xL4) [Risk rating INCREASED from 15 (C5xL3) to 20, Mar 2020]
* ~~2461: Need for qualified IT Security Officer for Data Security Toolkit (RR: 20; C4xL5)~~ [Risk removed from RR, Jan 2021]
* 2710: COVID-19 Pandemic: Risk to IT Operations Service (Digital Services) (RR: 20; C4xL5)
* 2408: Data & Cyber Security: (2) Cyber Infrastructure [Risk One] (risk rating: 16; C4xL4)
* 2369: Unsupported software, hardware and applications (risk rating: 16; C4xL4) [Risk rating INCREASED from 12 (C3xL4) to 16, Mar 2020]
* 2753: Viewpoint fetal database need to upgrade system to be compatible with other systems in the Trust for sharing of patient data infl (RR: 16; C4xL4) [Risk Rating INCREASED from 9 to 16, Jan 2021]
* 2713: Annual Penetration Testing Delayed (risk rating: 12; C4xL3)
* 2409: Data & Cyber Security: (2) Cyber Infrastructure [Risk Two] (risk rating: 12; C4xL3)
* ~~2749: Impact of Vacancy Funding Removal (RR: 12; C4xL3)~~ [Risk removed from RR, Nov 20]
* 2574: IT Systems Asset Register Annual Review (RR: 12; C4xL3)
* 2805: Upgrading NX workstations to Windows 10 (RR: 9; C3xL3)
* 2336: Requirement for the Trust to implement 2 factor authentication (RR: 9; C3xL3)
* 2616: Trust smartphone management risk through lack of Mobile Device Management System (RR: 9; C3xL3)
* 1325: Data Security - H Drive (RR: 9; C3xL3)
* 2674: Cyber Security Vulnerabilities - WebV (risk rating: 6; C3xL2)
* 2702: Account Weaknesses in V2 of WebV (risk rating: 6; C3xL2)
* 2703: Cyber Security: Outdated JavaScript Libraries in WebV (risk rating: 6; C3xL2)
* 2335: Ability to respond to CareCert issues communicated to NLaG (risk rating: 6; C2xL3)
* 6: Risk of IT Equipment Failure due to inadequate Disaster Recovery (risk rating: 6; C3xL2)

(b) Risks of non-compliance with the Data Protection Act:

* 2676: Risk of non-compliance with the Data Protection Act 2018 due to the Trust not having sufficient resource and technical tools (RR: 20; C5xL4) [Risk rating amended, N
* ~~2376: The risk of breaching the Data Protection Regulation re. reporting serious data protection incidents to the Information Commissioners Office (ICO) (RR: 12; C4xL3)~~ [Risk removed from RR, Apr 2020]
* 2296: Risk that Trust does not have a full understanding of the partners it shares information with. IG 207 (RR: 12; C3xL4)
* 2299: Risk that information assets not developed and implemented in a secure, structured manner and comply with IG security accredited (RR: 12; C3xL4)
* 2287: Ensuring sufficient IG Awareness and achieving required levels in mandatory training (RR: 9; C3xL3)
* 2295: Lack of Trust capability to monitor and audit staff access to confidential personal info to the SIRO. IG 206 305 (RR: 12; C4xL3) [Risk rating INCREASED from 9 to 12, N
* ~~2084: Management of A&E Notes inc Scanning; Destruction and Forwarding of paper records (risk rating: 8; C2xL4)~~ [Risk removed from RR, Nov 20]
* 2300: Insufficient processes in place to ensure records management /quality against national guidance (risk rating: 16; C4xL4) [Risk rating INCREASED from 8 to 16, Nov 20
* **NEW** 2850: Information Governance Risk from Quality Assurance Team Working Remotely (Risk rating: 9; C3xL3)
* 2795: Transmission of COVID-19 Antibody results by email (RR: 6; C2xL3)
* ~~2288: Risk of IG Breaches Across the Trust (RR:9; C3xL3)~~ [Risk removed from RR, May 2020]
* 2714: Off Site Mortality Case Note Review (risk rating: 6; C3xL2)
* 2737: Potential viewing of reports unaudited (risk rating: 6; C3xL2)
* ~~2803: Swabbing - Risk of Data Breach (RR: 8; C4xL2)~~ [Risk removed from RR, Jan 2021]

(c) Shortage of IT Equipment:

* 2433: Switchboard (Management of on-call rotas for hospital services) (RR: 12; C4xL3) [Risk rating reduced from 20 to 12, Nov 20]
* 2675: The IT Operations Department require a comprehensive IT Service Management System (risk rating: 15; C3xL5)
* 2109: Microsoft License Audit (RR: 12; C3xL4)
* 2778: Insufficent data for agile devices (C&T) (RR: 12; C4xL3)
* 2315: Switchboard Operator Console Function (risk rating: 9; C3xL3)
* 2195: Switchboard/Hub/Bleep Directory Names (risk rating: 6; C2xL3)
* 2215: Effective management of 2222 and 3333 calls (risk rating: 5; C5xL1)

(d) Strategic Direction:

* 2440: Development of the Digital 2020 Strategy (risk rating: 9; C3xL3)
* ~~2483: Reprographic Services (risk rating: 6; C3xL2)~~ [Risk removed from RR, Nov 20]

e) WebV

* 2495: WebV Server Warranty Renewal (risk rating: 16; C4xL4)
* 2617: Risk of not implementing electronic requesting in cardiology (risk rating: 16; C4xL4) [Risk rating REDUCED from 20 (C4xL5) to 16, May 2020]

* 2504: Discharge Summaries only reaching 75% (risk rating: 9; C3xL3) [Risk rating reduced from 15 to 9, Nov 20]
* 2738: Delay in Radiology Requesting Roll Out (risk rating: 9; C3xL3)
* 2496: WebV Interfaces (risk rating: 9; C3xL3)
* 2514: Patient Matching Criteria within Systems (risk rating: 9; C3xL3)
* 2458: Risk of WebV not being compliant with CE regulatory requirements (risk rating: 6; C3xL2)
* 2702: Account Weaknesses in V2 of WebV (risk rating: 6; C3xL2)
* 2459: WebV legacy codes (risk rating: 4; C2xL2)

(e) Trust's PAS and data Quality:

* 2515: Accuracy of Data of Business Decision Making (risk rating: 15; C5xL3) [Risk rating reduced from 20 to 15, Sept 20]
* 2615: Duplicate and merged digital patient records on various Trust' Health IT systems (RR: 12; C3xL4)
* 2799: Odyssey provision in Single Point of Access (SPA) (RR: 12; C3xL4)
* 2796: Website Accessibility (RR: 12; C3xL4)
* 2227: A&E System Implementation (risk rating: 6; C3xL2)
* 2441: NHS Accessible Information Standard (risk rating: 4; C2xL2)
* 2501: Delay in outpatient summary letters reaching recipient < 7 days (RR: 12; C3xL4) [Risk Rating INCREASED from 8 to 12, Oct 20]
* ~~2662: Duplication of Hospital Numbers (CMIS) [Maternity] (risk rating: 4; C4xL1) [Risk Rating reduced from 12 to 4, Apr 2020]~~ [Risk removed from RR, July 2020]
* 2516: Delays sending letter incorrect functioning of the Dictate IT system (RR: 10; C5xL2)
* 2224: Enterprise Imaging (PACS Replacement) - Management Service and Implementation (risk rating: 3; C3xL1)

Strategic Risk 8: STRATEGY: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

* Strategic Risk 10: Stakeholders

Strategic Risk 9: CLINICAL STRATEGY: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

* ~~2563: Lack of divisional strategy [Medicine] (RR: 9; C3xL3)~~ [Risk removed from RR, Jan 2021]
* 2565: Surgical Division 5 Year Strategy (RR: 8; C4xL2) [Risk rating reduced from 12 to 8, Sept 20]
* ~~2578: Risk of not having an agreed W&C division 5 year strategy (RR: 9; C3xL3)~~ [Risk removed from RR, July 2020]
* Strategic Risk 11: Leadership

Strategic Risk 10: STAKEHOLDERS: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

* There are no linked corporate or high level risks that underpin this strategic risk.

Strategic Risk 11: LEADERSHIP: Linked Corporate or High Level Risks that underpin this STRATEGIC RISK:

* Strategic Risk 9: Clinical Strategy
* Strategic Risk 8: Organisational Strategy

NLG(21)031

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

DATE	2 February 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Kate Wood, Medical Director
CONTACT OFFICER	Angie Legge, Associate Director for Quality Governance Jenny Hinchliffe, Deputy Chief Nurse Jackie France, Head of Patient Administration Dawn Harper, Deputy Chief Nurse Denise Gale, Associate Director for Cancer Lucy Kent, Associate Director for Compliance Abdi Abolfazi, Divisional General Manager Matt Overton, Assistant Divisional General Manager Maurice Madeo, Assistant Director for Infection Prevention Ivan Pannell, Head of Procurement Jeremy Daws, Head of Quality Assurance Helen Turner, Head of Nursing for Community Kelly Burcham, Head of Risk Jane Warner, Head of Midwifery Lynn Benefer, Interim Head of Safeguarding Debbie Bagley, Interim Head of Nursing for Surgery
SUBJECT	Patient Impacts Paper
BACKGROUND DOCUMENT	None
PURPOSE OF REPORT	The report outlines key areas of clinical risk and the mitigation steps during the Covid-19 pandemic.
OTHER GROUPS WHO HAVE CONSIDERED PAPER AND OUTCOME	Quality & Safety Committee
EXECUTIVE SUMMARY	The executive summary of the full report is provided over on page two. Key issues to note or, where relevant, the author of the report wishes to escalate concerns to the committee, are included within the 'Executive Comment' section below.

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

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

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

BOARD ASSURANCE FRAMEWORK	This links to the Quality Risk

TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: note the key risks identified and mitigation work, noting that the most significant risks at present are staffing and the waiting lists.

Executive Summary

This paper outlines the key issues relating to clinical risk / harm, and the mitigating actions, with significant pressures relating to Covid-19. The areas considered are:

Staffing
Daily Deputy Chief Nurse/Head of Nursing led staffing review meetings continue. This reviews SafeCare data enabling a review of patient acuity and dependency against staff availability. Staffing remains a daily challenge due to sickness, self-isolation. A number of actions are in place to support staff wellbeing with both onsite and virtual services utilised. Work is underway to bring in overseas nurses to augment staffing.

Waiting Lists:
Risk Stratification of the Out-Patient waiting list poses an increased challenge in Wave 2. The Trust has secured funds from NHSEI to engage with GP's to risk stratify patients within Medicine Patients last reviewed in June will require a re-review . Responses are awaited from the validation letter to understand patient's future intentions in regards to the waiting list. Elective work continues to be delivered at St Hughes and Goole, prioritising patients risk stratified as Priority 2.

Cancer
Performance in 2ww recovered in December but cancers diagnosed have continued to be significantly lower than last year with cancers diagnosed via emergency admission continuing to be higher. Cancer Surgery is significantly reduced through the last 3 months due to Wave 2. Work is underway to mitigate the drop in surgical performance, using St Hugh's for cancer surgery.

Complaints
The new Complaint process went live on 2 November with divisional ownership, this will be at risk during Wave 2 due to clinical pressures. The central team are concentrating on closing older complaints by 28th February 2021. There has been a significant rise in PALS due to difficulties in communicating with wards. A case is being made for Patient Liaison Officers to support this.

CQC Actions
Risk of slowing action delivery and evidence due to the Wave 2 impact on the frontline. The central team are endeavouring to source evidence to support and meetings continue with reduced attendance. Covid has affected the achievement of mandatory training targets.

IPC including Outbreaks:
There is a risk of Covid-19 outbreaks on wards; these are subject to an IPC RCA. Work continues to increase single room availability to reduce the risk, this has been supported by the arrival of redirooms and Cubi screens.

Lateral Flow Testing
Lateral Flow testing has been rolled out and feedback from staff has been positive.

PPE:
There are currently no supply concerns with PPE.

Sepsis
Poor compliance in regard to electronic sepsis screening. Agreed plan for sepsis icon on Web V to highlight requirement for Sepsis screening and monitoring. Virtual training currently in place for Sepsis screening and new sepsis icon. CNS working closely with clinical sisters on roll out of education on the wards. Identified individual currently undertaking retrospective audit on Sepsis to provide assurance.

12Hour Breaches
12 hour breaches significantly increased as patient numbers with Covid in Wave 2 increased. A number of initiatives, including discharge to assess, were undertaken to try to improve flow and reduce 12 hour breaches.

Black Ambulance Breaches
Black Ambulance Breaches in December reflected the greater pressure on SGH than DPoWH. A new handover process was implemented on 9th December 2020 to improve efficiency and clinical safety.

Mortality
The key aim to be within 'as expected' on SHMI has been achieved, with the Trust currently at 105.4. Revised Quality of Care screening has been rolled out. The key is to maintain the improvements in coding co-morbidities following the conclusion of the Grant Thornton work.

End of Life
End of Life improvement work is continuing via the Steering Group and the draft strategy is out for consultation. Concerns that some projects, such as: the training, launch of the pain assessment tool, use of the last days of life document and divisional engagement in the Steering Group, have been affected by Covid pressures. Mitigations are in place to reduce the impact.

Maternity
The Trust has reviewed the Ockenden report into the maternity concerns at the Shrewsbury and Telford Trust, and reviewed the recommendations. Work has commenced to address gaps in assurance.

Serious Incidents
The second wave has impacted on the ability to complete Serious Incident investigations in a timely way. Key investigations have been identified for prioritisation.

Safeguarding
Mortality in those with Learning Disabilities has increased, although this appears to be in line with the increase in mortality due to Covid-19 as a whole.
Work is ongoing to maintain training via online courses, with some face to face sessions being planned for level 3 compliance.
The Local Authority have not been sending staff into the Trust which creates risk to assessments being completed fully.

PURPOSE

This paper, written on behalf of the Medical Director and Chief Nurse, outlines the key issues relating to clinical risk / harm, and the mitigating actions, with significant pressures relating to Covid-19. The areas considered are:

• Staffing	• Waiting Lists	• Cancer
• Complaints	• CQC actions	• IPC & Outbreaks
• Lateral Flow Testing	• PPE	• Sepsis
• 12 hour breaches	• Black Ambulance Breaches	• Mortality
• End of Life	• Maternity	• Serious Incidents
• Safeguarding	•	•

Prior to the Covid-19 Pandemic, the Trust had a plan in place to improve quality and safety in a number of areas. Given the challenges of the pandemic, this report pulls together the key areas of concern both prior to and arising during the pandemic which impact on the quality and safety of our care to our patients.

The new areas included this month are sepsis and Safeguarding.

STAFFING

The Trust bed base needs to support management of outbreak principles where the outbreak is contained in the smallest possible footprint and is scalable whilst minimising risk of cross infection. The staffing for these areas has been reviewed and set by the Chief Nurse as wards are reconfigured to meet the changing needs of Covid admissions. Safe Care Live is in place to record and manage nurse staffing levels and is utilised daily as a tool to provide oversight and aid decisions about deployment of staff to support the delivery of safe care.

As the availability of staff has been affected by Covid, minimum acceptable nurse staffing levels have been determined to support decision making out of hours, however work continues to fill shifts to established levels.

Risk	Mitigation
Safe care of patients on the in-patient wards as the availability of staff decreases – in excess of the sickness target level of 4.1% due to the requirements for staff to self-isolate if they test positive or if alerted through the Track and Trace system. This is likely to increase as lateral flow testing is introduced.	Safe Care Live provides information regarding patient acuity, dependency and staffing in real time to support decision making regarding deployment of staff to maintain patient safety. Daily safe staffing meeting supported by the Deputy Chief Nurse and staffing reviewed at 3 times daily operations meetings. Morning huddle by Matron with shift leaders to review staffing and enact redeployment. Retraining for staff who can be redeployed to clinical areas and deployment managed by the Workforce Resource Centre. Use of bank staff with 20% incentive scheme. Use of agency staff with revised tier and authorisation

	framework. Forward review of rosters with early escalation. Super Surge Plan in place. IPC practices to reduce risk of transmission at work. Health and wellbeing support for staff 40 international nurses have joined the Trust since October 2020 and will sit their OSCE in January 2021 to gain their NMC registration. Planning is underway for an additional 40 overseas nurses to join the trust before the end of March with the support of funding received from NHSE. Recruitment underway with the aim of reaching or being close to zero HCSW vacancies by the end of March 2021. Funding received from NHSE to support this work and will involve enhanced onboarding programmes.
Safe care of patients requiring ventilation (Critical Care)	1:1 plus 1 buddy levels in Critical care 2 hour breaks for staff to change PPE Redeployment of theatre staff to ITU. Training for redeployed staff Critical Care Matron just focused on critical care Psychological care for Critical Care staff
Staff stress due to pressures of Covid-19	MH Lead Nurse availability to wards to provide support Care for Each Other Hub site NAVIGO practitioner to support staff Clinical Psychologist sessions available for staff Wobble rooms Vivup and Headspace apps available to all staff 24 hour staff helplines Mindfulness sessions available Remploy support Professional Voice email address introduced by the Chief Nurse to allow staff to raise concerns and share ideas.

WAITING LISTS*

A trajectory of improvement had been in place for waiting lists prior to Covid-19, to deliver on 3 key targets by March 2021.

Target	**Current Position on 31 October 2020**
Overall RTT waiting list not to exceed 23,000	27268 patients on the RTT incomplete waiting list (↓by 410)
No 78 week target	7 patients waiting in excess of 78w (improvement of 4 patients)
No patients waiting in excess of 52w for treatment	648 waiting in excess of 52w (↓ by 172)
No patients waiting in excess of 40w for treatment	3093 waiting in excess of 40w (↓ by 548)
Maximum of 9000 patients on the Out-Patient follow-up waiting list	29716 patients on the Out-Patient Follow-up waiting list (↓15257)

Mitigation

Each specialty has a plan on a page detailing individual trajectories and targets to improve the waiting list position, this includes narrative of; the current position, potential issues, plans to recover and any required escalations.

From Sept to Nov the performance against plan was as follows;

Activity	**Actual Performance v Plan**
Daycases	68%
In-Patients	90%
Out-Patients	95%
Overall	92%

Patients are being transferred to St Hughes for treatment under the Independent Sector Providers contract, and internal funding has been secured to enable Medicine specialties to insource resource to help with their RTT and Overdue Outpatients.

Referrals remain steady with 9418 received in November reduced from 12,552 received in November 2019.

Virtual clinics have continued to operate, which is helping to deliver the recovery plan. In November 14,620 patients were seen virtually compared to1,177 in November 2019, this is about 47% of the overall Out-Patient attendances..

In December, as planned and in line with the national clinical validation programme, approx.2,200 patients on the elective inpatient list were written to establish their treatment intention. There has been a good response to this letter, and the waiting lists are being updated to reflect patient's wishes.

96% of patients on the elective inpatient waiting list have been risk stratified, although 15% were done pre 1st June, so will require re-risk stratifying. This work will commence once the waiting lists have been updated with patients wishes as described above.

The Out-Patient Waiting List still presents the biggest challenge and the number of patients overdue continues to increase. Only a very small % of these patients have been risk stratified. We have secured some funding which will enable us to work with GP's over the coming 3 months to review patients on the overdue list in the medicine specialties, with a view to manage these in primary care, or risk stratify where they remain on NLAG waiting list.

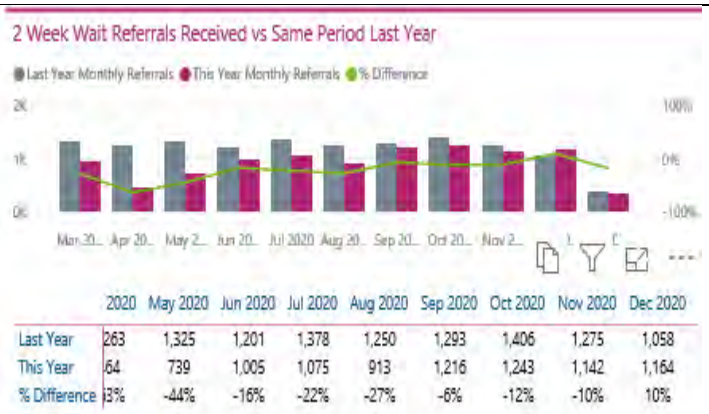
Assessment

Area	Risk	Mitigation
Radiology	CT colon capacity remains a risk across both sites	CT colon waiting list has been risk stratified. Capacity being flexed as much as possible – plans being worked up for Jan/Feb when new scanner is live.
	Shortfall in core capacity to accommodate all urgent, routine and follow up patients in CT and MRI within desired timescales.	Additional vans from NHSEI and independent sector capacity being utilised to minimize impact
	Independent sector central contract has been extended into the new year	Work continues with contracting team to ensure contracts in place to continue additional capacity
	Lack of capacity to undertake risk stratification / clinical harm on entire diagnostic waiting list	Using agreed referral priority Awaiting feedback from central waiting list validation team for next steps.
Endoscopy	Delays in Endoscopy impact diagnostics and therefore waiting lists, particularly in cancer.	79% activity levels achieved during November 2020 compared with Nov 2019 – reduced scoping capacity due to social distancing constraints & clinicians being redeployed to ward areas. Cancer diagnostics continuing as priority
Clinical Sciences	Gap in SMT cover for Clinical Sciences until new GM in post	Recruitment in progress, start date for GM 5/1/21 Cross cover being provided by the team

CANCER*

The key risks for Cancer during COVID-19 for NLAG are as follows:

Risk	Mitigation
2ww referrals: 2ww referrals fell by 70% during Phase 1 of the pandemic. Since July 20, 2ww recovery to end Sept reached 94%^ (in line with Phase 3 recovery trajectory). This fell to 90% (end Nov) but has recovered to +10% (110%) in December.	Primary Care are aware of the position compared to pre-covid levels. There is a national campaign encouraging patients to attend their GP if experiencing symptoms which could indicate cancer.



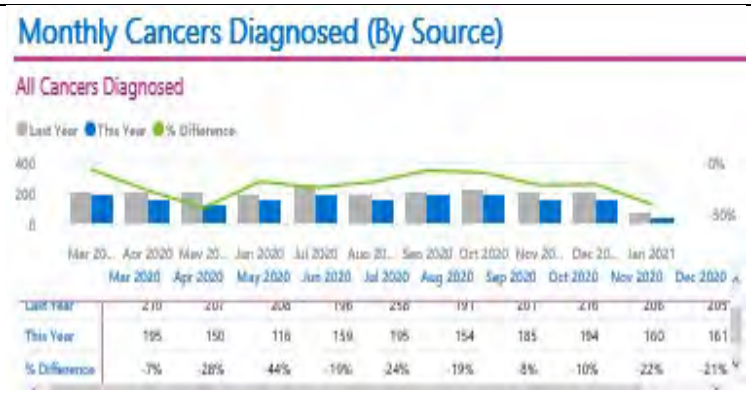
	2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Last Year	263	1,325	1,201	1,378	1,250	1,293	1,406	1,275	1,058
This Year	64	739	1,005	1,075	913	1,216	1,243	1,142	1,164
% Difference	-3%	-44%	-16%	-22%	-27%	-6%	-12%	-10%	10%

Diagnostics:

Cancers Diagnosed :
The volume of cancers diagnosed during the 1st wave of the pandemic was significantly reduced as a result of the reduction in 2ww referrals (-70%).

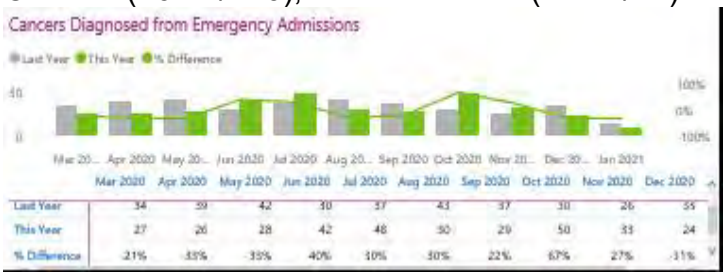
All Cancers diagnosed: The number of cancers diagnosed has declined in November (-22%) and December (-21%).

The peak in cancers diagnosed via emergency admissions was approx. 10% higher than the same month(s) in 2019. Those diagnosed via emergency admissions in 2020 had a high mortality rate (circa 48%), and were predominantly late stage (Stage 3 or 4) cancers



	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
This Year	195	150	116	159	195	154	185	184	160	161
% Difference	-7%	-28%	-44%	-19%	-24%	-19%	-8%	-10%	-22%	-21%

Cancers diagnosed from emergency admissions – the Trust saw a spike in June/July and again in October (+67%/+20), and November (+27%/+7).



	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
This Year	27	26	28	42	48	50	29	50	33	24
% Difference	-21%	-35%	-35%	-40%	-10%	-30%	-22%	67%	27%	-31%

The analysis has been shared internally and with North & North East Lincs CCGs via the Primary / Secondary care interface group. Further work to be agreed with primary care once the relevant PCNs have looked into the patients within their practices. This is being regularly monitored through the COVID-19 cancer impact Power BI report/PRIM.

Treatment

Surgery
Cancer Treatments (Drugs).
Some chemotherapy is given for palliative care/symptom control.

Surgery has been affected by Wave 2 of the pandemic and the need to cancel elective surgery during the first 2 weeks

All Cancer treatments (combined) : this had achieved 100% of pre-COVID levels at end September but reduced to -32% October, -16% November and -22% December.

of November. This has led to a decrease in recovery.

Surgery : At end Sept surgery (NLAG/tertiary) achieved 100% of pre-COVID levels. The position however deteriorated during October (-34%) and November (-59%). There has been some recovery in December to -48% of pre-covid levels.

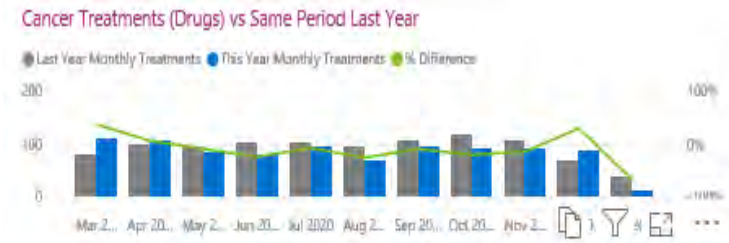
Drugs : this includes systemic anti-cancer therapy (SACT – chemotherapy), hormone therapy, and other drug regimens. At end Sept this achieved 92% of pre-COVID levels, but reduced to -20% (October), -14% (November) but recovered to +29% (129%) in December

	pr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Last Year	230	233	236	228	229	236	243	246	221
This Year	235	171	191	226	191	236	205	168	171
% Difference	2.2%	-26.6%	-19.1%	-0.9%	-16.6%	0.0%	-15.6%	-31.7%	-22.6%

Surgery : All elective surgery is risk stratified in line with national surgical guidance (this includes cancer patients). The Cancer Alliance are working with the ICS to ensure mutual aid, and are looking to establish an elective (diagnostic and surgical) hub within the region. The Trust is maximizing its use of GDH and St. Hughs Hospital to minimize cancellation of cancer surgery (unless a patient tests positive for COVID or is self isolating).

	r 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Last Year	78	79	83	78	89	78	79	95	92
This Year	54	41	64	72	70	78	52	39	48
% Difference	-30.8%	-48.1%	-22.9%	-7.7%	-21.3%	0.0%	-34.2%	-58.9%	-47.8%

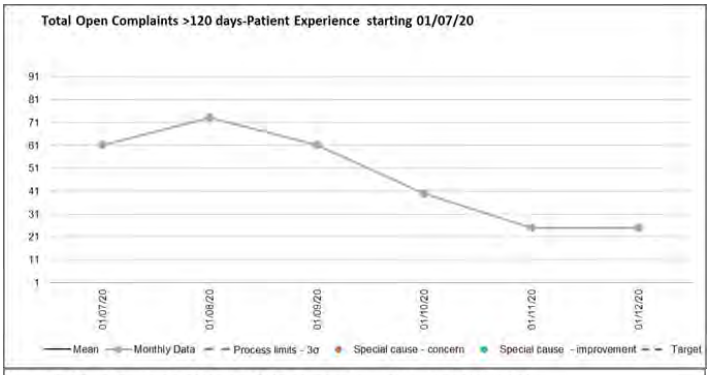
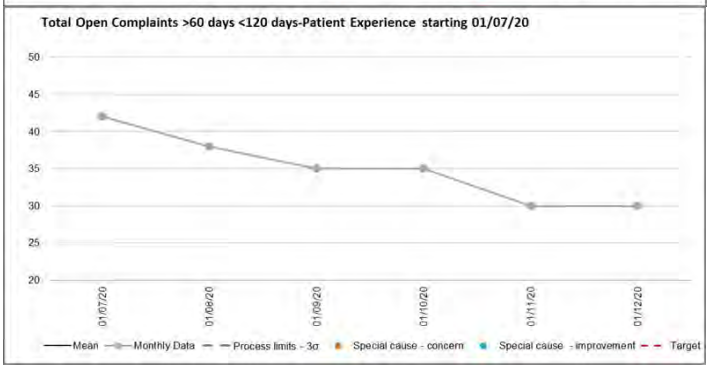
Cancer treatments (Drugs) :: There is a joint oncology working group between HUTH/NLAG to maximise the consultant oncology resource despite extensive sickness/vacancy factor. HUTH is looking to recruit locum(s) to work at NLAG. A joint oncology waiting times report is being developed to ensure transparency of waiting times for 1st oncology appointment.

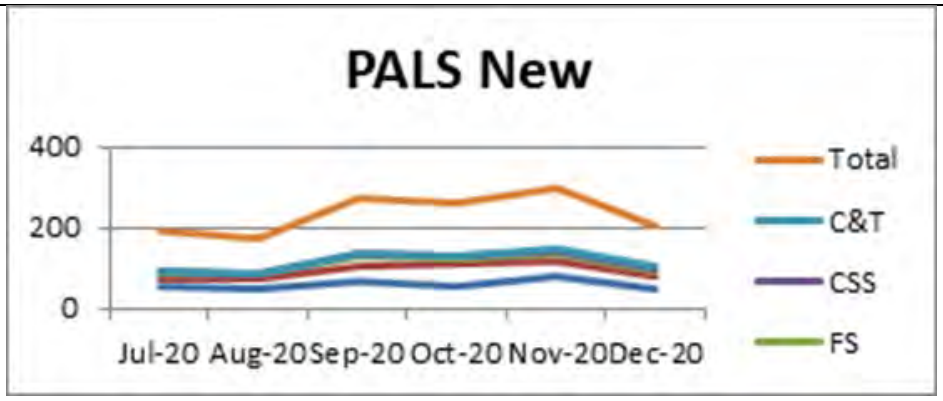


	2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Last Year	101	94	104	103	94	107	117	106	68
This Year	107	85	79	95	70	97	93	91	88
% Difference	5.9%	-9.6%	-24.0%	-7.8%	-25.5%	-9.3%	-20.5%	-14.2%	29.4%

COMPLAINTS*

The aim is for 85% of good quality responses to be sent to the complainant within 60 days. All old process complaints to be closed by February 28th 2021. The new complaint process went live from 2nd November.

Risk	Mitigation
Timescales for complaints responses will increase due to clinical staff having reduced capacity.	Increased resource in central complaints team to focus on old process complaint closures. Weekly monitoring through Complaints Support and Challenge Meeting of longest open complaints and all new process complaints. Plan for individual complaints greater than 120 days and progress continues as seen below   Reviewed the escalation process (detailed in new policy). Senior Nurse involvement in clinical validation of information to support process. Dedicated Project Manager providing additional support in divisions whenever necessary.
Increase in new complaints which may impact on capacity to manage caseloads effectively given increased volume	Use of electronic caseload tool to identify risks at facilitator level and assign appropriate actions Use of new complaints process to manage these within timescale by ensuring constant movement through process Monitoring of complaint numbers through Pals & Complaints Manager daily Tracking , weekly Support and Challenge meeting and monthly reporting

PALS concerns are increasing related to communication and connectivity. Relatives are unable to access information due to restricted visiting and reduced staffing capacity.	 A significant rise in Pals concerns since July demonstrates the challenges placed on communication between clinical staff and families. In mitigation a helpline was established and publicized through the website to help families to connect and seek information when normal channels are not successful. The aim has been to staff the helpline with redeployment of non-clinical staff however, this has not been sustainable. Instead a Patient Liaison role is being requested via Covid support fund to open communication channels across the inpatient wards.

CQC ACTIONS

Priority areas from the CQC Improvement plan are discussed elsewhere in this document, in those topics marked with an asterisk (*).

The Trust on 26th October undertook Urgent and Emergency Care Provider Collaboration review with the CQC, based on the Patient First guidance published in October 2020. No feedback is expected from the session but the responses feed into an app which will help inform when the next inspection will occur. The CQC continue to join the Divisional meetings

Overall summary of progress with CQC actions

	Sept	October	November	December	Jan	Change
Number of actions	143	144	144	120	115	↓
Blue	4.9% (7)	11% (16)	15.3% (22)	11.6% (14)	9.6 % (11)	↓
Green	47.5% (68)	45% (65)	40.3% (58)	62.5% (75)	68.7% (79)	↑
Amber	17.5% (25)	15% (22)	11.1% (16)	5.0 % (6)	3.5 % (4)	↓
Red	28.0% (40)	26% (38)	31.9 % (46)	20.8%(25)	18.2% (21)	↓
Need update	0.7% (1)	0.7% (1)	0%	0%	0%	=
On hold	1.4% (2)	1.4 % (2)	1.4% (2)	0%	1%	↑

All plans have been refreshed and are in the process of being signed off within the DivisionsMonth Actions have been combined or if signed off in the previous month removed. This allows more focus on the work remaining. The action plans are becoming more streamlined. In addition, more sub-actions have been added to help

achievement of the overall action and timescales refreshed to reflect the second wave of COVID 19. What is emerging is that the areas that are red are the difficult to maintain actions which dip in times of increased demand or staff sickness and annual leave such as Mandatory training, areas that have been impacted by COVID such as performance activity or others where transformational change or additional resources are required to meet the standards. In the latter case position papers are being written to detail the mitigatory actions and any proposed plans to work differently.

Risk	Mitigation
Delay in completing actions due to operational challenges	Maintaining Divisional meetings with reduced attendance Divisions continuing with Divisional Governance meetings
Delay in sign off and submission to CQC due to operational pressures and establishing a new process. Documents sent to the CQC which do not provide assurance.	Providing additional support to the Divisions to complete assurance templates Establishing a robust system which allows executive oversight and robust information to be submitted to the CQC First documents have been shared with the CQC awaiting feedback.

IPC including Outbreaks

The aim is to minimise the risk of cross infection within Trust premises. So far the Trust has had 14 ward closures due to COVID-19 over the course of the last 3 months. Many of the issues identified suggests asymptomatic staff, detection of COVID on day 6 which would mean other patients will be exposed and classed as contacts, as a result many then went on to develop COVID. There were also some issues with PPE compliance and DATIX have been submitted to highlight repeat offenders.

Risk	Mitigation
COVID outbreaks risk will occur due to poor infrastructure, surge of admissions and laboratory turn-around time and asymptomatic staff. In December new variants of the Coronavirus were identified that are believed to be 70% more transmissible,	Following national guidance in relation to Covid-19 Companies were asked to review the feasibility of erecting additional single rooms / PODS. These won't be in place until January 2021 at the earliest and likely a phased approach; as a result an alternative approach has been adopted. The Trust now has x30 Redirooms to act as additional isolation capacity to nurse yellow and Red patients and x30 Cubiscreen, (a plastic curtain that will provide a shield between patients and especially useful where Redirooms cannot be used due to space restrictions e.g. HASU). The lateral flow testing is up and running with over 4500 kits distributed. Currently a low positive prevalence of approx. 1-3%. This testing should help to reduce the impact of asymptomatic staff spread although the uptake is variable within patient facing staff. The Trust is following the 10 key actions document released on 17th November and has introduced day 3

	swabbing. There have been some technical issues with the WebV flags, This has now largely been resolved giving staff a daily list of patients requiring a reswab.
Given the surge of patients and movement from ECC to IAAU and then short stay a patient could have 3 moves before results are available which will impact on containment	The use of Redirooms will help to mitigate some of this risk but not remove it completely. Currently the reported HCAI rate for COVID patients is around 22% which is higher than it should be. This may in part be due to the changing epidemiology of COVID and also second wave surge. The day 3 reswab once fully embedded will also help to pick up new cases much earlier in the patient journey.

Lateral Flow Testing

The aim of this national programme is to test all patient-facing staff twice weekly for SARS CoV-2. Participation in this screening process is not compulsory but we are encouraging all eligible staff to participate. Any staff member who has tested positive by PCR will NOT need to perform the LFDs for a period of 90 days after their positive PCR. This is because the LFD may give a false positive result resulting in unnecessary further testing and self-isolation for you and your household.

Progress to date (12/01/2021)
Total test kits distributed: 4807
Total results returned: 17864
Positive returns: 151
Negative return: 17713

Risk	**Mitigation**
The trusts runs out of tests are unable to order more.	An ordering schedule is in place with the supply chain however the Trust is limited by the national supply of tests.
Staff have kit but are not registered on result processing system or input the results incorrectly	Results processed those not registered to a user still enter the database and are followed up. Text message reminder has been sent out to staff yet to submit a result. Database flags up any positive results that have been inputted incorrectly to ensure picked up.
Staff receive False positive	All positive result are followed up with PCR test – automated system informs line manager and swab team at time result inputted to ensure no delay in arranging PCR test. LFT lead also receives notification of result to confirm system working correctly.
Staff receive False negative	They will be testing twice weekly and regular before work. PPE/cross infection rules have not changed and staff still expected to adhere to government guidance on social distancing. Self-testing is extra precaution in ensuring limiting spread of Codid-19 on top of existing measures in place.
Staff receive inconclusive result	After 2 inconclusive results staff must contact the Self testing team for further instruction. Further demonstration on self-administering test may be required.
Staff stop using testing	Data monitored any staff that stop using kit who have not

kit	had positive PCR will be followed up by self-testing team.
Staff loose/damage testing kits	Staff who stop using kit who do not have positive results will be followed up, Damaged lost kits will be investigated further to assess reasoning for this. Replacements issued stock depending and when possible misuse determined.
Staff do not choose to take part	It is not compulsory, although we encourage and recommend, Stock permitting staff can opt in at any time. PPE/cross infection rules have not changed and expectation remains to adhere to social distancing.
The Trust will not achieve 100% participation in lateral flow testing of those who do not qualify for exclusions.	Communication continues to encourage all staff to participate
More staff will be absent due to false positives	Those testing positive self isolate immediately but are then sent for PCR tests. This will reduce absenteeism due to contact with Covid positive patients or individuals

PPE

The overall aim has been to ensure adequate and resilient supply of the necessary items of PPE across all sites and for all individual staff requirements, with the capacity to respond to fluctuations in demand driven by different factors, e.g. new guidance or changes in patient numbers.

Risk	**Mitigation**
Availability of key PPE products nationally has been placed under extreme pressure due to the nature of the pandemic	Availability of key products has improved significantly, helped by a move towards manufacturing and supply being more UK focused as well as an increased capacity in production of PPE globally. National distribution has become more sophisticated and is able to respond effectively to daily usage rates to deliver PPE in the necessary quantities. This 'Managed Inventory System' works on information provided by all Trusts on a daily basis. Its aims to provide an even approach to deliveries and provide buffer stocks to minimise the risk of critically low levels, which were regular features in Wave 1.. NLAG continues to play an active role within the STP PPE group which meets remotely thrice weekly to offer mutual aid on PPE stock where required. This enables the Trust to receive urgent supplies as required.. As a Trust we have moved to reusable respirators to help reduce usage on single use FFP3 masks. This has been a priority for RED areas. However due to the IAAU project and ward moves this has resulted in a loss of momentum and staff that were previously fit tested with these masks are no longer working in the same location.

Sepsis

The overall aim of the Trust is to recognise the deteriorating patient with Sepsis with appropriate management of the patient. The Trust Standard target is:

- 85% for patients to receive Sepsis Screening every 24 hours when they meet the above NEWS parameters.
- Patients screened positive for sepsis should be managed using the sepsis 6 bundle and all required treatments within one hour

Two Projects in progress within the Trust to lead on the improvement work:

1. 85% patients with a NEWS Score >5 (or 3 in any one single parameter) to have Sepsis Screening undertaken
2. 85% patients with a NEWS score >7 to have Sepsis screening undertaken

Plan was to have increase in completion of sepsis screening by 50% by December 2020 but unfortunately this has not been achieved, current plan to achieve 90% by end of March 2021. Plan to roll out an updated version of the electronic Sepsis tool on WEBV December 14th 2020; delayed due to a technical issue.

Risk	**Mitigation**
Lack of recognition of a deteriorating patient with Sepsis/patient harm	Project group for deteriorating patient and Sepsis. Clinical Nurse Specialist Lead for Sepsis – links in with all clinical sisters on wards. Early Warning Score (NEWS) enabling early identification and prioritisation of patients at risk of deterioration. Embedded escalation to Critical Outreach to ensure the appropriate action is taken in response to the NEWS score. Compliance September 2020 at 91.29% for recording NEWS; a continual increase since December 2019. Electronic Sepsis tool to be used to monitor patients and the requirement to be rescreened every 24 hours if the NEWS is greater than 5 (or 3 in any one parameter). Electronic training module for all medical and nursing staff • Sepsis awareness compliance (Community) 95% • Sepsis training compliance (Acute) 75%
Lack of compliance to the completing the electronic sepsis screen Below demonstrates the compliance September 2020	Manual audit undertaken June 2020 demonstrated 45% of patients had sepsis screen. Virtual training on New Electronic Sepsis tool rolled for all clinical staff

Sepsis Document Monthly

	Sep 2020
Number Of Sepsis Documents Created	3,398
Documents Complete	174
Documents Complete %	5.12%
Documents Abandoned	3,223
Documents Abandoned %	94.85%
Document Trigger To Time Complete Breaches	2
Document Trigger To Time Complete Breaches %	0.06%
Amber Moderate Risk Factors	14
Amber Moderate Risk Factors %	0.41%
Red High Risk Factors	25
Red High Risk Factors %	0.74%
Sepsis Six Pathway To Be Commenced	25
Sepsis Six Pathway To Be Commenced	0.74%
Sepsis Six Pathway Commenced	8
Sepsis Six Pathway Commenced %	32.00%

Impact of the Summary Hospital Level Mortality Indication (SHMI) data suggests sepsis increased the mortality position.	Project group leading on work on Sepsis All patient who have died have a structured judgment review – gaps identified and escalated if appropriate Mortality and Morbidity meetings within all specialties Trust wide Mortality Improvement group monitors all Mortality performance
Further delay in roll out in electronic Sepsis Tool	Approval for Electronic version has been agreed Working closely with WEBV team to establish a further time frame

12 Hour Breaches

The overall aim is to have zero 12 hour trolley breaches within the Trust. 12 hour breaches are when a patient within the Emergency Department has had a decision to admit made and accepted by the relevant specialty but there is a delay of 12 hours or more for a bed to be made available for their admission. There were 27 declared DTA breaches in December 2020 (DPOWH: 13, SGH:14). Validation has shown that continuing care was provided to patients during their prolonged stay within the Emergency Department. An apology is provided to the patients at the time of their breach by the senior clinical staff in the department.

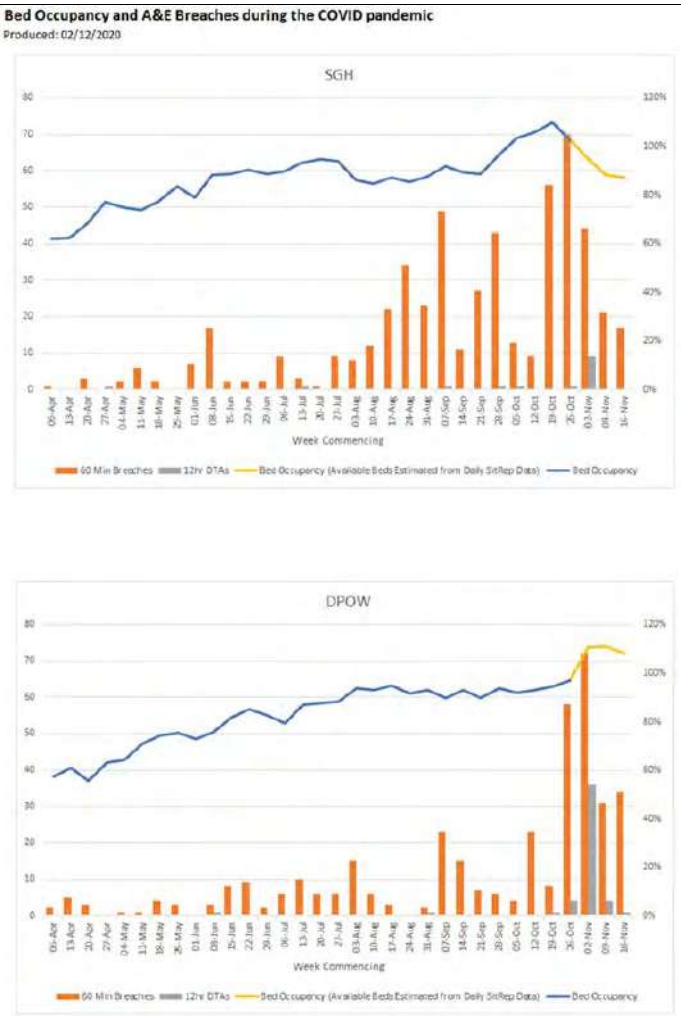
The average time patients were in ED before a decision to admit was made during December 2020 was 153 mins at DPOWH and 174 mins at SGH. This reflects the greater Covid numbers at SGH during December 2020 than DPoWH. The longest trolley wait for a patient awaiting admission during December 2020 was 21 hours at DPOWH and 22 hours at SGH.

Risk	Mitigation
There is a risk of 12 hour breaches occurring due to a lack of bed availability and patient flow out of the Emergency Department.	Daily operational meetings to review and amend the ward zoning and patient movements to enable bed availability for the patients requiring admission. Discharge to assess initiative to ensure patients are discharged in a timely manner to support adequate patient flow throughout the hospital. Review of the 12 hour escalation process to support early exploration of radical options to support prompt patient admission and 12 hour DTA breach avoidance. Development of a '10 is the new 12' initiative to treat 10 hours as the new DTA trolley breach deadline to be rolled out. Validation of all 12 hour breaches to identify themes and lessons to be learned to avoid future breaches.
Risk of harm to patients kept in ECC for more than 12 hours	Increased staffing to ECC 2 hourly board round with EPIC (Emerg. Physician in Charge) and Band 7 coordinator to identify risk Nursing care needs monitored through Care Round document (risk assessments for pressure ulcers, falls, nutrition, hydration and comfort) Alternatives to trolleys – beds, recliner chairs Red mattresses provided where needed Choice of meals including hot meals Medication and observations as required

Black Ambulance Breaches

The overall aim is to have zero black ambulance breaches within the Trust. A black ambulance breach is when a patient arrives at the Emergency Department by ambulance and the period of time for the ambulance handover to be completed exceeds one hour. The target time for an ambulance handover is 15 minutes. December 2020 resulted in 220 (DPoWH: 60, SGH: 160). Patients waiting in the ambulances are registered on the Emergency Department Symphony system and are included in the clinical board rounds to ensure ongoing safety and clinical escalation. An apology is provided to the patient by the clinical team at the time of the breach.

Risk	Mitigation
Black ambulance breaches occurring due to lack of available clinical cubicles within the Emergency Department. This has been impacted by the covid-19 implications and a lack of patient flow out of the Emergency Department. The chart below shows the link in hospital bed occupancy levels to ambulance handover 60mins+ black breaches:	Ambulance Handover Task and Finish Group chaired by Medicine Division involving EMAS and YAS. UTC moved out of the ED footprint at SGH to restore the Ambulance handover bay. Ambulance handover improvement plan. New ambulance handover process implemented on 9th December 2020 which improves efficiency and clinical safety of

	handover and moves to paperless triage. ED Matrons validation all black ambulance breaches to identify themes and lessons to be learned to avoid future breaches. Additional actions added to ambulance handover action plan which identifies fast track option for paediatric patients and records assessments of patients being held in ambulances awaiting capacity in ED to commence handover.

MORTALITY*

At the outset of the pandemic, there was a concern about monitoring the increased deaths for learning with the aim to maintain the Trust target for 2020/21 of screening 50% of deaths and undertaking subsequent Structured Judgement Reviews. The aim for the SHMI is to be within 'as expected'; at present the SHMI is 105.4, within 'as expected'. This covers the period to the end of July 2020, prior to the commencement of Wave 2.

Risk	Mitigation
Mortality will increase	Mortality Improvement Group monitors mortality performance including the impact of Covid-19 mortality. Clinical Ethics Committee and Clinical Reference Group re-established During Wave 2 not all Covid-19 deaths will be reviewed. A sample of deaths will be reviewed to seek understanding of current quality matters and to seek assurance that actions taken in response to learning from Wave 1 were effective. The latest SHMI data covers up to July 2020. There is a lag between Wave 2 pressures, where the Trust has been impacted by Covid-19 much more than during Wave 1. Whilst Covid-19 is excluded by SHMI, the impact of

	altered activity and increased number of deaths cannot be fully projected. The latest mortality crude mortality data for the month of November will be available towards the end of December.
Co-morbidities will not be fully recorded leading to an increase in the SHMI	Grant Thornton reviews have continued with Trust coding team members. During Summer, Divisional lead clinicians have been nominated to expand clinician led coding. This will continue following Grant Thornton's time with the Trust on this project ending in December 2020. In Division of surgery, engagement plans were delayed due to illness. This is planned to have been addressed during December 2020, an update will be provided to MIG in January 2021.
Inability to progress with mortality reviews within divisions resulting in a reduction in the proportion of deaths being reviewed for learning lessons purposes	In Wave 1 the Trust used shielding clinicians to review all Covid-19 deaths and BAU activities were maintained meeting the Trust's Quality Priorities. For Wave 2 the shielding criteria has changed resulting in fewer clinicians being available for mortality reviews. Those are shielding have been contacted and are prioritising urgent reviews. A revised quality of care screening process was piloted; This has been adopted and being rolled out to medical coding reviews at SGH and to Surgery coding reviews. As a result of this, for October and November 2020 more than 50% of all deaths have been screened. December data is still to be finalised, but currently stands at 46%. The rate of SJRs being completed, which is guided by the outputs from the screening process, but a separate process, has been adversely affected by operational pressures. Whilst January – June 2020 100% of SJRs have been completed, there are residual cases for July, August, October and November 2020.

Mortality related reviews of priority:

Area	**Risk during Pandemic**	**Action /Mitigation**
Liver Disease, alcohol related	Limited progress due to staff shortages in Gastroenterology. This is an externally notified (Dr Foster) outlier alert which will be followed up	Mitigated using shielding clinicians during wave 1. Review work concluded and discussed at collaborative meeting with CCG. Formal report being prepared for assurance
Sepsis mortality	Sepsis mortality has been identified as increasing, with a rise in February noted. There is possibly a connection with data quality given the latest report from Grant Thornton to MIG that identified an over recording of pneumonia deaths and the reassignment of these to other chapters, including sepsis, to ensure data accuracy	Review work has been undertaken and links to deteriorating patient and sepsis group. Outcome data not yet analysed. Formal reporting and feeding back to MIG will be required.

	and quality. The GT work commenced in February 2020 so likely this is linked to an increase seen in sepsis related mortality.	
Mortality reviews	The Trust is at risk of not meeting the quality priorities on mortality reviews (50% of deaths reviewed; 100% of priority cases reviewed). Agreed at MIG to add to the risk register.	Successful pilot completed linking coding reviews with quality of care screening (quality priority). Expansion of approach to cover all Medicine deaths equating to >50% of Trust deaths taken forward with Grant Thornton during November 2020. Update for medicine deaths at SGH to be sought by MIG in January 2021. Expansion of approach commenced in Surgery and Family Services. SJR reviews to utlise Wave 2 shielding clinicians underway.

End of Life*

The Trust's last CQC report identified themes and challenges in relation to end of life care. Some of the work required was for the Trust to lead on and others, to be successful in bringing about real improvement, required a wider system approach. The Trust is working with partners to strengthen the arrangements for governance and assurance for end of life services. The NLAG end of life group has been strengthened to include oversight of intelligence available from complaints, incidents, PALS, clinical audit and mortality reviews. From triangulation of these information sources, six key improvement themes were identified:

- Recognition that a patient is entering into the End of Life phase;
- Proactive and advanced care planning in preparation for end of life;
- Communication;
- Listening to the patient and family, involving them to develop personalised plans of care;
- Assessment of patient needs at EOL including pain assessment;
- Making best use of the care in the last days of life document

All key themes within the improvement plan are progressing within time frame with the exception of those identified in the risk table below. In May 2020, with support from NHSE/I, a collective approach with a strengthened governance structure, with partners across Northern Lincolnshire driving a system wide approach has been agreed.

Risk	Mitigation
Current Trust Palliative care arrangements not optimal - SGH does not have 7 day service; DPoW service is not comparable to SGH	NHSE/I Process mapping work to review/potential to streamline delivery of EOL services have been completed. Partner conversations ongoing around future EOL pathways and provision of services which have been identified as a priority project. EOL steering group looking at Specialist Palliative care cover/advice 24/7, across Northern Lincolnshire , not specifically focused on

	consultant cover. Process mapping sessions set up for January and current scoping of best practice underway.
Improvements required on the identification, planning and communication of EOL care with greater use of advanced care planning tools. There is a risk that the current pandemic surge will delay the accelerated work and training.	ReSPECT roll out has started and progressing. The work on EPaCCS has been accelerated to drive improvements across NLaG and partner organisations. Some delays with the role out within NLaG has been noted due to the operational pressures. Attempts are being made to accelerate this and formulate a timeline with additional coms to engage clinicians. These will occur early February 2021 Continue to use video technology and virtual training but the uptake is problematic due to the current operational pressures.
Mandatory training levels and core competencies continue to have pockets not meeting the trust targets. There is a risk that the current operational pressures will affect the training.	Virtual training in place and on ward training to capture staff but the uptake is problematic due to the current operational pressures. EoL Core Competencies training continuing and staff being supported on the wards to care for patients
Delay in the launch of the pain assessment tool and updated guidelines	Operational pressures have delayed the completion date. . There is a requirement for a clinical lead to support the developments and discussions are currently underway with the divisions to support finalise the tool and guidelines.
There is a risk that the care in the last days of life document will not be utilised to the full potential during the operational pressures	The EoL team have relaunched the Covid 1 page document as an alternative to the 15 page *Last day of life* document. The 1 page document was launched in Wave 1 and well received by the staff without concerns. This reduces the time staff taken to document care provided whilst providing the quality framework to ensure that patients and their significant other, receive appropriate care. Audit will take place on this document and support is being offered to all staff providing the care.
Divisional engagement into the EoL meeting may be reduced due to operational pressures	The divisional engagement into the EoL meeting has started to pick up momentum with good engagement evident from the two largest divisions Medicine and Surgery. Continue with the virtual meetings and reducing the length of the meeting as appropriate. A Northern Lincolnshire EOL strategy was drafted and is under consultation with organisations for comments.

Maternity*- Ockenden Report and CQC Actions

An independent review of maternity services was requested and undertaken at the Shrewsbury and Telford Hospital NHS Trust. The first report published 10 December 2020 follows 250 cases and forms seven immediate and essential actions. The aim of the actions is to improve safety in maternity services across England.

Risk	Mitigation
Enhanced Safety – to strengthen partnerships between Trusts and local networks. Work collaboratively to ensure SI's have regional and LMS oversight	Current collaborative working is limited to CCG involvement and external input at the Trust request. SI's are shared with the LMS, via the Safety Working Group. This approach will strengthen through a SOP which will be approved in January 2021. Perinatal Mortality Review Tool (PMRT) is used to review each case that meets criteria for review. Quarterly Board Report completed and a summary of all cases is presented at the Perinatal Mortality and Morbidity Meeting. Maternity Dashboards (Y&H Dashboard) shared regionally (Clinical Network). Local and regional dashboards on agenda at local Maternity Forum Meeting and Obstetric Governance Meeting. National Maternity Dashboard launched Jan 2021. In collaboration with the LMS and regional chief midwife, new guidance (Dec 2020) currently under review. Actions will be taken as identified, including strong governance processes and key relationships in support of full implementation of the perinatal clinical quality surveillance model. 24/7 theatre (SGH) access commenced 1/1/2021for caesarean sections and trial of instrumental births.
Listening to Women and Families – women and their families are listened to and heard	Current involvement of Maternity Voices Partnership. To work with LMS to create an independent senior advocate role. MVP completed survey – 'Maternity Care in 2020, before and during the Cocid-19 pandemic, in Humber, Coast and Vale' Non-Exec Director re-appointed with oversight into maternity services following recent retirement. Parents involved in PMRT process.
Mandatory Training and Staff training and working together	Multi-disciplinary training in place, to be evidenced by LMS. Virtual training has temporarily replaced face to face training in response to Covid-19 guidance. To work with staff to ensure percentage compliance meets Trust requirements, 88% for core at the end of November and 81% for specific training.
'Live' skills training	Further simulations planned for clinical areas. Report, lessons learned and action plan created following simulation.
Managing complex pregnancy – pathways	Women have named consultant lead locally. Development of maternal medicine specialist centres

and development of tertiary Maternal Medicine Centres	with 'hub & spoke' model. Trust already meets requirement for regional integration of maternal mental health services.
Risk Assessment throughout pregnancy	Risk Assessments undertaken locally – audit in progress
Monitoring Fetal Wellbeing	Requirement met for both midwifery and medical fetal monitoring leads. Do not currently meet Saving Babies Lives Care Bundle v2 (elements, smoking and CO2 monitoring, element 2 on fetal growth restriction and element 5 on reducing pre term births for trans vaginal cervix scanning). Progress is addressed in the paper for Quality & Safety Committee. CO2 monitoring initially paused nationally due to Covid-19 however has been re commenced.
Informed Consent	Information available on Trust website with link to LMS Website on NLaG website and plan to update website with a virtual tour 2021. Plan to audit information given to women, in collaboration with MVP.
24/7 theatre access, maternity SGH	24/7 theatre (SGH) access commenced 1/1/2021for caesarean sections and trial of instrumental births.

SERIOUS INCIDENTS

The 60 day timeframe for SI investigations remains suspended due to Covid-19. The Quality Governance Team in the MD Office is working with clinical areas to ensure:

- Patient safety is not adversely affected by delays in implementing actions / learning from SIs
- Patients or families are not distressed by the increased delays.
- Training on investigations continues virtually

There are currently 53 Serious Incidents under investigation, 10 of these are 12 hour breaches. De-logs have been requested for all 10 as care was given appropriately in each. Following direction from NHSE/I, 12 hour breaches will no longer be reported immediately, but will be reported to StEIS if significant harm has occurred as a result, as identified through the 48 hour report.

Category	**Number of Serious Incidents**	**Sign off**	**Risk of Delay**
Never Events	1 wrong implant	Medical Director	Moderate
Pressure Ulcers	13	Chief Nurse	High
Falls	6	Chief Nurse	High
Stop the Clock (confidential police investigation)	1 (=)	Medical Director	None
Major Incident, Oxygen Supply	1	Medical Director	High
<u>Maternity:</u> • HSIB - Unexpected admission to NICU following NVD • Unexpected admission to SCBU	2	Chief Nurse	High
Others	27 including	Medical	High

	10 twelve hour breaches	Director	

At the start of Covid-19 Wave 1 there were 77 Serious Incidents under investigation; a total of 75 have been concluded and submitted to the CCG, leaving 2 remaining under investigation from pre Covid. One of these reports are now at the final sign off stage and the remaining SI relates to a police investigation and is currently a 'stop the clock' investigation.

Investigations on Incidents of High Concern:
Open serious incidents monitored for potential safety concerns are:

Investigation	**Action / Investigation Progress**	**Risk during Pandemic**	**Mitigation**
Paediatric Sis	An infant was brought in having suffered a significant dog bite; there were queries in regards to the fluid resuscitation. This is a multi-agency investigation.	At final sign off stage	The NLAG side was discussed in the ECC department
Information Governance	Inappropriate access to health care records. Investigation in progress.	Medium	Emails have been sent to all staff reminding them of their IG responsibilities.
Never Event	Wrong Ophthalmology Implant undertaken by an NLAG surgeon at St Hughs	Priority investigation to maintain timescales	Immediate change in process for Ophthalmology at St Hugh's. Comparison review of other checklists and processes between NLAG and St Hugh's. This is a priority for completion on time.
MAJAX	A major incident was declared in relation to ensuring oxygen supply in regards to infrastructure. No patients came to harm.	Medium Potential delay due to the scale of the investigation	Daily monitoring of oxygen pressure by ward. Increased portable oxygen to enable alternative delivery. External Investigator HSIB also investigating this issue

Families are being kept informed of the delays to investigations.

Safeguarding

The Safeguarding Teams aim is to protect vulnerable adults and children who access our services. The safeguarding children and adult team are maintaining their involvement in the day to day business mostly virtual via electronic means between NLaG and its partners.

Risk	Mitigation
Issues around staffing in Safeguarding Adults as theNamed Nurse has retired and the Specialist Nurse for safeguarding adults is due to leave in January 2021. This will leave the Named Nurse MCA/DoLS to cover. This situation is concerning due to the Local Authority Safeguarding teams not sending Social Workers to the wards to carry out investigations. This has led to requests to the Trust Safeguarding Adult team to pick up some of this work, increasing the pressure on the Team.	Interviews have taken place to replace the Named Nurse Safeguarding Adults and the Specialist Nurse Safeguarding Adults, these posts will be in place by April 2021. The Acting Head of Safeguarding is to write to the Local Authority Safeguarding Teams and the CCG's to outline our current situation. Interviews have also taken place to recruit a Specialist Nurse Mental Capacity Act, to support the Named Nurse. The successful applicant is expected to be in place March 2021.
The Local Authority Deprivation of Liberty Safeguarding teams (DoLS) are currently not sending Best Interest Assessors (BIA) to the wards to carry out assessments on those patients who need an assessment following a DoLS application.	This is mitigated to an extent due to the use of technologies, speaking to patients and staff virtually or by phone. This isn't ideal as the role of the BIA is to ensure that any deprivation of liberty is lawful and proportionate, it is clear that this should be done face to face with patients and staff, also to allow the BIA to review patient records as necessary.
Reducing compliance with Safeguarding Training or reduced effectiveness of Safeguarding Training	Training moved online In regards to adult / children safeguarding training, work is ongoing to roll out additional 2 hour live virtual sessions to help achieve compliance to level 3. This is expected to be in place for April 2021. This will enable us to provide some local context to our training.
Increase in the number of deaths of people with a learning disability since September 2020 referred to LeDeR 	The occurrence of mortality in people with a learning disability since September 2020 is consistent with crude mortality increases. In the second wave of the COVID 19 pandemic there have been outbreaks of COVID in some of the homes for people with learning disabilities which have resulted in COVID related deaths. The Learning Disability Team continue to be part of the vulnerability rounds to ensure there is oversight of patients with a learning disability and we have been given funding for a 6 months temporary additional fulltime LD Nurse to be based at Scunthorpe

	Hospital. SJR's completed on deaths of people with a learning disability by the LD team has not raised any significant concerns or risks that require immediate escalation

CONCLUSION

In summary, the most significant risks remain staffing and waiting lists.

Mitigations are in place, including redeploying central staff and using central Governance staff to try to pick up some of the patient safety assurance work (for those not redeployed) where possible to alleviate the impact on clinical areas, however it is not possible to entirely remove the impact.

RECOMMENDATION

The Quality & Safety Committee is asked to

- note the key risks identified and mitigation work

NLG(21)032

DATE	Tuesday 2 February 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Lynn Benefer, Acting Head of Safeguarding Mel Sharp, Assistant Chief Nurse Vulnerabilities and Nursing Assurance Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Lynn Benefer, Acting Head of Safeguarding
SUBJECT	Safeguarding Annual Report
BACKGROUND DOCUMENT (if any)	**N/A**
PURPOSE OF REPORT	The purpose of the report is to provide the Trust with an annual report of the work undertaken during 2019 – 2020 giving assurance that the Trust is compliant with its safeguarding duties and those responsibilities specified under section 11 of the Children Act 2004, NHS Assurance Framework 2015 and the current safeguarding legislation.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	QGG Q&S
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The report demonstrates the continued performance of the Trust within the safeguarding arena which covers Safeguarding Children (child protection and looked after children, domestic abuse, FGM, county lines, unaccompanied asylum seekers, allegations against staff), Safeguarding Adults, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and the PREVENT strategy. Whilst managed within the Chief Nurse directorate the safeguarding agenda threads through all aspects of the Trust business and the Trust plays an active part within the wider safeguarding multiagency partnership. Significant areas of concern are the increasing number of children being added to a child protection plan or brought into care within North East Lincolnshire which is above the national average and the impact on the workload of the team. The CCG are aware of this increase as we are commissioned by the CCG to provide this service and since this report was written we have been able to secure some short term funding from the CCG to support this. In Spring of 2019 new safeguarding adults training guidance was published which requires a significant in-

	crease in the training required for staff for the trust to be compliant. A training strategy is in place and agreed with our commissioners which will allow the Trust to be compliant by the end of 2020. A key point and evidence of good practice is the development of midwifery electronic files. Moving away from paper files to an electronic version ensures that records can be updated and accessible to all midwives via Web V. Liberty Protection Safeguards (LPS) to be implemented by April 2022, this will have workforce and financial implications for the Trust.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Patient Safety
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: Receive the annual report Approve the plans for 2020 - 2021

Safeguarding Team Annual Report

2019/2020

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1. Forward

It is my pleasure to introduce the Safeguarding Annual Report for 2019/20. It demonstrates the team's achievements within the Trust in respect of safeguarding. The report also outlines our future priorities for 2020/21 with the ultimate aim to protect our local people from harm and exploitation. Whilst this will continue to be a challenge to us, we have appointed a new Head of Safeguarding, New Named Nurse for Adults and a Specialist Nurse for MCA who all bring new experience and expertise to the team as well as complimenting the extensive skills and experience of the dedicated existing team. We are also transferring our Vulnerabilities team (which include patients with Dementia and Learning Disabilities) over to our Safeguarding team- as we recognise the links with the increased vulnerabilities of these client groups. We have also strengthened the safeguarding leadership team further by the new role of Assistant Chief Nurse and a Deputy Head of Safeguarding in the first quarter of 2021, who will help the Chief Nurse to develop and embed our role, strategic vision and profile of Safeguarding across the trust.

We will continue to develop the team further, work collaboratively with our Health care Partners and wider community; I believe we can meet the challenges ahead.

Our local and national priorities for 2020/21 will be to focus on County Lines and Criminal exploitation (page 6), modern day slavery (page 8) - to which we have champions within the team to support this. We will continue to promote and undertake safeguarding training to our staff (page 28). We are also preparing for the Liberty Protection Safeguards (LPS) that replaces Deprivation of Liberty Safeguarding (DoLS) in April 2022. This will be a significant change for the trust.

This report provides assurance to the Trust, its patients and their families as well as our partner agencies that we see safeguarding as a key priority and ensures that all our staff are aware that 'safeguarding is everyone's business' and we all have a role to pay in ensuring our patients and their families receive outstanding care.

2019/20 has been a very busy and challenging year – particularly due to covid-19, however I am extremely proud of the achievements made by our dedicated and hardworking team which is demonstrated within our Good News Stories/updates (pages 32-34).

I hope you find this report interesting and informative as well as our response to the ever changing safeguarding agenda.

Melanie Sharp - Assistant Chief Nurse Vulnerabilities

Ellie Monkhouse, Chief Nurse and Executive Lead for Safeguarding

2. Introduction

Northern Lincolnshire and Goole NHS Foundation Trust has a statutory responsibility for ensuring that services by their organisation have safe and effective systems in place which safeguard adults, children and young people at risk of abuse, neglect and exploitation.

The aim of this report is to summarise the safeguarding activity within Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) during the period 2019 / 20.The revised guidance "Safeguarding Children, Young People and Adults at risk in the NHS: Accountability Framework (NHS England 2019)" sets out the safeguarding roles, duties and responsibilities of all NHS health and social care. The Trust has a range of statutory duties including safeguarding children and adults and is required to give assurance to both Local Safeguarding Partners and Commissioners of service to demonstrate that we have effective safeguarding arrangements in place.

Furthermore, the report aims to:

- Provide assurance to the Trust board that the Trust is fulfilling its safeguarding and Mental Capacity Act 2005 obligations.
- Assure service commissioners and regulators e.g. CQC and NHS Improvement that the Trust's activity over the year has developed in terms of preventing abuse and reducing harm; as well as embedding MCA/DoLs into clinical practice using the model of "Making Safeguarding Personal" and ensuring that the "Voice of the Child " is heard
- Appraise the Trust staff and managers regarding the activity and function of the safeguarding team and the support it provides to operational and clinical service delivery
- Ensure that patients, service users and carers know that safeguarding of children and adults is a Trust priority

The report will also provide an overview of developments within the safeguarding arena both locally and nationally over the last 12 months and how the Trust has worked in partnership with others to ensure that patients and their families are protected when accessing our services.

3 Safeguarding Team Structure and Functions

2019/2020 has seen some key changes within the safeguarding team, with the recruitment of a new Head of Safeguarding as well as a new Named Nurse for Safeguarding Adults.

New for 2020 is the combining of the vulnerabilities team with consists of Learning Disability and Dementia Specialist nurses who are led by the Senior

Nurse for Vulnerabilities with the experienced safeguarding team. This is an exciting opportunity to develop and build on already strong working relationships that exist between the two teams.

To enable this to progress smoothly Melanie Sharp, Associate Chief Nurse is leading on this transition along with the current Acting Head of Safeguarding.

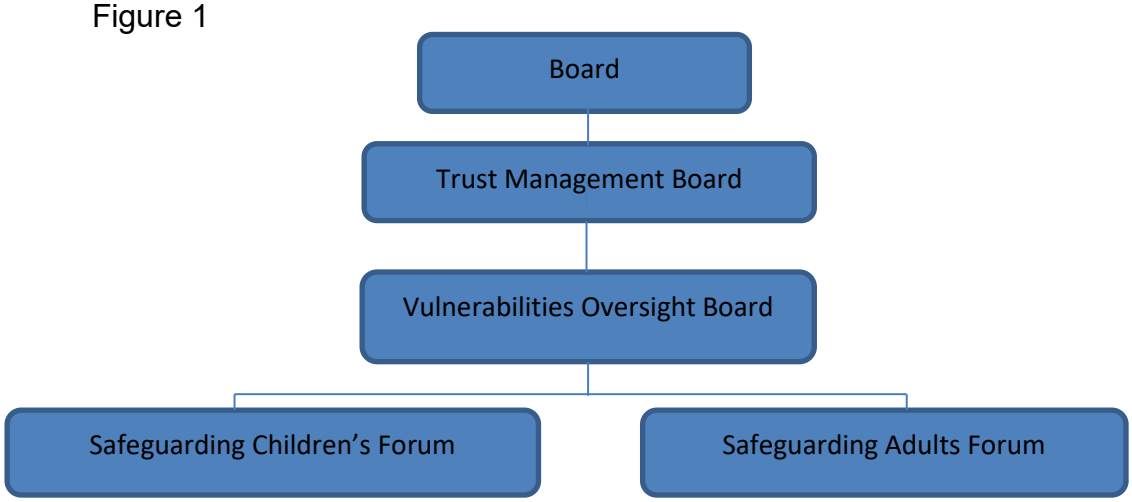
A full breakdown of the team and their functions can be found at Appendix I.

Safeguarding Governance Arrangements

The responsibility for safeguarding rests ultimately with the Chief Executive Officer, supported by the Executive Director with Board responsibility, Ellie Monkhouse, Chief Nurse and a Non-Executive Director. The Trust has a Safeguarding Children's Forum and a Safeguarding Adult's Forum which report to the Vulnerabilities Board, chaired by the Chief Nurse, which reports to Trust Management Board, with a quarterly Safeguarding update to the Quality and Safety Committee. Both these groups are active in their management of the current action plans/issues within their specialist areas. Both the forums are chaired by the Head of Safeguarding.

To provide assurance to our partners Joint Adult and Children Section 11 audits have been completed and submitted during 2020 and the Acting Head of Safeguarding has attended the challenge event with partners from NElincs.

Figure 1



4 Key National Themes

CSE (Child Sexual Exploitation) and CCE (Child Criminal Exploitation)

Child Sexual Exploitation (CSE) is a form of sexual, emotional and physical abuse which involves the manipulation and/or coercion of a child or young person under the age of 18 into sexual activity. This may be through the use of technology such as on line grooming.

Child Criminal Exploitation is child abuse where children and young people are manipulated and coerced into committing crimes. Criminal exploitation of children and vulnerable adults is a geographical widespread form of harm that is typical feature of county lines activity. County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of “deal line”. They are likely to exploit children and vulnerable adults to move or store the drugs and money and they will often use coercion and violence and weapons.

The safeguarding team continue to raise awareness of CSE /CCE in all levels of safeguarding children training and prior to the Covid 19 restrictions regularly invited multi agency partners into ECC to deliver awareness sessions on the subject including updates on county lines. Staff are also updated on the use of the “vulnerabilities and warning signs checklist” and the KYSS tool which assist staff in the identification of children and young people who may be at risk of CSE/CCE.

As an organisation NLaG continue to provide representatives at the Operational Vulnerabilities Meeting (OVM) and at the Multi Agency Sexual Exploitation (MACE) group which discuss and formulate multi agency action plans for children and young people identified as being at risk of CSE and or CCE. This ensures oversight of CSE/CCE at a local level, sharing information with other agencies to protect vulnerable children and young people. Children and young people identified at risk are flagged on the electronic records within ECC/A&E, enhancing information available to staff aiding effective and safe risk assessments.

Moving forward work around child exploitation will continue in 2020 - 2021 but with a key focus on county lines and criminal exploitation.

To increase staff awareness of contextual safeguarding

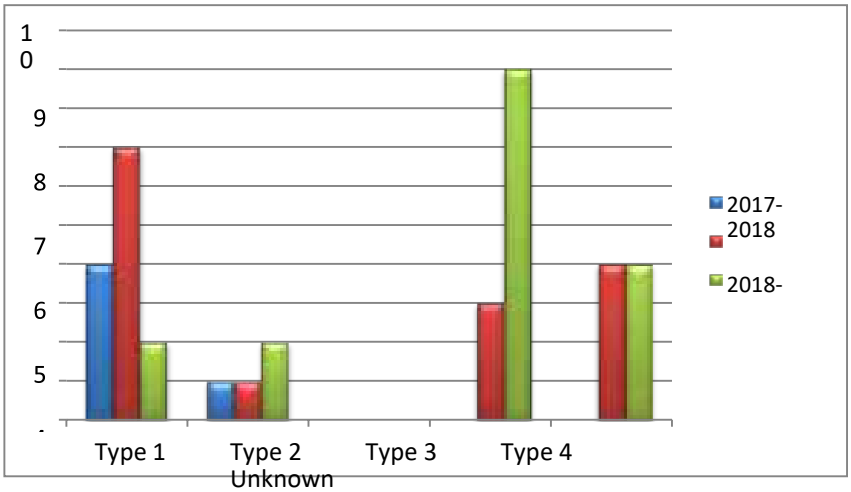
FGM (Female Genital Mutilation)

The Serious Crime Act 2015 introduced mandatory reporting by regulated professionals in 2015. In order to ensure compliance with legislation and to provide assurance to the board that NLaG staff are competent and confident to recognise and respond appropriately, FGM remains a key area included in all levels of safeguarding training.

Whilst the issue of FGM affects women/girls across all operational services the midwifery and gynaecological teams are key in the early identification and reporting of this specific area of abuse. The Trust has in place an FGM policy and specific working guidance for paediatrics and midwifery.

From 1st April 2015 the Trust began to submit FGM data in line with national guidance to HSCIC on a quarterly basis and to date NLaG are recorded in the national data set as being 100% compliant with the required submission.

During July 2019 to July 2020 the Trust reported two cases of type 1, two cases of type 2, nine cases of type 4 and four cases of unknown type (all in adults).



From 1st November 2015 the reporting of FGM in all girls less than 18yrs of age to the police became a legal requirement.

In 2017 the first phase of a national rollout of the FGM Risk Information System (FGM –RIS) began which runs on similar lines to CP-IS system. The rollout within NLaG began in the summer of 2018 and continues to be embedded into daily practice. As with CP-IS the checks require going outside of NLaG systems and using the NHS Spine.

Since the rollout 4 female infants born to mothers with disclosed FGM as part of their cultural history have been flagged on FGM –RIS.

Moving forward through 2020 /2021 we will continue to embed the FGM – RIS within maternity

Modern Day Slavery

Modern Slavery was introduced as a separate category of abuse in the relation to adults at risk under the Care Act in 2014. It involves the recruitment, movement, harbouring or receiving of children, or adults through the use of force, coercion, and abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK. They may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Modern Slavery Act 2015 identifies Modern Slavery as a national and local priority and two members of the safeguarding team have been identified as modern slavery champions.

Moving forward further awareness training about Modern Slavery will be disseminated throughout the Trust in 2021

Increased awareness to be disseminated throughout the Trust via the Modern Day Slavery Champions.

MCA/DoLS

During the last year work has continued to ensure the Trust is meeting its legal requirements linked the Mental Capacity Act and DoLS. We have ongoing work to ensure staff have a good understanding of carrying out mental capacity assessments, this includes: A new project commenced in March 2019 where staff can now record mental capacity assessments on the WeBV digital platform, this has also enabled us to collect detailed data on when assessments are completed, when they were completed and by whom they were completed by.

An audit of the data has shown us that we have seen a steady increase in assessments carried out since the launch of the project, it is important to note that we have seen a significant drop in assessments completed from January 2020 to March 2020 this can be attributed in part to the Covid 19 crisis and a drop in admissions to the Trust at the start of the pandemic. The numbers have increased since April 2020 as hospital admissions have since increased.

In partnership with North East Lincolnshire CCG and Grimsby Institute we have developed a collection of short video clips demonstrating a series of capacity assessment scenarios, these are to be used as a tool to help staff understanding of completing capacity assessments.

In terms of training, we have rewritten all our Safeguarding Adult Training to incorporate MCA/DoLS with a particular emphasis on capacity assessments and its importance to obtaining consent to treatment. This included a new

level 3 package for decision makers and senior staff at the Trust. Training figures have slightly improved and as of March 2020 we were at 83% for the MCA and 88% for DoLS. (Despite moving to online packages due to Covid our training figures have maintained).

Training continues to be a priority and moving forward we need to be creative in how we do this and we are looking at bespoke packages that can be done on the wards to small groups. This won't impact compliance but it is hoped that it will help to improve staff understanding of the MCA and it main principles related to practice.

The 2019-2020 figures for DoLS applications remain consistent with 423 applications across Trust, with a low level of approved applications. This is due to patients being discharged; they regain capacity, or sadly die before having an application approved. This to be expected within Acute Hospital settings and is consistent with other Trusts across the Yorkshire and Humber regions.

To conclude, the Trust is in a better position than it was in terms of staff understanding of the MCA, but there is much more to do, particularly in light of the proposed change to LPS.

Moving forward to 2020 - 2021, we will continue to develop staff understanding of our legal requirements to the MCA framework and how this is crucial to proving excellent rights based care.

Work will continue to prepare the Trust for the new Liberty Protection Safeguards (LPS) process that is to replace DoLS in April 2022; this will mean that the Trust will become the responsible body for monitoring and assessing whether we have the legal authority to deprive an individual of their liberty. This will present the Trust with challenges, there will be administrative implications and a broader need for more staffing resources to manage the change over from DoLS.

There are LPS steering groups to collaborate on and attendance is required. The MCA Lead role is a crucial role to ensure we are ready in April 2022. There is significant training required for all staff to ensure we are compliant with being a "Responsible Body" and to ensure patient safety is paramount. As a Trust we need to follow all the new legislation to ensure we have sufficient evidence to justify depriving our patients of their liberty.

Making Safeguarding Personal (MSP)

Adult protection continues to expand with an increasing workload not only within the safeguarding team but impacting on the general roles within the Trust i.e. Patient Experience Team, PALs, Matrons and operational staff.

The safeguarding team continue to promote and develop meaningful discussions which are person led, that mean they engage the adult in a conversation about how best to respond to the individual safeguarding concerns.

During 2020 /2021 mandatory training will support completion of MSP referrals identifying how people want to improve or resolve their circumstances and evidence engagement with people about the outcomes they want.

Moving forward into 2020 – 2021 NLaG will continue to develop and embed an approach that is person led

Domestic Abuse

NLaG continues to work with partner agencies to identify and support victims of domestic abuse who access our services. Nationally 52% - 66% of child protection cases involve domestic abuse and 30% of domestic abuse cases start during pregnancy. During the period 01.04.18 – 31.03.19 there were 9595 domestic violence incidents which was a 4.7% increase across North and North East Lincolnshire area.

NLaG is represented at Multi-Agency Risk Assessment Conference (MARAC) by the Named Nurse Safeguarding Children. The purpose of the MARAC is to provide a structured forum for the sharing of information, risk assessment and safety planning in relation to victims, offenders and their children in cases of domestic abuse to also ensure support services are aware of a high risk or potential risk of domestic abuse situation and that adequate and appropriate support is available to the victim and any dependents. Each organisation involved has an information sharing agreement that details what information that organisation will make available to partners.

During Covid 19 pandemic the number of MARAC conferences increased to weekly meetings to enable the increasing number of cases to be heard. Although the number of MARAC conferences has now reduced from weekly they are still being held fortnightly.

During 2018 – 2019 the Trust signed up to a new national Multi Agency Tasking and Coordination (MATAC) scheme which focusses on identified perpetrators of Domestic Violence that do not meet the MARAC criteria.

Within the safeguarding team there were 2 independent Domestic Violence Advocates (IDVA) who provided 1:1 work with victims and support staff. These professionals are provided free by Blue door and worked with NLaG under a license to attend contract.

The support service across the NLaG area is provided via Blue Door and The Blue Door has increased engagement with clients by 21% over the last 12 months.

During 2018 the Trust launched its new Staff Domestic Violence policy in conjunction with HR which assists in identifying victims and perpetrators of DV who work within the Trust. Over the 12 months, the team have advised and supported the HR and operational teams with both victims and perpetrators of DV.

Moving forward into 2020 - 2021 domestic abuse will remain a key theme and the policy will be revisited and relaunched within the Trust

PREVENT

Prevent is part of the Government's counter-terrorism strategy known as CONTEST. Raising awareness of the health sectors contribution to the Prevent strategy is crucial as we are best placed to identify individuals who may be groomed into terrorism activity.

The Head of Safeguarding remains the lead for Prevent for the Trust and represents the Trust at Channel Panel meetings which discuss referred individuals who have been identified as causing concern due to their views or actions which in turn may put them at risk of radicalisation.

When PREVENT became a statutory duty, the training strategy / plan was amended to ensure that all staff within the trust undergo a level of Prevent training every 3 years. As of 2016 Prevent training (Level 1) and as of 2018 (level 2) is part of all staff training matrix. Currently all Prevent training is assessed via e learning.

5 Safeguarding Team Activity

Safeguarding Adult Reviews (SAR) AND Domestic Homicide Reviews (DHR) and Children Serious Case Reviews (CSP)

NLaG has a statutory requirement to engage in multi-agency Child Safeguarding Practice Reviews (CSPR), Safeguarding Adults Reviews (SAR) or Domestic Homicide Reviews (DHR) where we have had involvement in the care of the victim, perpetrator or their family, if relevant.

Safeguarding Adult Reviews (SAR)

Serious Adult Reviews within the safeguarding adult's process have taken place since 1st April 2015 and form part of a statutory process. NLAG regularly joins with Safeguarding Partners in such undertakings. As SAR's have been in place for some time each of local review groups from North & North East Lincolnshire, Lincolnshire, and East Yorkshire, has been considering ways of improving their function. This has involved the use of external chairpersons; faster implementation of action plans; and more robust longitudinal reviews of action plans. Meanwhile, regular attendance at Emergency Centres; Mental Health; and Problems with Transition have emerged as problem areas from recent reviews.

Safeguarding Adult Reviews	NELincs	NLincs
2019	3	1
2020	3	0

Domestic Homicide Reviews (DHR)

A DHR is very similar in nature to a CSPR / SAR however takes place when a death occurs in a young person (16 & 17 years) or an adult and the cause is Domestic Violence. Currently NLaG are involved in two DHR were the Trusts involvement with the victims has been minimal. The DHR being undertaken in NElincs is the first to have been commissioned.

Child Safeguarding Protection Reviews (CSPR)

Under the new arrangements the requirement to undertake what was a Serious Case Review or some other type of learning review has been replaced by guidance on the circumstances in which a local Child Safeguarding Practice Review (CSPR) should be considered (Working Together 2018).

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but has wider importance for all practitioners working with children and families and for the

government and policy makers. Understanding whether there are systematic issues, and whether and how policy and practice needs to change, is critical to the system being dynamic and self-improving.

During 2020 / 2021 NLaG have been involved in one Child Safeguarding Protection Review with the final report due April 2021.

An area that has increased is the safeguarding team involvement with “Line of Sight” audits. The purpose of the line of sight process is to identify themes and potential practice issues as well as good practice. This process has been undertaken in NLincs for several years and is well embedded with safeguarding partners and has just been adopted by NElincs in 2020.

During 2020 the safeguarding team at SGH where involved in 10 line of sight audits which was a slight increase of the 9 that were undertaken in 2019.

NELincs have only recently adopted this process have completed 2 line of sight audits with another planned for early 2021.

6 Working with Partners

Local Safeguarding Adult Boards and Safeguarding Children Partnerships

Safeguarding Children Partnerships and Safeguarding Adults Boards were set up as statutory bodies. They are a partnership of the relevant statutory, voluntary and community agencies involved in safeguarding and promoting the welfare of all children and young people/Adults at Risk of Abuse. They do this by co-coordinating the safeguarding work of member agencies so that it is effective. Monitoring, evaluating and when necessary, challenging the effectiveness of the work and advising on ways to improve safeguarding performance.

The Local Safeguarding Children Partnerships/Adult Boards of North Lincolnshire, North East Lincolnshire and East Riding all have Independent Chairs and membership has been reviewed ensuring that attendance at the Partnerships / Boards is at the required levels and members have sufficient seniority

The Trust is represented by the Head of Safeguarding at the following Partnerships and Boards:

- North East Lincolnshire SCP and LSAB
- North Lincolnshire MARS and LSAB
- East Riding SCP and LSAB

There is representation by other key professionals on the sub committees of the above Partnerships/Boards.

Since 2013 there has also been closer working with the Lincolnshire LSCP due to on-going serious case reviews across the Lincolnshire and North East Lincolnshire Partnerships.

In 2015 the government commissioned a review into the role and functions of the LSCB. In 2016 the report was published which covers several areas of change and as a result Safeguarding Children Boards were disbanded in 2019 and were replaced with Local Safeguarding Arrangements although several key functions remained. The Wood Report (2016) formed part of the review into the role and functions of Local Safeguarding Children Boards (LSCB) and concluded that to safeguard children and to achieve the best outcomes, children and families should receive services in a coordinated way. There are now three organisations that are jointly responsible for the partnership arrangements to keep children safe. They are Local Authority, Police and the CCG working alongside other relevant agencies. The key messages are still around improving partnership working and joint responsibility. Whilst the statutory partners hold lead responsibility, NLaG will still be held to account for undertaking and delivering on its key safeguarding duties.

Key priority areas for SCP are	**Key priorities for LSAB are**
• Children Sexual Exploitation • Child Criminal Exploitation • Missing • Neglect • Self-Harm • Domestic Abuse	• Modern Day Slavery • Financial Abuse • Keeping Adults safe in the care settings • Self-neglect and hoarding • Making Safeguarding Personal

NLaG are actively involved in all of the above areas by way of delivering the topic areas within training and or sitting on operational groups to actively target the perpetrators and support the victims of abuse. CSE / CCE, Missing & Domestic Abuse are all indicators that are flagged within SystmOne, Symphony and WebV records.

NEL Health Forum

The Named Nurse Safeguarding Children and Adults as well as the Named Midwife represent NLaG at this forum Chaired by the Designated Nurse for Children. The aim of this meeting is to provide a forum to discuss, share and facilitate learning and developments around safeguarding practices within NELincs, as well as to identify gaps and ways of overcoming them.

NEL & NL Multi Agency Child Exploitation Meeting (MACE)

The Named Nurse for Safeguarding Children represents NLaG at this meeting. The aim of this group is to have oversight of individual young people who have been identified by agencies or are subject to CSE strategy meetings; particularly where there is a high risk or a concern that existing plans may not be decreasing the level of risk. Where appropriate to provide scrutiny, challenge and guidance. The group also shares intelligence relating to CSE activity, to inform mapping and analysing the profile of CSE in the NELincs / NLincs, generate intelligence for investigations and identify any trends or problem locations and work together to formulate action plans. This also includes oversight of known perpetrators within NELincs / NLincs.

NEL & NL MARAC (Multi Agency Risk Assessment Conference) Meeting

The Named Nurse or Named Midwife represents the Trust at the MARAC meetings. During Covid 19 MARAC meetings have been held remotely on a weekly and now fortnightly basis to ensure that victims continue to be supported. During the last 12 months the team have attended all MARAC meetings and have discussed a total of 1265 high risk domestic abuse cases.

A theme that runs through many of the MARAC cases is the use of alcohol as well as mental health issues for many of the victims and perpetrators of domestic abuse.

2019/2020 also saw an increase in the number of children being supported through the MARAC process with 188 children in NE Lincs identified as living in households of a MARAC victim.

NEL MARAC Steering Group

The Named Midwife represents the Trust at this meeting which looks at the MARAC process in detail and any areas that need developing as well as agency attendance at the MARAC meetings. Work involves close liaison with partner agencies including Police, IDVA's and Adult Mental Health.

NEL & NL MATAC (Multi Agency Tasking and Coordination)

The Specialist Nurses attend this meeting. This is a fairly new meeting starting in 2018. Each organisation involved has an information sharing agreement that details what information that organisation will make available to partners and the aim of the scheme is to engage with perpetrators and give them access to intervention programmes in order to help them understand their behaviour and reduce offending.

Child Death Overview Panel (CDOP)

The CDOP is attended by the SUDIC (Sudden Unexpected Death in Children) nurse and the SUDIC doctor. This meeting is a process which aims to review all child deaths within the Northern Lincolnshire area.

The Safeguarding team and members of paediatric / midwifery directorate come together with our partner agencies (Local authority / Safeguarding Partnership, Police, Health) to ensure that all child deaths (expected or unexpected) are assessed and where possible identify any factors which may have contributed to or indeed may have lessened the risk of death.

During 2019 - 2020 there were 5 deaths in North East Lincolnshire and 8 deaths in North Lincolnshire which met the CDOP criteria.

Whilst some deaths are unavoidable (terminal illness / life limiting conditions) some may have contributory factors such as changes in weather (heat waves), poor road conditions or poor sleeping conditions.

When modifiable factors are noted these are shared nationally and local initiatives are adopted (Social media adverts / face book in relation to hot weather and suitable sleeping advice)

During 2019 to 2020 the child death process is being changed. Whilst NLaG will continue to support the process and discussions will continue to take place in our local areas, the function will move from the local safeguarding partnership to Public Health team which sit within the local authorities.

MAPPA (Multi Agency Public Protection Arrangements)

MAPPA are a set of arrangements to manage the risk posed by the most serious sexual and violent offenders under the provisions of the Criminal Justice Act 2003.

The Head of Safeguarding or their deputy Named Nurse Safeguarding adults attended all high level MAPPA meetings to ensure that the health needs of these complex clients are met and that any safety issues for the client, NLaG, our staff and other patients / visitors are balanced and assessed to maintain a safe situation for all.

All MAPPA eligible offenders are presently flagged with regards to their assessed risks on ECC, Community and Hospital systems.

Moving forward in 2020 - 2021 we will continue to review our engagement with partners and how we disseminate information/ outcomes within the Trust

7 Multi Agency and Internal Audits

Multi Agency Audits

NLaG have been involved in three multi agency audits covering issues of Child Criminal Exploitation, use of chronologies and transition.

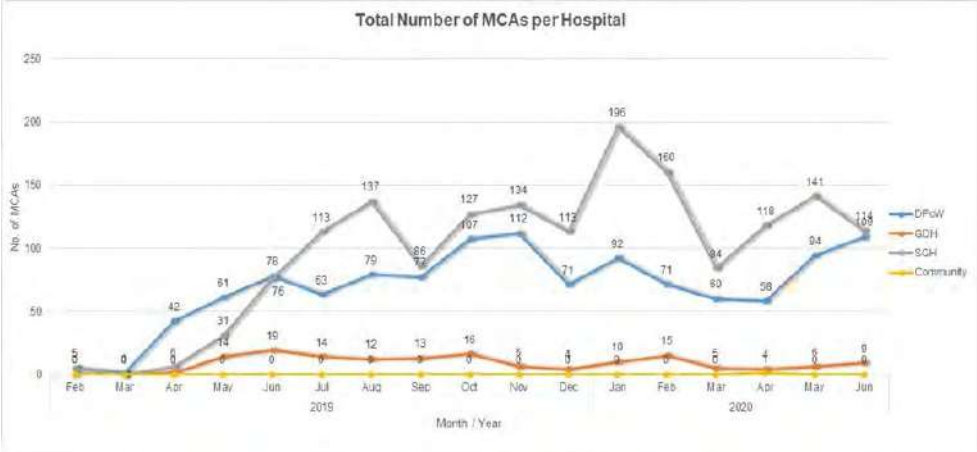
Internal Audits

A member of the safeguarding team has been supporting a junior doctor with an audit on the quality of safeguarding medical reports. This audit is now complete and awaiting presentation at the next audit meeting.

The safeguarding team have also continue to audit the quality of safeguarding referrals made by staff in NLaG and feedback to staff recommendations to strengthen practice in this area.

The annual NEL self-harm audit, identifying how NLaG works together with primary care and Young Minds Matter to support young people who attend NLaG , has been delayed due to staff pressures from Covid 19 as it is usually undertaken in May but is now due to be completed November 2020.

The Named Nurse MCA/DoLS has undertaken an audit on Capacity Assessment Documentation on Web V. The graph below demonstrates a steady increase of capacity assessments since its launch in February 2019, a significant drop can be seen from January 2020 to March 2020, this can be attributed in part to Covid 19 crisis and a drop in admissions to the Trust at the start of the pandemic. The numbers have increased since the beginning of March 2020.



8 Quantitative Activity and Progress

The data below highlights the Trust safeguarding activity that we are able to evidence. Moving forward into 2020 /2021 we will continue to review the data, evidence and information obtained. The safeguarding team will continue to use the information to analyse what we need to do and areas that we need to develop.

The Safeguarding Team provide a quarterly report to the CCG as well as the Quality and Safety Group for overview and assurance.

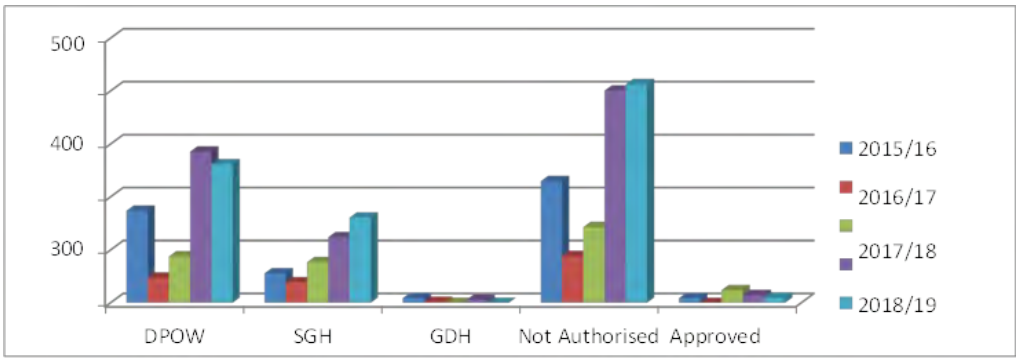
Safeguarding Adult Referrals

The adult safeguarding team have recently put processes in place to collect data on referrals made to safeguarding adults services. Going forward this will enable the safeguarding team to identify themes and trends as well as areas requiring support and or training.

The Trust has in place a process for making Deprivation of Liberty Safeguard (DoLS) applications. Most patients can consent to being in hospital. Generally speaking, capable patients (other than those subject to the Mental Health Act 1983) who do not want to stay in hospital are entitled to leave. For patients who lack capacity it is important that staff consider whether the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty.

DOLS applications

Figure 1: DOLS applications as of 31st March each year



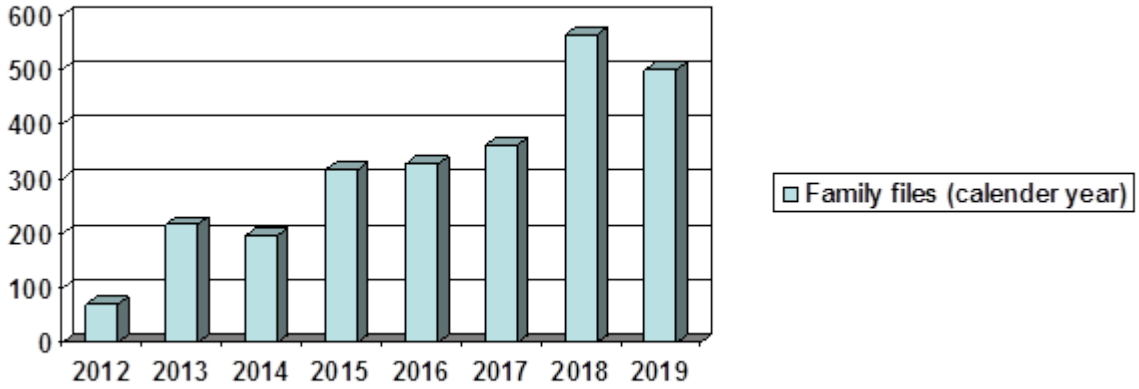
The 2019-2020 figures for DoLS applications remain consistent with 423 applications across Trust, with a low level of approved applications, this is due to patients being discharged, they regain capacity, or sadly they die before having the application approved by a Best Interest Assessor. This is to be expected within Acute Hospital settings as DoLS were initially developed for longer term residential settings. (I am awaiting Data from East Riding of Yorkshire Supervisory Body). The number of applications from East Riding are traditionally low.

Safeguarding and Pregnancy

The Role of the Named Midwife has continued to develop within the team with targeted training delivered to Midwifery / Gynaecology staff covering subjects of domestic violence, child sexual exploitation and female genital mutilation.

A development during 2019 is that the Trust moved to using electronic family files with a template on Web V. Midwifery family files enable risks such as domestic abuse, substance misuse and previous social services input to be noted and multiagency actions and plans to be brought together in one document. This has now been rolled out at both DPoW and SGH/Goole. This development has improved the information sharing between midwives and when required NICU ensuring that up to date information, pre-birth plans and actions are accessible at any time and at site of delivery.

Figure 3: Family Files Maternity



The Named Midwives have also been working closely with local authorities in their areas and in NELincs a new multiagency process has been developed for pregnant women and their unborn who are open to services with the local authority to ensure that information is shared appropriately and timely, monitor the progress of the pregnant women and their unborn babies and make recommendations about the level of risk in respect to safeguarding issues.

Safeguarding Children Social Care Referrals

The collation of quantitative information regarding safeguarding referrals for children has previously been gathered from Children's Social Care. However this information was limited to how just how many referrals had been made from NLaG and did not give any qualitative information.

The safeguarding team now have processes in place to gather this information and are able to review and assessment the referrals, for example quality of documentation, reason for referral and numbers of referrals made month on month. This will enable the safeguarding team to target specific

areas for training and or supervision as well as being able to identify trends and themes going forward.

Safeguarding Children Supervision

Supervision data is held centrally within OLM and is monitored via the safeguarding children forum. This is to ensure that the safeguarding team is consistently applying high standards, which are measurable.

Challenges for 2019 - 2020 are to increase the numbers of staff accessing this specific supervision and will include a review of the current policy.

Presently all staff requiring level 3 safeguarding children are required to undergo safeguarding supervision at intervals of 3 monthly, 6 monthly and 12 monthly dependant on their specific role. In total this equates to 891 staff. The safeguarding team have continued to offer supervision to staff using a variety of methods, including one to one and group sessions.

Figures for 31st Dec 2020

Safeguarding Supervision	Not in date	In date	Grand total	% compliance
3 monthly	37	62	99	63%
6 monthly	345	395	740	53%
12 monthly	88	79	167	47%

We have seen a drop in the compliance figures due to Covid and the impact this has had on staff being unable to access group supervision sessions in some areas. This is something the team have discussed and plans are in place to look at different ways to deliver supervision to staff to improve compliance and provide staff with the support safeguarding supervision offers.

Moving forward into 2020 - 2021 although these figures show an increase from 2018 – 2019 figures a review and benchmarking exercise is planned to ensure that targets of achievement in this area are not unreasonable and a review of the current delivery model.

Safeguarding Adult Supervision

Whilst less prescriptive, safeguarding supervision for adult protection cases is readily available and provided to staff who require it on a needs lead basis. This is often delivered at source on the clinical areas on a case by case basis and is noticeably a bigger part of the work as staff begin to effectively recognise the complexities within vulnerable / safeguarding adults cases.

Safeguarding Training

Safeguarding training has always been a high priority to the Trust and has been delivered in a variety of ways and at different levels across the organisation. A training plan is in place for safeguarding children and safeguarding adults and the safeguarding team have delivered a significant amount of sessions throughout the year.

Since the initial review of the training strategies in 2011, there have been several updates and as a result new training plans were developed in 2018 to strengthen the Trusts position in relation to training and maintain its compliance with statutory guidance. Prior to Covid 19 the safeguarding team updated all levels of safeguarding training which evaluated well. Due to Covid 19 restrictions all face to face training has been suspended since March 2020 and we have encouraged all staff to access on line training. Although originally concerned that training figures may drop this was not the case and training figures remained fairly stable for the first half of 2020. As Covid has continued to impact on our staff we have seen a small fall in our compliance rates.

To support the online training the safeguarding children team have been emailing supplementary reading to all those staff that have completed online level 3 training and the safeguarding specialist nurse has been producing a bi-monthly newsletter.

The reported training levels within the Trust as of 31st December 2020 were as follows:-

	Trust Compliance %	Compliance Target
Child protection Level 1	87%	85%
Child protection Level 2	81%	85%
Child protection Level 3	81%	85%
Child protection Level 4	100%	100%
Child protection Level 5	100%	100%

In August 2018 a new ‘Adult Safeguarding Roles and Competencies for Health Care staff’ was published which re wrote the training process around Safeguarding adults training and as a result a completely new training program has been written and launched in January 2019. This now incorporates FIVE levels of safeguarding adult training.

The current figures for this new training as of 31st Dec 2020:-

	Trust Compliance %	Compliance Target
Adult protection Level 1	89%	90%
Adult protection Level 2	82%	65%
Adult protection Level 3	50%	50%
Adult protection Level 4	86%	100%
Adult protection Level 5	100%	100%

Moving forward into 2020 – 2021 maintain momentum to achieve 85%

across safeguarding training areas

Prevent Training

Figures as of 31st Dec 2020

PREVENT Level 1	88% (compliance target % 100%)
PREVENT Level 2	86% (compliance target % 100%)

PREVENT training is delivered online and quarterly figures are required to be submitted. NLaG has continued to submit quarterly reports within the required time frame (100% compliance). PREVENT training is undertaken 3 yearly and we have seen a slight drop in the compliance % due to many staff coming out of their 3 yearly compliance towards the end of 2020. The safeguarding team have a system in place to alert both managers and staff when they are required to update their PREVENT compliance.

MCA /DoLS Training

MCA and DoLS training is mandatory and included in the Trust's mandatory training policy training needs analysis (TNA). Monitoring compliance with mandatory training requirements is undertaken by the Trust's Mandatory Training Group. For general awareness training the Trust uses the National Learning Management System (NLMS) e-learning modules. Staff who require greater understanding of the requirements in respect of making applications to deprive someone of their liberty are required to attend more in-depth training. The Trust collaborates with Local Authority.

MCA leads to ensure Trust staff have access to the more advanced MCA and MCA/DoLS training. Mandatory training attendance compliance for Mental Capacity Act and DoLS awareness is outlined below.

Training Figures March 2020

	MCA	**DOLS**
March 2020	83%	88%

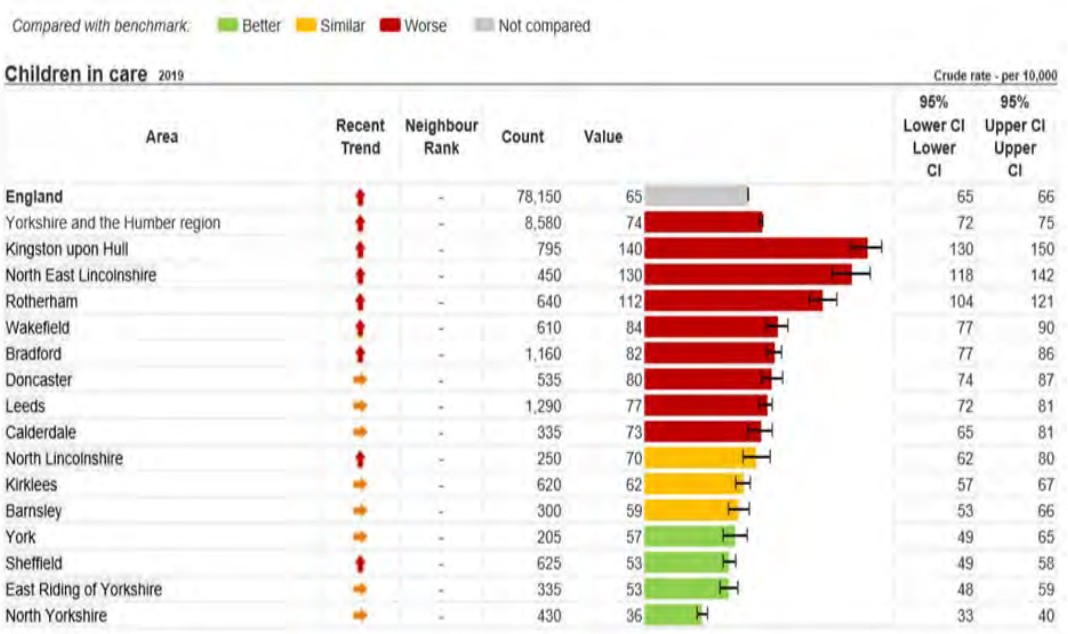
Online training packages have been identified for MCA and DOLS and are currently being promoted through training and development, on the staff HUB.

9 Looked After Children

Children and young people who are looked after are amongst the most socially excluded groups in England and Wales. They have profoundly increased health needs in comparison with children and young people from comparable socio- economic backgrounds who have not needed to be taken into care. These greater needs however, often remain unmet and as a result, many children and young people who are looked after experience significant health inequalities and on leaving care experience very poor health, educational and social outcomes.

The latest figures for children looked after (2019) shows North East Lincolnshire had the second highest number of children looked after in comparison to our neighbours in the region and higher than the rates per 10,000 in England. North Lincolnshire trend of children looked after experience lower number of children looked after but equally experienced and upward trend (fig. 1).

Fig. 1(Ref: https://fingertips.phe.org.uk)

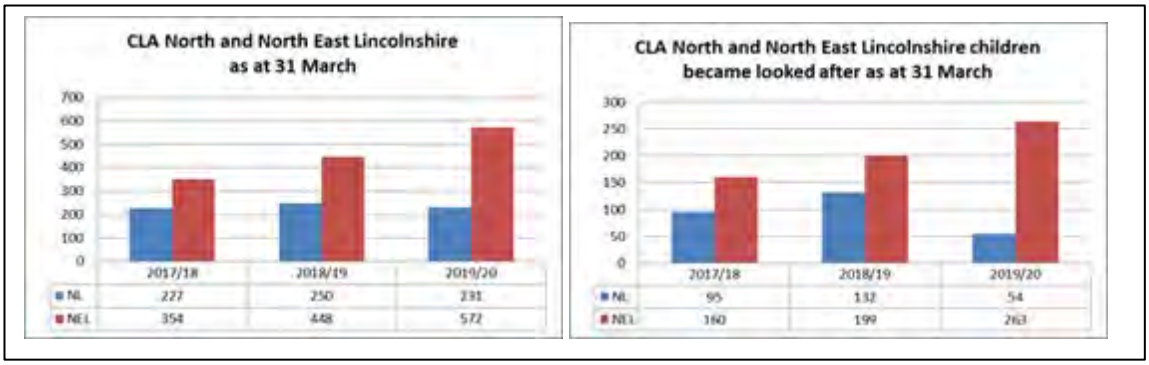


Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI Lower CI	95% Upper CI Upper CI
England	↑	-	78,150	65	65	66
Yorkshire and the Humber region	↑	-	8,580	74	72	75
Kingston upon Hull	↑	-	795	140	130	150
North East Lincolnshire	↑	-	450	130	118	142
Rotherham	↑	-	640	112	104	121
Wakefield	↑	-	610	84	77	90
Bradford	↑	-	1,160	82	77	86
Doncaster	→	-	535	80	74	87
Leeds	→	-	1,290	77	72	81
Calderdale	→	-	335	73	65	81
North Lincolnshire	↑	-	250	70	62	80
Kirklees	→	-	620	62	57	67
Barnsley	→	-	300	59	53	66
York	→	-	205	57	49	65
Sheffield	↑	-	625	53	49	58
East Riding of Yorkshire	→	-	335	53	48	59
North Yorkshire	→	-	430	36	33	40

Northern Lincolnshire & Goole NHS Foundation Trust are commissioned to deliver health service to both North and North East Lincolnshire serving North and North East Lincolnshire Clinical Commissioning Group and North and North East Lincolnshire Local Authorities.

There is a significant disparity between both the numbers of children looked after on 31 March (Fig. 2) and those who became newly looked after during the year (Fig. 3) for both North and North East Lincolnshire

Fig. 2 Fig. 3



Moving forward into 2020/2021 explore development of a permanent post for out of area LAC

10 Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DoLS)

The Mental Capacity Act 2005 (MCA) came into force in October 2007. The MCA provides a legal framework for assessing capacity and making decisions about the care and treatment of adults who lack capacity. This could be due to a mental health condition, a severe learning disability, a brain injury, a stroke or unconsciousness due to an anaesthetic or sudden accident. It also created new protections and powers in respect of the decision making process. The MCA applies to young people aged 16 and over. Treatment of children under 16 is governed by common law principles of consent.

The Mental Capacity Act provides:

A duty to treat an incapacitated person in accordance with their best interests. Limited ability to restrain an incapacitated person in accordance with their best interests, it is only lawful where:

- It is necessary to prevent harm.
- Proportionate to the likelihood and seriousness of harm and in the least prohibitive way.
- Cannot lawfully deprive an incapacitated person of their liberty, even in their best interests, unless:
- The statutory DoLS process is followed and an authorisation is obtained.

When carrying out acts of care and treatment in the best interests of a person who lacks capacity, staff will be legally protected through Section 5 of the MCA against legal challenges, providing that they:

- Have taken reasonable steps to assess the person's capacity to consent to the act in question.

- Reasonably believe that the person lacks capacity to consent.
- Reasonably believe that the act they are carrying out is in the person's 'best interests'.
- The Act is accompanied by a 'Code of Practice' which gives essential guidance on the implementation of the key principles.

Other provisions of the Act include:

The Act provides for the appointment of Independent Mental Capacity Advocates (IMCAs) to support and represent people without capacity who have no-one to speak for them when decisions need to be made about serious medical treatment or a change in a care home or hospital accommodation.

The Court of Protection is a specialist court with powers to deal with complex matters affecting adults who may lack capacity to take a particular decision.

Lasting Power of Attorney (LPA) enable people to appoint one or more people they know and trust to make decisions for them on their behalf relating to Personal Welfare (including healthcare decisions) and property and affairs, an LPA must be registered with the Office of the Public Guardian before it can be used.

Planning for future care – Advance Decisions are applicable when a person who made it does not have the capacity to consent to or refuse the treatment in question, it refers specifically to the treatment in question and the circumstances to which the refusal of treatment refers are present.

Deprivation of Liberty Safeguards (DoLS)

The Safeguards came into effect in 2009. They are part of a legal framework set out in the Mental Capacity Act 2005 (MCA). They set out the principles that should guide such decisions, including the need to act in the person's best interests and to achieve the desired outcome in ways that put the least restriction on the person's rights and freedom of action, and empowering people to make their own decisions wherever possible. The reason the Safeguards were introduced was to address the problem that arises if a person does not have the mental capacity to make an informed decisions about care or treatment.

There is no simple definition of deprivation of liberty and each decision must be made on a case by case, patient-specific basis. Certain key factors can be relevant in identifying whether the steps taken in caring for a patient amount to a deprivation of liberty. These include:

- The use of restraint (including sedation)

- Staff exercising complete and effective control over the care and movement of a person for a significant period.
- Staff exercising control over assessments, treatment, contacts and residence.
- Decisions being made that the person will not be released into the care of others, or permitted to live elsewhere unless the staff considers it appropriate.
- The refusal of a request by carer's for a person to be discharged to their care.
- The person being unable to maintain social contacts because of restrictions placed on their access to other people.
- The person losing autonomy because they are under continuous supervision and control.
- Staff must consider whether the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty.
- Staff are required to consider the following factors before considering a Deprivation of Liberty Safeguards application:
- Can the patient receive the planned care or treatment using a less restrictive but still effective care plan which avoids an unauthorised deprivation of liberty? It may be possible to reduce the risk of a DOL by e.g. minimising restrictions, encouraging social contact, involving family and carer's and considering less restrictive options.
- Is the patient receiving treatment for a mental disorder? If so, consider a mental health assessment and the use of the Mental Health Act 1983.
- If the patient cannot receive the planned care or treatment with there being a risk of depriving them of their liberty, and all practical and reasonable steps have been taken to avoid a deprivation of liberty, an application for authorisation of deprivation of liberty must be considered.

The Trust is responsible for ensuring that it does not deprive a person of their liberty without an authorisation, and must comply with the law in this respect.

Wherever possible, an application for authorisation of Deprivation of Liberty should be made in advance of any deprivation of liberty. An application can be made if there is a risk of deprivation of liberty within the next 28 days. If there is a need for the person to be deprived of their liberty immediately, the Trust (Managing Authority) can give an urgent authorisation itself and at the same time apply to the Local Authority (Supervisory Body) for a standard authorisation. Urgent authorisation is necessary; the Supervisory Body must

be contacted immediately. The relevant Supervisory Body then assess whether a deprivation of liberty should be authorised.

Assessors appointed by the supervisory body will determine whether 6 requirements are met:

- Age: the patient must be 18 or over
- No refusals: there must be no Advance Decision or valid Lasting Power of Attorney/Deputy which conflicts with the authorisation
- Capacity: the patient must lack capacity in relation to the decision to be in hospital
- Mental Health: the patient must be mentally disordered as defined in the Mental Health Act 1983
- Eligibility: in certain circumstances the patient will not be eligible for DoLS authorisation because use of the Mental Health Act is more appropriate
- Best Interests: it must be in the patients best interests to be a detailed resident; it must be necessary to prevent harm to the patient and a proportionate response to deprive them of their liberty

Once the assessment has been completed the Supervisory Body (Local Authority) will notify the outcome of the assessment to the Managing Authority (the Trust), and relevant others.

Where a request for an authorisation is turned down, the person's actual or proposed care arrangements to ensure that a deprivation of liberty is not allowed to either continue or commence.

Once a Standard Authorisation has been given, the Supervisory Body must appoint the relevant person's representative as soon as possible and practical to represent the person who has been deprived of their liberty. The role of the relevant person's representative once appointed is:

- To maintain contact with the relevant person.
- To represent and support the relevant person in all matters relating to the

Deprivation of Liberty Safeguards; including, if appropriate, triggering a review, using the complaints procedure on the person's behalf or making an application to the Court of Protection.

Under Regulation 18(2) (c) and (d) of the Health and Social Care Act 2008 applications to deprive a person of their liberty under the Mental Capacity Act 2005, and their outcomes must be notified to the Care Quality Commission.

In March 2014 the Supreme Court handed down its ruling in respect of a case of deprivation of liberty, (Cheshire West and Cheshire Council v P [2014]

UKSC 19) setting out a fresh approach to determining whether individuals are deprived of liberty (DOL). It is essential that if we are responsible for the care of any person who would not be allowed to leave our care, that we review the persons position with regard to DOL. It is unlawful for us to deprive a person of their liberty without proper authorisation in place.

There is still not clear division between restrictions and DOL. The “concrete situation” of each patient matters, but the key elements are:

- The patient lacks capacity.
- Under constant supervision and control.
- Not free to leave (it does not matter if the patient is co-operative or not, or trying to leave, or saying they want to leave. The question is whether the patient would be free to leave if they wanted to). This is referred to as the ACID Test.

Therefore if a patient is in hospital lacks capacity and would not be allowed to leave even if the patient wanted to and objection would be made if relatives tried to remove them, it is possible that the patient might be being deprived of their liberty.

CQC Review of Compliance with the requirements of the Deprivation of Liberty Safeguards

CQC’s Role

The CQC has a duty to monitor the operation of the Deprivation of Liberty Safeguards in England. A Code of Practice to the Mental Capacity Act and a Code of Practice to the Safeguards sets expectations for CQC to monitor them through an existing programme of inspections, and to report annually. Although CQC monitors the operation of the Safeguards, there are no enforcement powers associated with the role. If the CQC finds that the Safeguards are not being used correctly, this could lead to action under the Health and Social Care Act. A number of the Health and Social Care Act regulations contain references to elements of the Safeguards – for example in the regulations dealing with consent, safeguarding, and general care and welfare.

What the CQC will do:

- Listen to the experiences of people with personal involvement in the Deprivation of Liberty Safeguards, and consider how the MCA is being used in inspections of providers that supply services to people aged 16 and above.

- Use inspections and reports to encourage improvements in practice and, where necessary to protection people who use services, take enforcement action to drive improvement.
- Make sure that inspectors have the confidence and competence to recognise and encourage good practice.
- Take enforcement action where they find that providers are failing to notify them of Deprivation of Liberty Safeguards authorisations.

What the CQC expect others to do:

- Expect local authorities to do all they can to assess the backlog of requests for authorisation and prevent its recurrence, for example by use the triage tools created by the Association of Directors of Adults Social Services (ADASS).
- Expect providers of all adults health and social care to work within the framework of the MCA and where relevant, the Supreme Court judgement, pending the Law Commission review and any changes that arise from it.
- Expect joint working, locally and nationally, to make sure that local authority and NHS commissioning, training and policies take into account the need to avoid deprivation of liberty wherever possible.
- Expect providers to examine care and treatment plans for individuals lacking capacity, to determine if there is a deprivation of liberty (following the revised test supplied by the Supreme Court). The test is clearer and easier to apply than previously and, where a potential deprivation of liberty is identified, alternative ways of providing the care and/or treatment should be fully explored, so that where possible less restrictive ways of providing that care can be identified.

The CQC recommend that:

- Local authorities continue to consider using advocacy services for all those subject to the Deprivation of Liberty Safeguards.
- Local authority leads for the MCA and Deprivation of Liberty Safeguards create good working relationships with their local coroners. This is likely to be of great benefit to ensure that a consistent message is given to providers and that they can work together in dealing with the considerable extra activity as a result of the Supreme Court judgement.
- Local authorities and Independent Mental Capacity Advocacy (IMCA) providers work together to enable IMCA's to support the person or their unpaid relevant person's representative to challenge an authorisation to the Court of Protection when it is the person's wish, whatever the IMCA's views on the rightness of the authorisation.

- Hospitals and care homes continue to request authorisations when they think that people are being deprived of their liberty based on the new ‘acid test’. However, they must also continue, within the provisions of the wider MCA, to seek less restrictive options to meet the needs of each person.

CQC visit to the Trust September 2019

The Trust received an inspection to its acute services and a revisit to community services during September 2019.

Key notes: The report highlighted that Staff knew how to support patients using the Mental Capacity Act 2005.

The report highlighted that the Trust was not meeting its MCA/DoLS training target set at 85%, at the time we were around 79-80% compliant.

The report commented that staff needed to improve the documentation of mental capacity a The Trust’s arrangements for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

The monitoring of the Trust’s arrangements for MCA and MCA DOLS is undertaken by the Safeguarding Adults Forum which is a subgroup of the Vulnerabilities Oversight Board. In particular, the group monitor performance on training attendance levels to ensure wide spread awareness of the MCA and DOLS and also will monitor DOLS applications in order to ensure these are appropriate and that notification to the relevant external bodies has occurred as required.

The Trust has in place a policy covering the requirements of the Mental Capacity Act “Mental Capacity Act (MCA) and MCA Deprivation of Liberty Safeguards (DOLS) Policy”, which sets out the requirements and responsibilities of staff.

In line with the Trust’s Policy for MCA, all staff are required to appropriately document information in the patient’s health records for patients deemed to lack capacity where:

- An assessment has been made as to the individual’s mental capacity. Staff must document their objective reasons for believing the person lacks capacity to make the specific decision in question.

- Decisions are made for patients who lack mental capacity with professional judgements used to support the provision of care, treatment or service. These decisions must be based upon the ‘patient’s best interest’, in line with the requirements contained within the Mental Capacity Act Code of Practice.

- The records should show: What the decision was; why the decision was made; how the decision was made; who was involved and what information was used.

The MCA states that if an assessment is challenged, they (the person who made the assessment decision) must be able to describe the steps they have taken. The Trust has in place checklist flowcharts for Assessment of Capacity and Best Interests Decisions. Available on the HUB via the MCA/DoLS website assessments.

The Trust does not have any formal complaints relating specifically to failure to comply with the MCA.

The Trust has also not had any litigation cases related to failure to meet the requirements of the MCA.

Court of Protection Cases/Legal

The Trust has had one case go to the Court of Protection; we are likely to see more in the future as a result of Liberty Protection Safeguards.

The Trust monitors incidents and comments from the local authorities relating to the provisions of the MCA and DOLS in order to inform practice changes and staff training. Themes in the last year are:

- Incidents where DOLS applications not completed adequately
- Failure to inform statutory body when DOL no longer required, patient discharged, regained capacity etc

Legal Change - Liberty Protection Safeguards the process to replace DoLS has been proposed. The DoLS process has been poorly understood and overly bureaucratic nationally so Government have proposed a new system which will attempt to make the system more effective, while still protecting the rights of patients who may be deprived of their liberty, in Hospitals, Care Homes and Nursing Homes. On the 14th April 2019 the final stage of the Liberty Protection Safeguards (LPS) Bill has been passed. LPS received Royal Assent in May 2019. There will then be a delay to the start of LPS to allow for organisations such as ours to get ready for the new process. LPS could be expected to start late 2020 (this is now unlikely due to Covid 19). The final code of practice document is still being developed by the Department of Health and it is unclear at this time what this will look like, however it is anticipated that this will have financial implications for the Trust, currently the Supervisory Bodies (Local Authorities) have the responsibility for overseeing the process and providing a Best Interest Assessor (BIA) to visit a patient to review a DoLS application, to ensure the deprivation is necessary, proportionate and in the patient's best interest, under LPS this responsibility will be passed onto the Trust. The Trust will have to ensure that there are skilled staff to do this work and also this will incur administrative costs.

11 Celebrating success and key achievements

Covid 19 Challenges

The safeguarding team have adapted well to the restrictions that Covid 19 has brought with staff embracing the challenge of remote working. All the safeguarding staff have supported each other in organising ways of working that ensures that they all remain safe whilst safeguarding adults and children who access our hospitals.

A positive that has come from Covid 19 is the increased use of technology and the skills learned to ensure that staff have attended meetings either from home or the office. The fact that staff did not have to travel to meetings has also been a positive by reducing the amount of time out of the office needed to travel to and from various meeting venues.

Vulnerability ward rounds have also continued with the assistance of Skype to enable the Named Nurse for MCA/DOLs to dial in and be a presence at the bedside, be it virtually. This has proven to increase the awareness of the safeguarding team as well as supporting and assisting the vulnerability team professionals in identifying areas that improve patient care.

Multiagency safeguarding meetings have continued to be held and although Covid 19 has increased the frequency of some meetings, in particular MARAC, the safeguarding team have ensured that they have all been attended.

The safeguarding team have also embraced the challenge of supporting fellow colleagues within the Trust with staff being redeployed to adult wards, the Infection Control and Prevention Team and in ECC.

The Looked After Children team have also had to adapt their working patterns undertaking child health assessments over the phone with children and foster carers instead of face to face**.**

Good News Stories/updates

- The development and roll out of electronic family files within maternity
- The Named Nurses for safeguarding children attends regional safeguarding forums to share information and learning to keep abreast of any changes
- The development of pre-birth multiagency planning meetings

- The development of a monthly safeguarding children newsletter highlighting a different theme bi monthly to support safeguarding training
- The continued development of the vulnerability ward rounds incorporating the safeguarding adults team
- The safeguarding children team have updated all levels of safeguarding children training and began to deliver prior to Covid19 restrictions
- The renovation of the safeguarding “Garage” to a child friendly space for the LAC team to undertake health assessments.
- Electronic recording of capacity assessments on Web V with training being rolled out within the Trust
- The Named Nurse continues to input to quarterly training for junior doctors, taking cases for discussion and learning
- The Named Nurse attends and supports the safeguarding peer review meetings led by Named Doctor for safeguarding children
- MCA/DoLS training has been updated to ensure all staff are aware of the requirement to carry out assessments of mental capacity on patients and when to submit an application for a Deprivation of Liberty Safeguards Authorisation.
- The Named Nurse has: maintains key relationships with the Supervisory Bodies. Ward rounds continue in partnership with the Nurse Specialists for Learning Disability and Dementia, more time at the bedside has been a big positive, being more accessible to staff working on the ward.
- The MCA/DOLS policy has been reviewed and is compliant with the Social Care Act 2014.
- The MCA/DoLS site on the HUB has been made more user friendly and more accessible for staff.
- The Named Nurse attends the North East Lincolnshire Best Interest Assessors forum, to keep abreast of any changes, specifically relevant case law. Additionally this gives an insight into the role of the BIA specifically the challenges they face when trying to complete the volume of assessments they are tasked with doing for the Supervisory Body.
- Mental Capacity Audits are now quarterly.

- Bespoke training continues across the Trust; this involves role playing capacity assessments to key staff to improve their understanding. This is being developed as a webinar by NEL CCG.
- A new project commenced in March 2019 where staff can now record capacity assessments on WebV, training has been rolled out across Trust.
- The Named Nurse MCA/DoLS attends the Yorkshire Regional MCA forum for Acute Hospital leads to share good practice.
- In partnership with North East Lincolnshire CCG and Grimsby Institute, we produced a collection of short video's demonstrating how to complete a mental capacity assessment using a series of role play scenario's. These are to be embedded into our training packages and used for bespoke training sessions. The CCG plan to use these with GP practices to improve awareness.
- All levels of safeguarding adult training re written to incorporate MCA/DoLS with a big emphasis on capacity and consent. This includes a level 3 Safeguarding Adults, MCA/DoLS full day training session aimed at decision makers, senior staff, ward managers, matrons etc.
- A new template for documenting Best Interest Meetings has been developed in partnership with WebV; training is to be rolled out across Trust in the coming months.

"Our Stars"

In 2019 the Named Nurse MCA /DoLS Richard Painter was nominated for an "our stars" award for his support of staff and safeguarding of adults within the Trust. Although he did not win this was recognition of the great work Richard does.

Domestic Abuse Conference 2019

"On Friday I attended the Trust's first domestic abuse conference hosted in partnership with the police. The event was fully booked and I was impressed that so many staff had dedicated their time to learning about such an important issue. I personally became aware of the ravage of domestic abuse when I was a student in the 1970s living in Cambridge. Some friends of mine were instrumental in setting up a women's refuge and having come from a family where domestic abuse was not present it was a horrible eye opener. The conference was a full day event which looked at what we can do – within the Trust and with our partners - to make sure we can maximise the help and support to anyone suffering from this type of horrible abuse. Thank you to Lynn Benefer and Louise Gilliat for organising the event and attracting such high quality speakers; it was a tremendous achievement." Dr Peter Reading.

Beyond Bea Bereavement Conference

In 2019 a study day was arranged with Beyond Bea, a charity that focuses on raising awareness about baby loss and bereavement and educating health care professionals in order to improve bereavement care.

The study day was full to capacity and 60 members of staff, they learned about different types of loss; breaking bad news and caring for bereaved families; personal accounts were given by bereaved parents and there were interactive memory making workshop. The study day was well received by all those who attended and further days will be held in the future.

Abbie's Fund, a charity that provide memory boxes to families, supported the day and the trust are receiving continued support from Abbie's Fund and we have been able to provide memory boxes to both ITU's for children who lose a parent and we are working with them to improve the memory work that we undertake for bereaved families.

12 Conclusions

This report demonstrates the continued development and increased awareness of safeguarding children and safeguarding adults' issues within the Trust. The Trust continues to respond to the rapid national and local pace of change as well as maintaining an input external to the Trust.

Over the coming 12 to 18 months the changes on the Deprivation of Liberty process and replacement with Liberty Protection will add new challenges to the Trust (see MCA/DOLS section) however these changes will be planned for to ensure that the transition is as seamless as possible.

The strengthening of the safeguarding governance structure with the introduction of the Vulnerabilities Oversight Board will ensure the continued effectiveness of the forums. This board will oversee the management of the current action plans as well as moving services forward.

External to the Trust, NHS improvement have sort support from the safeguarding team to undertaken reviews of 3 other NHS organisations safeguarding systems and processes and as such recognise the level of knowledge and expertise within the team that can be used to support and shape other organisations.

The forthcoming year promises to be full of further developments and challenges for both the team, the new Head of Safeguarding and the Trust.

MCA/DoLs

Progress continues to be made in regards to staff developing a deeper understanding of the MCA and its main principles in particular mental capacity assessments, audits are showing steady progress in this area (the mental capacity assessment template on Web V has made a difference with compliance) but there is more to do. Liberty Protection Safeguards will present challenges; more responsibility will be handed to Providers to manage patients who may be deprived of their liberty.

There will be administrative implications and a broader need for more staffing resources to manage the change over from DoLS. It was anticipated that LPS would commence in October 2020, however due to Covid 19 this has been delayed) the Trust will need to be ready for this new legal process. A continued emphasis on improving our understanding of the MCA in particular training compliance will be a focus for 2020-2021 to reach our target and maintain our target of 85%.

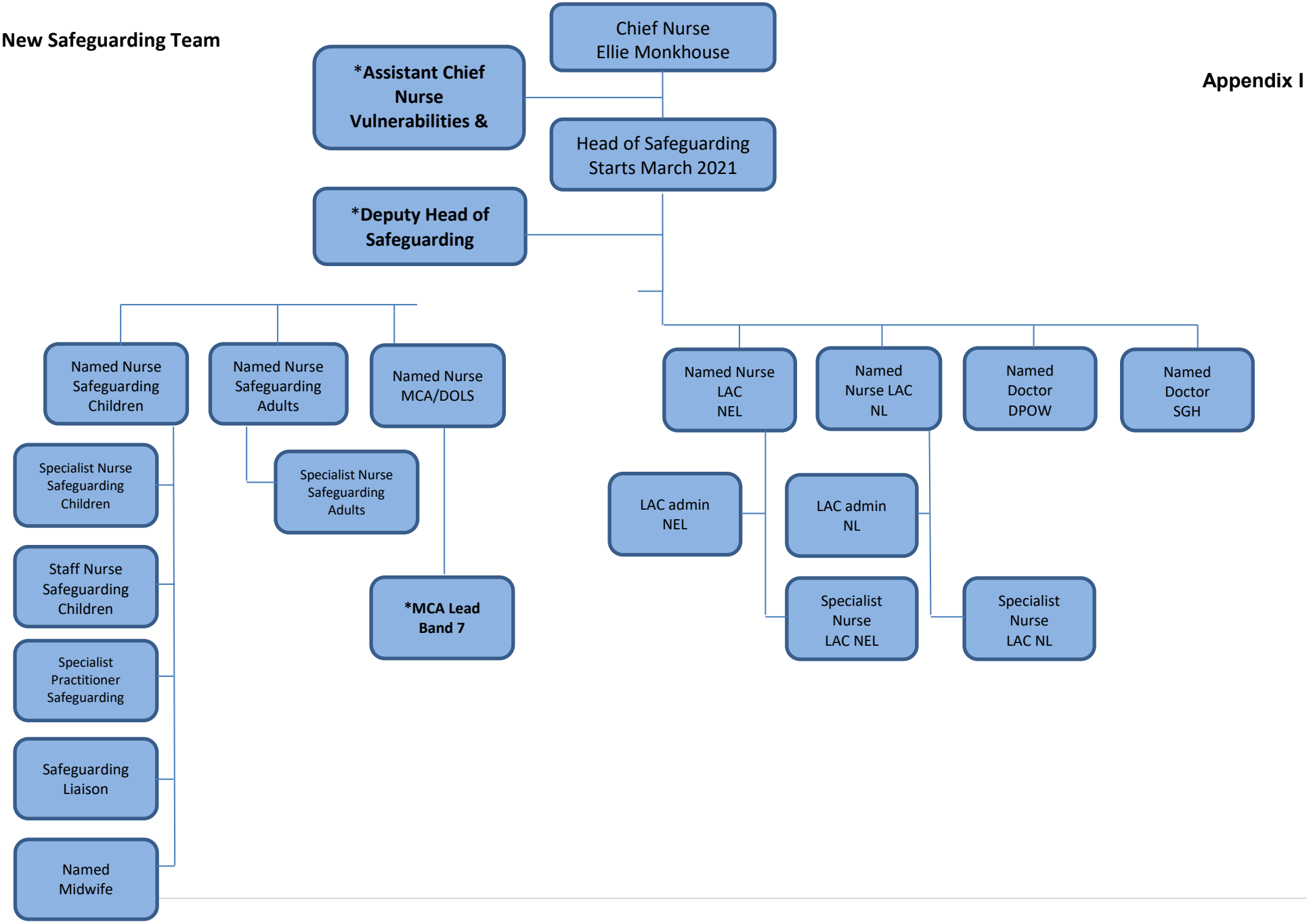
13 Priorities for 2020/2021

Working with the Chief Nurse, the new strengthened team will be working on continuing to raise the profile of the team and their role further, with the development of a Vulnerabilities Strategy which will support the Nursing, Midwifery and AHP Strategy.

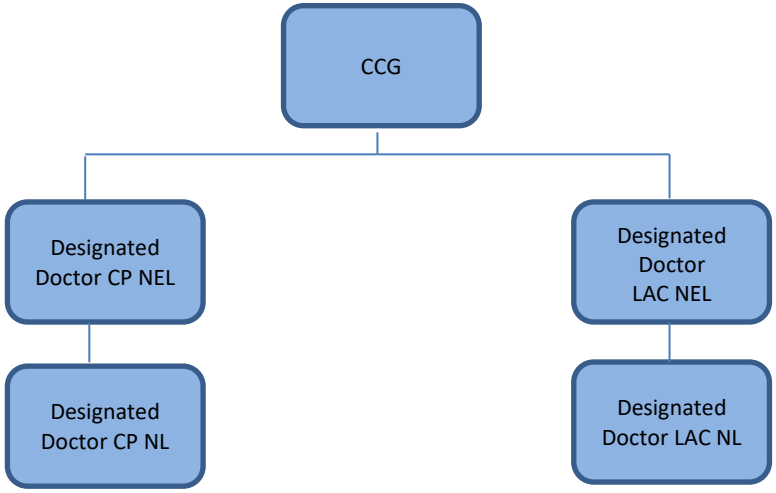
- Move to towards becoming the Vulnerabilities Team during 2021
- Continue to embed awareness around child exploitation with a focus on county lines and child criminal exploitation.
- Continue to embed the FGM –RIS within maternity
- Modern day slavery awareness training to be disseminated throughout the Trust during 2021
- Continue to develop staff understanding of our legal requirements to the MCA framework and how this is crucial to providing rights based care.
- Develop the rollout process for Liberty Protection Safeguards as guidance allows and identify any risks to the trust that the new legislation may pose (including possible business case for increased funding for this new process)
- To continue to develop and embed an approach that is person led with regard to making safeguarding personal
- Revisit the domestic abuse policy and relaunch within the Trust
- To continue to review how we engage with partners and how we disseminate information / outcomes within the Trust
- Review and benchmark safeguarding supervision to ensure that the target of achievements in this area are not unreasonable
- Maintain momentum to achieve 85% across safeguarding training areas
- Continue to develop systems that support the collection of safeguarding performance data.
- Explore development of a permanent post for out of area LAC
- Review SLA for North Lincs Looked after children team

New Safeguarding Team

Appendix I



Midwifery Team (Women & Children's)
Paediatric Team (Women & Children's)
CCG Role – employed within NLAG



NLG(21)033

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	02/02/2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Ellie Monkhouse, Chief Nurse Jane Warner, Head of Midwifery
CONTACT OFFICER	Jane Warner, Head of Midwifery
SUBJECT	**Ockenden Review**
BACKGROUND DOCUMENT (if any)	Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust (2020) Clinical Negligence Scheme for Trusts (2020)
PURPOSE OF REPORT	To provide assurance
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Maternity Transformation Board - Confirm and Challenge Meeting 26.1.2021
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	This report details the submission that will be made on 15th February to NHSEI detailing the gap analysis conducted in response to the Ockenden Report and the subsequent assessment and assurance tool. We report full compliance for 3 and partial compliance for 7. The reduction in compliance is as a result of incorporating not only the initial 12 urgent clinical priorities but also CNST compliance including Saving Babies Lives v2 care bundle, workforce review, leadership, NICE guidance as well as broader issues within the Ockenden report. A programme of actions have been identified; • Implementation of Standard Operating Procedure from LMS regarding sharing of SI's • Confirmation of reporting to NLAG Trust Board re SI's • Implement Independent Senior Advocate Role once information released • Develop care pathway to Regional Maternal Medicine Centre once further information released • Implement National Antenatal Risk Assessment once further information released • Address neonatal medical workforce, specifically junior staffing rota for SGH • Further work on Saving Babies Lives, Carbon Monoxide monitoring, Uterine Artery Doppler scanning, pre- term birth clinic • Ongoing improvement for multidisciplinary training, increase compliance of K2 and PROMPT training across all staff cohorts • Safety Champions, additional evidential

	requirements required from all Safety Champions The Risks • Neonatal medical workforce challenges • Timely release of further information in regards to Senior Advocate role, Regional Maternal Medicine Centers and National Antenatal Risk Assessment process. • Ongoing challenges of working differently due to COVID • Challenge of working through a period of transition and transformation as a result of the Humber Acute Services Review whilst maintaining compliance with these standards. • Managing collaborative system wide working in conjunction with significant operational change. • Financial costs of achieving Ockenden Report, approx. £230,514

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	**Quality Priority 2: Clinical Effectiveness: Reduce mortality rates and strengthen end of life care;** 2671 CTG Archiving [Maternity] (risk rating: 12; C3xL4) 2669 Lack of high observation machine on the antenatal/postnatal ward [Maternity] (risk rating: 9; C3xL3) 2393 Risk of deteriorating patients not being escalated [Maternity] (RR: 6; C3xL2) 2661 Maternity Data scopes [Maternity] (risk rating: 6; C3xL2) [Risk Rating reduced from 20 to 6, Feb 2020] **Miscellaneous Quality Related:** 2768: Re-audit of Maternity Documentation (Limited assurance) (RR: 6; C2xL3) **Strategic Risk 4: Skilled staff:** **Other staffing risk** 2759: Gap in staffing due to 1 year maternity leave not covered - 37.5hrs [CSS] (RR: 12; C3xL4) 2756: Reduced therapy cover due to maternity leave within the Unscheduled Care Team (RR: 12; C3xL4)
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: Note the report.

Northern Lincolnshire and Goole NHS Foundation Trust

Family Services Division

Ockenden Report

Executive Summary

1.0 Introduction

The Ockenden Review is the initial report 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 Fetal Wellbeing
- Informed Consent

The urgent action that was requested following publication from NHS E/I included 12 urgent clinical priorities related to the above 7 Immediate and Essential Actions. Confirmation of implementation of the 12 urgent clinical priorities was reviewed by the Chief Nurse and Non- Executive Director aligned to Maternity Services then signed by Trust Chief Executive with a further overview by the Chair of the LMS, this was sent to the Regional Chief Midwife on 21st December. The Trust reported compliance with 10 of the urgent clinical priorities and partial compliance with the remaining 2 – SI's shared with Boards and Risk Assessment recorded at every contact.

2.0 Milestones

The next step has been to populate a more comprehensive assurance assessment tool which draws together more than the 7 immediate actions and which is being reviewed at the Trust Board on 2nd February 2021, reported through the LMS and to be forwarded to the regional team by 15th February 2021. Following this the evidence will be forwarded by an electronic portal, expected in April/May 2021.

A Confirm and Challenge meeting took place on January 26th 2021 with the Chief Nurse and Non- Executive Director aligned to Maternity to review the submission. The next submission has been reviewed and is attached as an appendix to this paper.

The assurance assessment tool includes –

- 7 Immediate and Essential Actions
- NICE guidance relating to maternity
- Compliance against the CNST safety actions
- A current workforce gap analysis

Actions	Compliance	Expected Date of Compliance	RAG rated
Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks	Currently a report goes to the Quality & Safety sub-committee monthly and bi-monthly to the Trust Board. During Covid, there is a Patient Impact paper that goes to the Trust Board monthly. <u>Action</u> Implement Local Maternity System (LMS) Standard Operating Procedure (SOP) with regards to sharing SI's. Need to establish submission to NLAG Trust Board on monthly basis.	28/2/2021 – LMS SOP 31/3/2021 – Trust Board submission	
Listening to women and families	To provide independent senior advocate role (once national guidance is released). Further develop role of safety champions following updated guidance from CNST.	TBC 31/3/2021	
Staff training and working together	To comply with MDT training compliance across all staff cohorts – need to meet 90%. Current position 73.9% (Dec 2020)	31/7/2021	

Managing complex pregnancy	Will develop a Standard Operating Procedure and care pathway which identifies how women are referred into a	TBC	
	Regional Maternal Medicine Centre once National guidance released.		
Risk Assessment throughout pregnancy	To establish National Antenatal Risk Assessment process once nationally published.	TBC	
Monitoring fetal wellbeing	To comply with Saving Babies Lives v2 – see CNST action plan. Long lead time due to work being undertaken to meet multiple criteria.	31/7/2021	
Informed Consent	Working link to the HCV LMS Maternity website on Trust webpage. Reviewing Chelsea and Westminster resource. https://www.humbercoastandvalematernity.org.uk/		
Current workforce gap analysis	Workforce analysis approved 2020. Fully compliant with midwife: birth ratios (1:28). 2021 review planned.	31/03/2021	
NICE guidance relating to maternity	On-going work with compliance against NICE guidance, currently 90% Action (Trust target – 90%) 10 NICE guidance – partial compliance NG158 Venous Thrombolysis Diseases outstanding.	31/3/2021	
Compliance with CNST Safety Actions	Non-compliance with Safety Action 4 Clinical Workforce, 6 Saving Babies Lives, 8 MDT Training, 9 Safety Champions.	30/4/2021	

3.0 Summary of Actions

The Ockenden report Assessment and Assurance Tool (**See Appendix I**) which is due for submission on 15 February 2021 incorporates not only the initial 12 urgent clinical priorities but also CNST compliance including Saving Babies Lives v2 care bundle, workforce review, leadership, NICE guidance as well as broader issues within the Ockenden report.

Ockenden Report (from Assessment and Assurance Tool) –

- Implementation of Standard Operating Procedure from LMS regarding sharing of SI's

- Establish reporting to NLAG Trust Board re SI's
- Implement Independent Senior Advocate Role once information releasedDevelop care pathway to Regional Maternal Medicine Centre once further information released
- Implement National Antenatal Risk Assessment once further information released

CNST

Report – January 2021 highlights the areas that are currently outstanding -

- Clinical workforce, element 4, neonatal medical workforce, specifically junior staffing rota for SGH
- Saving Babies Lives, element 6, CO monitoring, uterine artery Doppler scanning, MDT training, pre-term birth clinic
- MDT training, element 8, increase compliance of K2 and PROMPT training across all staff cohorts
- Safety Champions, element 9, additional evidential requirements required from all Safety Champions

NICE guidance

Outstanding actions for NICE guidance are included in the Integrated Governance Report – January 2021.

Ockenden Report Assessment and Assurance Tool

This is the document to be reported to the LMS and Regional Team by 15 February 2021.

4.0 Neonatal plan

The analysis of Neonatal Services and care delivery throughout the review was overall very positive with only a small number of recommendations made to further improve the safety and quality of neonatal services at Shrewsbury and Telford Hospitals. The learning identified has been analysed from a local perspective and an action plan developed for NLaG to ensure the learning is applied to local practice.

There are 4 recommendations for Neonatal Services:

- Medical and Nursing notes must be combined to avoid important clinical information not being shared between all members of the team.
- There must be documented early consultation with a neonatal intensive care unit for all babies requiring intensive care.
- The Neonatal Unit should not undertake even short term intensive care, except when awaiting the transfer service, unless there is appropriate medical staff available on-site 24 hours per day.
- Consultant Neonatologists and Advanced Neonatal Nurse Practitioners must have the opportunity of regular observational attachments at another neonatal

intensive care unit.

NLaG Neonatal Services are currently compliant with two of the four recommendations and partially compliant with the remaining two with a trajectory to meet full compliance by November 2021.

5.0 Risks

- Neonatal medical workforce challenges
- Timely release of further information in regards to Senior Advocate Role, Regional Maternal Medicine Centers and National Antenatal Risk Assessment process.
- On-going challenges of working differently due to COVID.
- Challenge of working through a period of transition and transformation as a result of the Humber Acute Services Review whilst maintaining compliance with these standards.
- Managing collaborative system wide working in conjunction and significant operational change.

Financial aspects to achieve Ockenden Report –

Additional finance requirement	Cost	Detail
Birthrate + review	£6,000	Full review incl Continuity of Carer
Independent Senior Advocate Role	£58,657	AFC Band 8a
Fetal monitoring	£12,000 per year	0.5 PA x 2 Consultants
Trust wide Uterine Artery Doppler Scanning	? £5,000 training	Require clarity of any additional costs
CO monitoring equipment	£4,000	
Pre-term birth clinic	£12,000	1 PA Consultant
Pregnancy journey booklet / care plan	?£5,000	
Director of Midwifery	£18,100 per year	Uplift 8D from 8C
Digital Midwife	£51,100	AFC Band 7
Consultant Midwife (education)	£58,657	AFC Band 8A
TOTAL	**£ 230,514**	

5.0 Recommendations

The Board is asked to:-

- Note the position statement against each of the Ockenden recommendations

Appendix I

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birth-rate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1a	Describe how we are using this measurement and reporting to drive improvement	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
We are committed to follow the new regional process for the Perinatal Clinical Quality Surveillance Model.	We have the details and have produced an action plan.	We have developed a learning culture within the Division through our improvement group and governance processes. Any improvements will be fed through this route. We also escalate learning through Quality Governance Groups (QGG), Quality and Safety Sub-committee (QSC) and up to Trust Board. Within the wider systems we meet weekly as Heads of Midwifery with the LMS and then LMS Safety Working Group which meets quarterly.	Implementation of action plan and auditing of progress.	Sarah Smyth (Divisional General Manager) 28/02/2021	None	None

What do we have in place currently to meet all requirements of IEA 1b	Describe how we are using this measurement and reporting to drive improvement	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
We currently share the maternity dashboards (Y&H maternity dashboard) via LMS agendas at least every 3 months. Y&H maternity dashboard Q1 and evidence of discussion Maternity Dashboard discussed at Maternity Forum (quarterly). Evidence of the above available. National maternity dashboard launch 7/1/21 Neonatal action plan Local Maternity Dashboard fed into Nursing Metrics Meeting	The Trust benchmarks against other Trusts within the region and the LMS. Performance is discussed at the Obstetric and Gynaecological Clinical Governance meeting and fed into Quality and Safety Group and Quality Governance Group	The LMS provide challenge, this is fed back in through our improvement meetings and included for information in governance meeting. Evidence of where discussed by LMS (delivery Board) Has been on Maternity Forum agenda from October 2020 Part of regional Yorkshire and Humber network maternity safety learning group. Contributed to Maternity Collaborative 3rd wave	Continue to report fully and utilise launch of national maternity dashboard as further benchmarking opportunity. Improve the quality of the minutes for meetings Standardisation of core papers – agenda / minutes To gather evidence of improvement from Maternity Forum work more systematically Need to ensure formal item on LMS agenda	Jane Warner (Head of Midwifery) 31/03/2021	None	None

Regular submission of data to the Maternity Services Dataset – Receipt of Scorecard each month.	Discussed as part of Quality Improvement Group and CNST. Currently reporting on 11 sets of data (max 11)	Increase in data reporting, initially 9 data sets, now 10.	Continue to report fully monthly	Carrie-Louise Dixon (Senior Information Analyst) Ongoing	None	None
External clinical specialist opinion sought through reporting of 100% of all relevant cases to HSIB and NHS Resolution's Early Notification scheme	Thematic review following cluster of HSIB cases (4 cases) to aid learning including action plans.	Good working relationship with HSIB. HSIB reports fed back in through our improvement meetings and governance	Continue to report fully and work with HSIB as required Developing SOP for process	Jane Warner (Head of Midwifery), Natalie Jenkin (Clinical Governance Lead) and Claire Wickerson (Quality Facilitator) Ongoing	None	None
National Perinatal Mortality Review Tool completed for each case that meets criteria for review. PMRT Board Report submitted to Trust Board quarterly, Jan 2021 available	Perinatal Mortality Review Tool Cases from the previous quarter are presented quarterly at the Perinatal Mortality & Morbidity meeting.	PMRT feeds back in through our improvement meetings (Action 1 CNST) and governance meeting every quarter	Continue to review each case that meets the criteria with use of the Perinatal Mortality Review Tool by the multidisciplinary team.	Natalie Jenkin (Clinical Governance Lead) / Nicola Foster (Deputy Head of Midwifery) Ongoing	Consultant cost currently 0.25 PA each not in current financial envelope	N/A

Process for sharing SI's with Trust Board being implemented, currently included in the temporary Patient Impact report. Will be reported to Quality and Safety Sub-Committee on a monthly basis and then through to the Bi-monthly Trust Board for their oversight. SI's are shared with the LMS, via the Patient Safety Group. This approach will strengthen through a Standard Operating Procedure (SOP), currently drafted, which will be approved in January 2021. LMS SI SOP / SI Action plans	LMS SI SOP implemented and monitored via LMS Safety Group. Learning from other Trust's SI's are shared through Integrated Governance report.	SIs feeds back in through our improvement meetings and governance to the Division. Learning from incidents and complaints standing item on Humber, Coast and Vale health and care partnership LMS safety working group	Continue to report and implement action plans. Implement LMS SOP Draft SOP for reporting to Trust Board	Jane Warner (Head of Midwifery) / Natalie Jenkin (Clinical Governance Lead) 28/02/2021	None	None

Immediate and essential action 2: Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2 a & b?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
We be committed to providing the independent senior advocate role	Awaiting detail	Awaiting detail	Awaiting detail	TBC	There will be cost associated with this role	None

Local MVP chair works with maternity services, co-production of work plan. **CNST Safety Action 7 implemented.** **Communications to public produced, agreed and shared so consistent message given.**	MVP ToR and minutes Clinical Governance ToR and minutes Draft Better Births Strategy Group ToR and minutes Scan appointments communication Visiting during Covid collaboration work	Work to be undertaken	Final sign off of ToR for Governance group Explore the effectiveness of the roles	31/03/2021	None	None
Involvement of parents in the PMRT process	All relevant parents are involved in PMRT process, have been documenting this since beginning of 2020	Anecdotally parents are pleased to be involved. Many parents come back with questions demonstrating engagement with process.	Continue with the existing process ensuring at all times that we fully involve parents.	Natalie Jenkin (Clinical Governance Lead) Ongoing	None	None

Executive Director and Non-Executive Director with specific responsibility for maternity services and Trust safety champions meeting bimonthly and escalating to the above as appropriate,	Executive Director is Ellie Monkhouse and Non- Executive Director is Michael Proctor	They provide challenge at QSC and the Steering Group	Continue to develop and evidence relationship and strengthen ways of working Collect evidence of bimonthly meetings and escalation	Ellie Monkhouse (Chief Nurse) and Michael Proctor (Non-executive Director) 28/02/2021 31/03/2021	None	None

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities: (a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place						
What do we have in place currently to meet all requirements of IEA 3 a & b ?	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
Consultant ward round performed twice a day 7 days a week. Draft SOP for process out for comments Evidence available.	Spot check audit of handover at DPOW and SGH	Audit meeting	To add to monthly maternity audit once SOP signed off at January Governance	Preeti Gandhi 31/01/2021	None	None
Multi-disciplinary training occurs based on PROMPT training which is currently virtual due to COVID. Training discussed at LMS Safety Working Group Evidence available of training levels and 2019 Maternity Services Department Multi-Disciplinary Training Needs Analysis, Detail of online course and simulation exercises when they could be run	Patient Safety Midwives take the lead in co-ordinating the training and monitoring attendance	LMS Safer Group, Performance review and Improvement meeting (PRIM), QSC (CNST Report), Obstetric and Gynaecological Governance Group	To reach and maintain compliance across all staff cohorts. PRIM slides and Governance meeting to be reported as a stand-alone independent of Mandatory Training Further focus at LMS Safety Working Group re MDT Training	Natalie Jenkin (Clinical Governance Lead) 31/07/2021 (CNST target)	Consultant Midwife (education) AFC Band 8a	Monitor via incident reporting

CNST - Demonstrate effective system of clinical workforce planning to the required standard. Currently meet all aspects of Safety Action 4 however awaiting model roster from SGH Paediatricians* *model roster at this time as awaiting neonatal re-design outcomes / HASR.	Availability of relevant staff at all times – review of rosters, incident reporting, red flag data	Clinical Governance GP, Quality and Safety Committee (CNST).	To ensure model roster received from SGH Paeds	Preeti Gandhi (Divisional Clinical Director) 28/02/2021	None	Monitor via incident reporting

The Trust has invested £1.4m over the last 5 years into improving the safety of its midwifery services in order that the Midwifery establishments align to Birthrate Plus recommendations. In addition, funding has been allocated to meet the training needs of the maternity staff. The Trust is committed to funding these investments on a recurrent base utilising the Maternity Incentive refund where appropriate. The Trust will assess any further requirements for additional investment into the service, as part of its annual planning process.	CNST report to QSC	CNST report to QSC	None	Brian Shipley (Deputy Director of Finance)	None	None

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead

- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

What do we have in place currently to meet all requirements of IEA 4a?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
All women with complex pregnancy have a named consultant lead	Currently Spot check audit conducted 21/12/2020 DPOW – 100% (8 sets of notes) SGH - 100% (10 sets of notes) – although limited sample, will be incorporated in monthly maternity documentation audit	Audit meeting and Obstetric and gynaecological governance meeting.	Linked with York Teaching Hospital NHS Foundation Trust to share learning and practice. Review audit tool and methodology. Incorporate specific question in monthly maternity and audit to include paper and electronic records Re-audit via Mandatory training group monthly	Natalie Dowell 28/02/2021	Link with other organisations to share learning and ideas for auditing.	None

What do we have in place currently to meet all requirements of IEA 4b?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Will develop a Standard Operating procedure and care pathway to which identifies how women are referred into a Regional Maternal medicine centre once guidance released	We will expect data from the Regional Maternal Medicine Centre	Family Services Divisional Board meeting	Develop the SOP / Care Pathway once further detail known.	Preeti Gandhi 30/04/2021	Regional Maternal Medicine Centre	Continue to refer complex / high risk women as per current processes

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Risk assessment recorded at every contact including place of birth. Documentation audit undertaken and presented at audit meeting, however methodology not robust and concern re validity of results Personalised Care and Support Plan (PSCP). Reported via MSDS (Scorecard).	Spot check audit completed – DPOW – 100% (15 sets of notes) SGH – 93% (15 sets of notes)	Audit meeting For the two audits that were done, need to write a short methodology section and put them in a paper	Linked with York Teaching Hospital NHS Foundation Trust to share learning and practice. Review audit tool and methodology. Audit to include paper and electronic records Re-audit via Mandatory training group monthly	Natalie Dowell 28/02/2021	Link with other organisations to share learning and ideas for auditing	None
We are committed to sign up to the National Antenatal Risk Assessment process when available.	Dependent on what the National Antenatal Risk Assessment process is.	Dependent on what the National Antenatal Risk Assessment process is.	Dependent on what the National Antenatal Risk Assessment process is.	Dependent on what the National Antenatal Risk Assessment process is.	Dependent on what the National Antenatal Risk Assessment process is.	None

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Name of the Midwife Lead for Fetal Monitoring and Well Being – Linda Keech. Midwife has 0.2wte specifically for SBLv2. Name of the Consultant Obstetrician Lead for Fetal Monitoring and Well Being – Miss Mohammed – SGH, Miss Kotlinska - DPOW	0.4 WTE midwife dedicated time for each site, Fetal monitoring lead Evidence – training sessions, K2 evidence,	Improvement in training, reduction in related incidents and complaints. This will contribute to improved outcomes for women.	Obstetrician role is new so this needs further development. Clarification of role to others.	Preeti Gandhi 30/04/2021	Link with other organisations to support development of the role. 0.5 PA per consultant unfunded	Continue to monitor outcomes, incidents.
Saving Babies Lives Care Bundle v2 – 5 elements, full implementation of element 3 & 4.	Assessment of progress reported quarterly to LMS	Assessment of progress reported quarterly to LMS	Continue to work on the implementation of standards 1,2,5 and sustaining 3 and 4.	Jane Warner 31/07/2021 (CNST timeframe)	Trust wide uterine ultrasound scanning CO monitoring equipment for SGH Preterm birth clinic - PA	Continue to monitor outcomes, incidents.

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
There is a working link to the HCV LMS Maternity Website. All women throughout their journey are signposted to the website and link.	When website updated there will be an automatic update onto link. All women signposted at first contact with maternity services and throughout pregnancy.	Consistent up to date information being given across entire LMS.	Continue to ensure that the information is up to date and accurate. Link with other organisations to see how they measure effectiveness	LMS Midwife / Jane Warner Ongoing	None	Monitor through patient feedback and complaints.
Pathways of care described within HCV LMS Website.	Ensure updated as necessary	Regular updates	Consider similar good practice e.g. Chelsea & Westminster to be implemented by LMS.	Jane Warner / LMS 31/03/2021	Finance to support development of similar booklet	Monitor through patient feedback and complaints.
Service User Feedback – NLaG Maternity Facebook site, Friends & Family, Family Services newsletter, National Maternity Survey, Ask The Midwife service, MVP meetings Patient report Evidence of working with MVP	National Maternity Survey – annually, Ask The Midwife, NLAG Facebook, FFT – on-going MVP survey	Service user feedback gained and acted upon.	Feedback from specific CoC teams which includes BAME, teenagers, smokers	CoC leads, Jane Warner 31/01/2021	Continued working with MVP	Monitor through patient feedback and complaints.

Section 2
MATERNITY WORKFORCE PLANNING
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Birthrate Plus was undertaken in 2018, together with a clinical judgement process with Head of Midwifery and Chief Nurse early 2020. Outcome approved and funded increase in midwife appts to full establishment. Further workforce review planned March 2021.	Routine review of escalation requirements, Red flag data, incident reporting, vacancy factor. Daily staffing return Use of agency Staffing plan Christmas Monthly review by Labour Co-ordinator, Matron (tool) Senior Management team discussion - Nursing metrics mins (draft)	Recruitment to full establishment. Regular establishment reviews monthly / annually with Chief Nurse	Regular workforce reviews. Further Birthrate Plus exercise incorporating Continuity of Carer teams.	Jane Warner / Ellie Monkhouse / Frontline teams 31/03/2021	Funding for Birthrate Plus - £6K + vat Cost implications of next review	Continue to review escalations and Red Flag data / adverse incidents / unit closures / vacancy increases by Datix / Escalation documentation.

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

The Head of Midwifery is professionally accountable to the Chief Nurse, with the HoM being a key role in the senior nursing leadership structure for the trust being a member of the Nursing, Midwifery and Allied Health Care Professionals Board. The HoM has a strong profile with the trust board and Quality and Safety Committee regularly presenting information and reports.

There is a Deputy Head of Midwifery, x2 Matrons and specialist midwives in Clinical Governance, Perinatal Mental Health, Clinical Skills and Safety, Bereavement as well as a Consultant Midwife specialising in Public Health issues.

There has been committed support for leadership development which has been well received and helpful and which has included Executive mentoring and coaching. This has been part of a bespoke programme developed by the Chief Nurse working closely with other Heads of Nursing across the trust. The trust also has a commitment to support training and development across the workforce and all requests have been met in the last year 20/21.

Succession planning promoted via PADR i.e. Band 6 midwives acting up as Labour Co-ordinators, temporary specialist posts; NHS Leadership Academy courses promotion / in-house management courses. Encouragement of secondment opportunities i.e. x2 HSIB, x1 HCV project management post.

With respect to the recommendations within the Royal College of Midwives ‘Strengthening midwifery leadership: a manifesto for better maternity care’, there would be a requirement for funding for a Director of Midwifery post.

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
NLAG Guidelines – Reviewed and updated 6 months prior to review date. A reviewer is assigned with an editable version. Subsequently shared amongst all members of the O&G Governance group and other related groups for comments. Further updates and then discussed and ratified at O&G governance meeting. Uploaded to Intranet via Document Control lead. Shared with all staff via Up2Date (accessible Intranet area for all staff which highlights learning lessons, updated guidance/policies etc.) (Circa 900 docs within division)	Monthly at O&G Governance meeting	Robust review of docs, benchmarking to current guidance	Continue with Process	Natalie Dowell Ongoing	None	None

NICE facilitator and reported via Integrated Governance report at O&G Governance meeting = 90%. Maternity Services have one active deviation in place which relates to: NG133 Hypertension in pregnancy: diagnosis and management.	Monthly	Moderate assurance – they are up to date, accurate. Where our weakness is in the implementation of the action plans	Review and embed a robust process to ensure that actions are met. Set up a separate NICE meeting to manage process.	Preeti Gandhi 30/04//2021	Multi-disciplinary involvement increase in clinician engagement	Regular review of incidents and complaints
No non-evidence based documents						

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	02/02/2021
REPORT FOR	Trust Board
REPORT FROM	Kate Wood
CONTACT OFFICER	Lucy Kent
SUBJECT	CQC progress report
BACKGROUND DOCUMENT (if any)	None
PURPOSE OF THE REPORT	To update on progress of CQC Improvement plans
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Trust Management Board
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The team continues to focus on completing templates to demonstrate progress and getting the new refreshed action plans signed off. Some information has been transferred to CQC but need to gain pace with this process.

	Sept	Oct	Nov	Dec	Jan
Number of actions	143	144	144	120	115
Blue	4.9% (7)	11% (16)	15.3% (22)	11.6% (14)	9.6 % (11)
Green	47.5% (68)	45% (65)	40.3% (58)	61.7% (74)	68.7 % (79)
Amber	17.5% (25)	15% (22)	11.1% (16)	4.5 % (5)	3.5% (4)
Red	28.0% (40)	26% (38)	31.9 % (46)	21.7% (27)	18.2 % (21)
Need update	0.7% (1)	0.7% (1)	0%	0%	0%
On hold	1.4% (2)	1.4 % (2)	1.4% (2)	0%	0.9% (1)

Month by month comparison is more difficult for November, December and January as during these months actions have been combined, rewritten or closed and removed. Removing signed off actions helps make the improvement plans more manageable and facilitates the focus on the work that is left to do. In addition, new

	sub-actions have been added to help achievement of the overall action and timescales refreshed to reflect the second wave of COVID 19. Areas that are ragged as red can be largely themed into 3 groups • The difficult to maintain actions which dip in times of increased patient demand, staff sickness and/or annual leave • Areas that have been directly impacted by COVID such as activity • Areas where transformational change or additional resources are required to meet the standards. In the latter case a revision of a position paper is being rewritten to detail the mitigatory actions and any proposed plans to work differently.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Strategic Risk 1: Risk of non-delivery of constitutional performance targets, specifically: (a) Cancer 62 day, (b) A&E, (c) RTT - 18 weeks, (d) Diagnostics - DMO1. Strategic Risk 2: Risk of non-delivery of agreed quality and clinical improvements (includes the risk of non-delivery of a reduction in the mortality ratio). Strategic Risk 4: Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and longer term. Strategic Risk 5: Ineffective staff engagement and ownership of Trust agenda affects morale and failure to change and improve the culture. Strategic Risk 8: Inability to pursue a clear organisational strategy that staff and stakeholders are aware of and support. Strategic Risk 9: Lack of an integrated ICS, Humber and Trust clinical strategy which delivers long term system, service and organizational sustainability including the ability to attract inward investment. Strategic Risk 10: The risk of ineffective relationships with stakeholders.

TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: To note the report

Kindness · Courage · Respect

CQC Progress in December 2020

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1. Summary

This paper details the progress that has been made over the last month and highlights the areas where assurance cannot be provided due to lack of progress or high level of risk. In general, progress continues but it has been negatively impacted on by the second surge of COVID 19 and staff taking much needed Annual Leave. Whilst formal reporting was stood down in November actions were still collated and the improvement plans for four of the Divisions, Medicine and Urgent Care, Surgery and Critical Care. Family Services and Clinical Support Services (Clinical Sciences) were reviewed and a draft report produced. In December further refinement with the improvement plans has happened and the fifth Division, Community and Therapies has been reviewed. These new plans are in the process of being agreed and signed off by the Divisions, but again this is taking longer than anticipated. Despite the challenges of COVID-19 there is continual focus on addressing actions that are ragged red and the completion of assurance templates and position papers to evidence work done.

Month of Impact Report/PRIM slide	Sept	Oct	Nov	Dec	Jan
Number of actions	143	144	144	120	115
Blue	4.9% (7)	11% (16)	15.3% (22)	11.6% (14)	9.6 % (11)
Green	47.5% (68)	45% (65)	40.3% (58)	62.5% (75)	68.7 % (79)
Amber	17.5% (25)	15% (22)	11.1% (16)	5.0 % (6)	3.5% (4)
Red	28.0% (40)	26% (38)	31.9 % (46)	20.8% (25)	18.2 % (21)
Need update	0.7% (1)	0.7% (1)	0%	0%	0%
On hold	1.4% (2)	1.4 % (2)	1.4% (2)	0%	0.9% (1)

Straight comparison of the numbers across November, December and into January is not recommended due to the work that was being undertaken on the plans. During November and December we (as a central team) reviewed the plans in terms of

- removing those actions which had been blue for several months,
- combining actions which were very similar and required the same sub actions to be carried out,
- rewriting sub actions with the divisions where the desired outcome had not been achieved from the previous sub actions.

Unfortunately although we attempted to review all the plans during one month this was not achievable. Divisional buy-in with the plans was again seen as paramount and although many good discussions have been had, many meetings have been postponed or had limited attendance so to ensure cross divisional engagement the process has carried on over the cut off timeframes for December and January - therefore leading to changes in the reported numbers. Therefore direct comparison of month on month should be avoided. We also had a few assurance templates that were expected to, but did not, get signed off at the December Governance meetings, however these are being picked up in January. We expect a further couple of alterations to the plans during January and then the plans will then be signed off by the Division and the CQC. What has been

extremely positive is the amount of engagement with the Divisions on these plans with good challenge on sub actions, timescales and revision of responsibilities, it has therefore felt the right thing to do to spend longer on them to get them right and make the improvement journey more achievable and sustainable.

There are still 21 actions that remain red, these can be largely themed into 3 groups

1. The difficult to maintain actions which dip in times of increased patient demand, staff sickness and/or annual leave such as mandatory training, appraisals and reviewing documents.
2. Areas that have been directly impacted by COVID, but also need system support, such as performance activity Outpatient Appointments (OPAs), Cancer waiting times, Referral to treatment (RTT).
3. Areas where transformational change or additional resources are required to meet the standards e.g. paediatrics medical staffing, Registered Sick Children's Nurses (RSCNs) in Emergency Departments.

Following the NHSEI Quality Improvement Board on 13th December there was a call to review the expectations of these with the CQC in light of current challenges within the system and a paper reviewing these last 2 points will be presented at the February NHSEI Quality Board.

2. Progress

- The Divisions have continued to meet with us to work through the plans, although some meetings have been cancelled or have had reduced attendance.
- Meetings with the CQC ambassadors were cancelled due to COVID in November but have been reinstated virtually in December. Attendance has been poor so we are thinking differently about how to engage, including recording the sessions and then making sure they are accessible to everyone. As soon as possible we would like to return to face to face meetings as this is the most effective way of creating a network. One particular positive action is linking in with the Practice Development team at DPOW because of the cross-hospital nature of their role it is hoped that they can be very effective in sharing the information.
- Some uploading of information to the CQC that has been reviewed and signed off by the Executives.
- External oversight of progress continues to be provided through the NHSEI Quality Board.
- Monthly relationship meetings continue with the CQC.
- Attendance of our two CQC relationship managers to the Divisional meetings with Family services in November; Surgery and Critical Care, Clinical Sciences and End of Life in December; and Medicine in January. They have asked to continue to attend these meetings moving forward.
- Mitigation paper has been shared with CCGs, indirect feedback received, work up for presentation to Quality Improvement Board in February.
- Position papers are now being written for key areas of improvement, including governance, complaints, mandatory training, referral to treatment and Outpatient appointments. Corporate data is being used and narrative is being supplied by the Divisions. Position papers recognise that there are still developments that need to be made in an area, for example governance, but that huge improvements have already been made and we want to share that progress with the CQC, CCGs and NHSEI. It also starts to embed a culture of improvement rather than tick box approach to the CQC recommendations which fundamentally are all about the safety of our

patients and staff. There needs to be recognition that some of these areas are either fundamental to the running of a safe organisation such as governance or that they remain fragile in our organisation, vulnerable to the many other competing pressures e.g. mandatory training, that we are facing at the moment. Therefore a continual improvement approach is needed to embed them for many months as the culture of the organisation changes.

- Two divisions have identified additional actions that they want to add as a separate tab to their CQC improvement plan which marks the start of making these divisional improvement plans rather than improvement plans driven solely by CQC recommendations for action.

3. Risks to delivery of CQC Improvement plans

- The organisation has been experiencing particular challenges in the last few months due to the significant increase in the numbers of COVID positive patients and staff, or staff needing to self-isolate. There has been a continual process of reconfiguration of services and particular challenges around oxygen delivery resulting in patient moves to maintain safety. At all times patient safety has been the priority and there has been some negative impact on the progress with the plan, in particular on the actions around performance, mandatory training and PADRs. Further challenges are anticipated if we experience a third wave of COVID.
- Culture around measurement and the continuing challenge of defining and collecting evidence which is both sufficient and pragmatic continues to develop.
- Lack of capacity within corporate teams and Divisions to do the work with competing priorities. The organisation is delivering change on multiple aspects for example the work around the new Emergency Departments, the Acute Integrated assessment Units and Discharge to assess and regularly planned system wide accelerated discharge events, the first of which happened week commencing 14th December and the second 11th January.
- Financial cost of CQC actions: -separate financial paper.

4. Areas of learning

- Ongoing learning about what is evidence.
- Need to maintain the momentum despite many other competing priorities
- Changing nature of the CQC monitoring process and the need to start transferring a steady supply of evidence to them.
- Managing the actions that are signed off to become business as usual. There is concern that the improvements achieved may falter or be lost. The proposed future approach is that once the new plans are agreed and work is ongoing we will also revisit the actions that have been signed off to check these have been embedded, encouraging a continuous approach to improvement.

5. Areas where there is concern on progress

Those CQC actions that have been ragged red in the monthly matrix for PRIM are presented below under the relevant Trust Board Safety Committee for closer scrutiny with key sub-actions included. The reason for the rag rating is included, whether recovery is anticipated or whether this is a significant problem that the Division requires additional internal or external to NLAG support. It is also highlighted whether the action is on the Trust Risk register and whether evidence will start to be shared with CQC for the action.

Appendix 1 details the plans that have been reviewed this month for Medicine, Surgery, Diagnostics, Community and Therapies and Family Services that are rated green and amber. All CQC actions have been presented in one report to prevent silo reporting.

Appendix 2 demonstrates the movement of actions across into the new Community and Therapies plan.

6. Quality and Safety Committee

Policies and guidelines in use within clinical areas are compliant with National Institute for Health and Care Excellence (NICE) or other clinical bodies.

Ragged red because not achieving target and within current constraints anticipate this will remain a major challenge. This is within the remit of the Division to resolve but they are looking at their processes to see if they can make improvements although one of the significant issues is clinician availability which is significantly affected by COVID 19.

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating/On risk register
9S – Surgical Care	The service must ensure that policies and guidelines in use within clinical areas are compliant with National Institute for Health and Care Excellence (NICE) or other clinical bodies.	Process in place to identify and distribute documents, focus of activity. Currently at 84%, 83 full compliance, 13 partial compliance, 7 outstanding	Report progress to achieve target of 90% - **This action is off track.** Address backlog by utilising clinicians that are shielding – **This action is on track.** Revise document checklist to ensure quicker and simpler to use as already incorporates these key areas – **This action is on track.** Ensure compliance with evidence base for policy guidelines, NICE guidance, Royal college Guidance etc. – **This action is on track.**	31/03/2021 31/01/2021 31/01/2021 31/03/2021		Evidence being collated/ Not yet submitted Detail of process, NICE report from Integrated Governance report, Revised document checklist	Likely but also area for continuous improvement.	Not on risk register
28M – Medicine	The service should ensure that version-controlled documents are reviewed in line with trust policy and national guidance.	82.1%, 31 documents currently awaiting formatting and upload. All 90 documents that are currently overdue have been reviewed with many being reallocated to new (more appropriate)	Report progress to achieve target of 90% - **This action is off track.** Scoping virtual approval process – **This action is on track.** Checklist review and improvement – **This action is on track.** Re-audit of documents of records via Governance Lead Walk rounds – **This action is on track.**	31/03/2021 31/03/2021 30/04/2021 28/02/2021		Document control register Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement.	On risk register

		reviewers with good response. Expect to see impact in February figures. This is being considered as priority.						

Patients on the pre-assessment unit have access to an emergency call system.

This is ragged red because although there is a new completion date we are not confident that it will be achieved as this now requires significant funding. This work is interdependent on NLAG facilities and has been escalated at PRIM. The issue that has emerged is the age of the call system within the department. Work was started to just add additional units however what has emerged is that this is not a viable solution due to the age of the overall system and it needs replacing in entirety. Therefore currently action is to review costs of new system and also whether use of rooms can be reconfigured across the department.

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating/On risk register
19S – Surgical care	The service must ensure that patients on the reassessment ward have access to an emergency call system.	Emergency call system requested at DPOW.	Undertake spot check audit to ensure in place and operational – **This action is off track.**	28/02/2021	Patients do not currently wait in the room. Not affecting flow currently due to reduced services being offered in the Department.	Photo or emergency call system Evidence being collated/ Not yet submitted	Dependent on funding	Reviewing whether should go on risk register

7. Finance and Performance

Challenges regarding overdue new and follow up appointments.

The work in respect to the following three actions, Outpatients, RTT and 62 Day cancer waits are managed externally to the CQC plan through PRIM and the system wide Outpatient Transformational Programme. They are ragged red because of the risk around this area, increasing numbers in most areas and the degree of pace that is required. Further work is being undertaken on the wording of the sub actions to distinguish between the facts that we have achieved improved monitoring of the patients but we are having difficulty achieving the performance targets that were agreed for 2020/2021. Additional work is also ongoing on the monitoring on risk stratification.

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating/On risk register
4D – Medical Division	The service must continue to address the challenges regarding overdue new & follow up appointments & ensure patients receive their appointments in a timely way across OP specialties.	Regular performance report available	Report average wait to first new appointment – **Data not available yet.** Report the number of overdue follow-up with no due date – **This action is off track.** Report the number of outpatients with follow-ups overdue – **This action is off track.** Monitor the % risk stratified, 1a, 1b, 2, 2a, 3, 4 in-patient list – **This action is on track.** Monitor the management of those patients not seen within	31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/03/2021	To help minimize the risk to patients who are due or overdue a follow-up appointment, we have agreed with our local GP's to work collaboratively with the Trust to clinically validate/risk stratify their patients. We have received a sum of money from NHSEI to	Position paper being collated	Unlikely	On risk register

			that timescale – **This action is on track**		support this work.			
4D – Surgery Division	The service must continue to address the challenges regarding overdue, new and follow up appointments and ensure patients receive their appointment in a timely way across the outpatient specialties.	Regular performance report available	Report average wait to first new appointment – **Data not yet available** Report the number of overdue follow-up with no due date – **This action is off track.** Report the number of outpatients with follow-ups overdue – **This action is off track.** Monitor the % risk stratified , 1a, 1b, 2, 2a, 3, 4 in-patient list – **This action is on track.** Monitor the management of those patients not seen within that timescale – **This action is on track.**	31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/03/2021	As above	Position paper being collated	Unlikely	On risk register
4D - Women's & Children Division	The service must continue to address the challenges regarding overdue new & follow up appts & ensure patients receive their appt in a timely way across OP specialties.	Regular performance report available	Report average wait to first new appointment – **Data not available yet.** Report the number of overdue follow-up with no due date – **This action is off track.** Report the number of outpatients with follow-ups overdue – **This action is off track.** Monitor the % risk	31/03/2021 31/03/2021 31/03/2021	As above	Position paper being collated	Unlikely	Paediatrics on risk register

			stratified, 1a, 1b, 2, 2a, 3, 4 in-patient list – **This action is on track.** Monitor the management of those patients not seen within that timescale – **This action is on track.**	31/03/2021 31/03/2021				

Cancer 62 day waits

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating/On risk register
5D – Surgery Division	The service must ensure that 62 day cancer waiting times target for appointments is achieved.	Regular performance report available	Report the Cancer PTL 62 days + performance – **This action is off track.**	31/03/2021		Position paper being collated	Unlikely	On risk register

Referral to treatment

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating/On risk register
18M - Medicine	The service must continue to meet national treatment and performance standards in all specialties.	Regular performance report available	Develop clear processes of reporting of RTT waiting times **This action is on track.** Report the number of patients waiting over 52 weeks – **This action is off track.** Monitor the management of those patients not seen within that timescale **This action is on track.**	28/02/2021 31/03/2021 31/03/2021	Each specialty has a plan on a page detailing individual trajectories and targets to improve the waiting list position, this includes narrative of; the current position, potential issues, plans to recover and any required escalations.	Position paper being collated	Unlikely	On risk register
10S – Surgery	The service must continue to meet national treatment and performance standards in all specialties.	Regular performance report available	Develop clear processes of reporting of RTT waiting times **This action is on track.** Report the number of patients waiting over 52 weeks – **This action is off track.** Monitor the management of those	28/02/2021 31/03/2021 31/03/2021	As above	Position paper being collated	Unlikely	On risk register

			patients not seen within that timescale **This action is on track.**					

Challenges regarding waiting lists for treatment and ensure patients receive their appointments in a timely way.

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating/On risk register
4Da - Clinical Sciences	The Service must continue to address the challenges regarding waiting lists for treatment and delays in reporting results and ensure patients receive their appointments in a timely way across all modalities.	Regular performance report available	Report average wait to appointment – **This action is off track.** Monitor those patients not seen within the timescale – **This action is on track.** Monitor the management of those patients not seen with the timescale – **This action is on track.**	31/03/2021 31/03/2021 31/03/2021	Have a plan of the current position, potential issues, plans to recover and any required escalations.	Evidence being collated/ Not yet submitted	Unlikely	On risk register

Ensure risks associated with delayed access to an emergency (2nd) theatre are closely monitored &minimised (Room 2).
This is rated red as requires additional capital expenditure which is not anticipated to be secured and therefore do not expect to achieve this action in the short term.

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/	Likelihood of Compliance	Rag Rating/On risk

						submitted to CQC		register
33O&G	The service should ensure risks associated with delayed access to an emergency (2nd) theatre are closely monitored &minimised.	24/07 access being delivered by surgery and critical care,	Identification of a second theatre remains here and involves capital investment in room 2 at SGH– **This action is off track.**	28/02/2021	Procedure for Theatre Access for obstetric emergency cases at Scunthorpe General Hospital	None	Unlikely without further resource	Not on risk register

8. Workforce committee

Mandatory training and appraisal standards

Ragged red for Family services, Medicine and Surgery as second wave has negatively impacted on compliance. This is dependent on working with the Training and Development department and course leads. Each Division is developing a recovery plan building on the strategies used pre the second COVID wave which were proving to be successful.

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating/On risk register
10P – Paediatrics 16P – Paediatrics 20O&G	The service must ensure that all staff complete mandatory (core and specific) training to meet the trust's set standard of 90% core, 80% role specific.	Core 86% IG 83% Role specific 79%	Consistently meet Trust target of 90% Core MT across the Division – **This action is off track.** Consistently meet Trust target of 95% IG across the Division – **This action is off track.** Consistently meet Trust target of 85% Role specific MT across the Division – **This action is off track.**	31/03/2021 31/03/2021 31/03/2021	Recovery plan being written	Training records Process for non-compliance Position paper being written	Likely but also area for continuous improvement.	Not on risk register

		Medical and Dental Core = 68% Role specific = 86% Venous Thromboembolism (VTE)|= 69% Nasogastric Tube Displacement|= 0%	All Individual staff groups consistently meet Trust target of 90% Core MT, 85% Role specific and 95% IG – **This action is off track.** Individual competencies meet level of compliance to achieve 90% for Core competencies, 85% Role specific and 95% IG – **This action is off track.** Implement process of escalation for noncompliance as appropriate, – **This action is on track.**	31/03/2021 31/03/2021 31/12/2020				
8Sa – Surgical care	The service must ensure medical and nursing staff comply with Mandatory Training, Safeguarding and mental capacity training requirements and are appraised annually.	Currently 86% Core IG 85% 78% Role specific	Consistently meet Trust target of 90% Core MT across a Division – **This action is off track.** Consistently meet Trust target of 95% IG across the Division – **This action is off track.** Consistently meet Trust target of 85% Role specific MT across the Division – **This action is off track.** All individual staff groups consistently meet Trust target of 90% Core MT, 85% Role specific and 95% IG – **This action is off track.** Individual competencies meet level of compliance to achieve 90% for Core competencies, 85% Role	31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/03/2021	Recovery plans being written	Training records Process for non-compliance Position paper being written	Likely but also area for continuous improvement.	Not on risk register

			specific and 95% IG – **This action is off track.** Implement process of escalation for noncompliance as appropriate, where other avenues have been exhausted – **This action is on track.**	31/12/2021				
8Sb – Surgical care	The service must ensure all staff have up to date appraisals.	71% 72% 74% 69% 89% 47% 69%	Consistently meet 85% Division overall – **This action is off track.** Consistently meet 85% for Prof Scientific and Technic – **This action is off track.** Consistently meet 85% Additional Clinical Services – **This action is off track.** Consistently meet 85% Administrative and Clerical – **This action is off track.** Consistently meet 85% Allied Health Professionals – **This action is on track.** Consistently meet 85% for medical and dental – **This action is off track.** Consistently meet 85% Nursing and Midwifery Registered – **This action is off track.** Evidence of escalation of non-compliance – **This action is on track.**	31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/03/2021	Recovery plans being written	Training records Process for non-compliance Position paper being written	Likely but also area for continuous improvement.	Not on risk register
6D – Medical	The service must ensure that all	Core 83%	Consistently meet Trust target of 90% Core MT	31/03/2021		Training records	Likely but also area for	Safeguarding and resus on

Division	staff complete mandatory (core and specific) training to meet the trust's set standard of 90% core, 80% role specific and 95% IG	IG 80% Role specific 73% Core Medical and Dental Core 51%, and Role specific = 43%% Nasogastric Tube Displacement| =36% Moving & Handling - Module 11 - Once Only = 6%	across the Division – **This action is off track** Consistently meet Trust target of 95% IG across the Division – **This action is off track** Consistently meet Trust target of 85% Role specific MT across the Division – **This action is off track** All Individual staff groups consistently meet Trust target of 90% Core MT, 85% Role specific and 95% IG – **This action is off track** Individual competencies meet level of compliance to achieve 90% for Core competencies, 85% Role specific and 95% IG – **This action is off track** Implement process of escalation for noncompliance as appropriate, where other avenues have been exhausted – **This action is on track**	31/03/2021 31/032021 31/03/2021 31/03/2021 31/12/2020		Process for non-compliance Position paper being written	continuous improvement.	risk register

50% of nursing staff hold a post graduate qualification in critical care nursing

Ragged red due to a historical shortage of training opportunities across the Region, this looks like it is improving, but will take time for our figures to reflect the increased number of courses available. This has been escalated as this is outside the Division and NLAG's control.

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating/On risk register
37CC – Critical care	The service must ensure that at least 50% of nursing staff hold a post graduate qualification in critical care nursing to meet the GPICS standards.	Escalation of issue Implementation of Critical Care Workbooks with aim that 90% will be working through them or completed.	Continue to escalate need for additional local provision and access available resource – **This action is off track.**	31/03/2021	Critical care competency workbooks 1&2 Clinical educators provide regular education to staff	Position paper will be shared	Likely but also area for continuous improvement.	Not on risk register

National standards for medical staffing

Rated red as delay in review work funded for delivery NLAG, looking at working differently within NLAG but still anticipate some additional resource will be required if service configuration remains the same.

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating/On risk register
9P - Paediatrics	The service must ensure that they are meeting national standards for medical staffing.	Rotas have been rewritten with costing for new model vs old done, achieving partial compliance.	Review work that is funded for delivery by NLAG – **This action is off track.** Explore different ways of working – **This action is on track.** Continue to mitigate staffing levels and escalate issues – **This action is on track.**	31/01/2021 28/02/2021 31/03/2021	Locum doctors both internal and external are being used to fill the gaps on the medical rota to ensure safety, this is at financial risk to the Division.	Included in finance paper In addition job plans and rotas	Unlikely without additional resources in current configuration	On risk register

RSCNs meeting the Intercollegiate Emergency Standard

Significant amount of work has been undertaken and continues to mitigate the risk however the Department is still not compliant with the recommended level of staffing. This action requires system wide support as additional resources are required if this service continues to be delivered across 2 sites.

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating/On risk register
7ED	The service must ensure they appropriately recruit staff specifically registered sick children's nurses (RSCN) to meet the Intercollegiate Emergency Standard of two RSCN's per shift.	Introduction of the Paediatric Emergency Nursing team	85% of appropriate adult nurses undertaken theory paediatric competency Day 1 – **This action is on track.** 85% of appropriate adult nurses had paediatric competencies signed off – **This action is on track.** 85% of Band 6 and Band 7 RNS to complete European Paediatric Advanced Life support (EPLS) – **This action is off track.** Reduction of serious incidents relating to sick children in ED – **This action is on track.** Increase in learning and discussion of incidents and potential gaps – **This action is on track.**	31/03/2021 30/09/2021 30/04/2021 31/03/2021 28/02/2021	Paediatric team Staff undertaking Intermediate Life Support training	Included as part of the structured conversation and a business case in the financial paper	Unlikely	On risk register

The service should ensure that there are sufficient qualified, competent, skilled and experienced staff to meet the needs of people using the services.

This is emerging as a potential challenge, currently working on reviewing the capacity and demand detail but anticipate a requirement for additional staffing from establishment review.

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating/On risk register
CT5	The service should ensure that there are sufficient qualified, competent, skilled and experienced staff to meet the needs of people using the services.	Currently out for procurement of allocation system.	Continue to work through some acuity and complexity scales and plan to trial one in next 3 months. Continue to draft a caseload review tool– **This action is off track.** Write Business Case for additional nurse staffing – **This action is on track.**	31/03/2021 31/03/2021		None	Likely with resources	Evening service on risk register

9. Trust wide recommendations

Action	Progress	Lead
The Trust must ensure they have evidence to show that complete employment checks for executive and Evidence being collated/ Not yet submitted executive staff have been taken in line with the Fit and Proper Persons Requirement (FPPR) (Regulation5).	Ongoing piece of work to audit every file for every piece of required paperwork. Not to be presented to Trust Board until February 2021. No evidence submitted.	Helen Harris
The Trust must ensure that effective and robust systems are in place to support the management of governance, risk and performance. (Regulation17).	Picked up in Divisional plans and to start sharing information.	
The Trust must develop a clinical and financial strategy that addresses the delivery of safe and sustainable services. (Regulation17).	Clinical Strategy picked up within Division and overall Clinical Strategy is out for wider consultation to be presented at Trust Board in February. Financial strategy is expected to be presented at April	Kerry Carroll Finance Director

	Trust Board.	
The Trust must ensure complaints are addressed in line with the trust policy. (Regulation16).	Picked up in Divisional plans. Corporate team also had a plan which reports into Quality and Safety Committee. No evidence submitted.	Dawn Harper/ Jo Loughborough

Appendix 1 - Other actions

Medicine and Urgent Care

Division	CQC Action	Progress to Date	Further Actions Required / Agreed to provide assurance	Due Date for Completion	Actions to mitigate risk	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Overall Rag Rating
1D – Medical Division	The trust must ensure that effective and robust systems are in place to support the management of governance, risk and performance.	Position paper to include Divisional level progress.	Trust documentation is adopted for Service Governance meetings, Agenda, Action log and Minutes – **This action is on track.** Ensure there is clear evidence of learning from incidents, complaints, audits, SIs and mortality feeding through to the wards– **This action is on track.** All speciality meetings to meet X times a year and have an agenda and action	31/01/2021 28/02/2021		Position paper will be submitted detailing improvements at Divisional level.	Likely but also area for continuous improvement.	

			log – **This action is on track.** Speciality meetings not to be cancelled unless Tri agreement – **This action is on track.** Review mins of Governance meetings to ensure that all standing items are being discussed – **This action is on track.** Review previous scoping document of need for additional governance/administration support – **This is action is on track.**	31/03/2021 31/03/2021 31/03/2021 28/02/2021				
3D – Medical Division	The Trust must ensure that 85% of complaints are addressed in line with Trust policy	Position paper being written to show reduction in overdue complaints over last year	Implement new complaints process – **This action is on track.** Close down complaints within old (pre - November 2020) process – **This action is on track.** Achieve Trust aspiration - 85% of all complaints - within the new process being resolved within 60 days – **This action is on track.** Achieve Trust aspiration of 85% of all reopened cases to be resolved within 20 working days – **Data not available** Strengthen the process for	30/11/2020 31/01/2021 31/07/2021 31/12/2020		Position paper will be submitted detailing progress so far.	Likely but also area for continuous improvement.	

			learning from complaints, incorporating the proposed monthly report from the Corporate Team, so staff in the Divisions they can evidence an understanding of key themes arising from complaints and the resultant learning and improvement action taken – **This action is on track.**	30/04/2021				
5D – Medical Division	The service must ensure the 62-day cancer waiting times target for appointments is achieved.	Position paper to include Divisional level progress.	Develop clear processes of reporting of 62 day cancer waiting times – **This action is on track.** Report PTL Cancer 62 days – **This action is off track.**	28/02/2021 31/03/2021		Cancer waiting times Evidence being collated/ Not yet submitted	Likely	
9ED	The service must ensure that the mental health room is compliant with the Psychiatric Liaison Accreditation Network (PLAN) standards.	Much work has been carried out redesigning the rooms, tenders being reviewed	Redesign completed – **This action is on track.** 100% of risk assessments completed on all relevant patients until rooms available – **This action is on track.** Learning from any self-harm or suicidal incidents – **This action is on track.**	31/03/2021 31/01/2021 31/01/2021		Audit of risk assessment Learning from self-harm or suicidal incidents Evidence being collated/ Not yet submitted	Likely	
10ED	The service must ensure all staff have up to date appraisals.	Overall 79% 85% 72%	85% Division overall – **This action is off track.** 85% Additional Clinical Services – **This action is on track.** 85% Administrative and Clerical – **This action is off track.**	31/03/2021 31/03/2021 31/03/2021		PADR records Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement.	

		100% 47% 79% 60%	85% Allied Health Professionals – **This action is on track.** 85% Healthcare Scientists – **This action is off track.** 85% Nursing and Midwifery Registered – **This action is off track.** 85% Medical staff – **This action is off track.** Evidence of escalation of non-compliance – **This action is on track.**	31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/12/2020				
11ED	The service must ensure that oxygen is prescribed appropriately to all patients.	All PGDs extended by 6 months , have had initial reviews awaiting sign off	Oxygen PGD updated and disseminated – **This action is on track.** Gain clinician involvement – **This action is on track.** Audit oxygen prescribing via the WAT – **This action is on track.**	30/04/2021 30/04//2021 30/06/2021		PGD Evidence being collated/ Not yet submitted	Likely	
12ED - SHOULD	The service should ensure patients are given pain relief medication appropriately (adult).	New card live 9/12/20, pain scores communicated to staff, visual prompts in Department, assessed at screening, triage and ongoing, includes prompt for reassessment	A&E card goes live which incorporates pain tools for adults, learning disabilities, patients with dementia and children and mapping and assessment and reassessment – **This action is on track.** Review WAT results for assurance – **This action is on track.**	31/12/2020 28/02/2021		Evidence being collated/ Not yet submitted	Likely	

			Incident review completed 6-monthly – **This action is on track.**	31/06/2021				
16M	The service must ensure oxygen for patients is prescribed, in line with national guidance.	Escalation of prescription of oxygen through nursing and medical structures	Electronic prescribing rolled out across all sites – **This action is on track.** Review previous audits and conduct a high level re-audit completed – **This action is on track.** Escalation of prescription of oxygen through nursing and medical structures – **This action is on track.** Electronic spot check audit completed on WebV and EPMA – **This action is on track.**	30/06/2021 31/01/2021 31/01/2021 30/06/2021		Evidence being collated/ Not yet submitted	Likely	
17M	The service must ensure that confidential records are stored and disposed of securely in line with national guidance.	Audit of storage arrangements of records via Governance Lead Walk rounds Escalation of safe storage of confidential records through nursing structures	Re-audit of storage arrangements of records via Governance Lead Walk rounds – **This action is on track.** Escalation of safe storage of confidential records through nursing and medical structures – **This action is on track.**	28/02/2021 31/01/2021		Summary of walk around and 15 steps Minutes of nursing and medical meetings Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement.	
19M	Average LOS for elective and non-elective patients	Trust wide discharge events being held	Assurance template completed with November LOS data and accelerated discharge event overview – **This action is on track.**	31/01/2021		Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	
20M	The service must ensure that all staff receives an appraisal.	Overall 79% 85%	85% Division overall – **This action is off track.** 85% Additional Clinical	31/03/2021		PADR records Evidence being collated/ Not yet	Likely but also area for continuous improvement.	

		72% 100% 47% 79% 60%	Services – **This action is on track.** 85% Administrative and Clerical – **This action is off track.** 85% Allied Health Professionals – **This action is on track.** 85% Healthcare Scientists – **This action is off track.** 85% Nursing and Midwifery Registered **This action is off track.** 85% Medical staff – **This action is off track** Evidence of escalation of non-compliance – **This action is on track**	31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/12/2020		submitted		
21M	The service must ensure safe medicines management in all areas, specifically in relation to recording of controlled drugs' prescriptions,	Audit of safe medicines management via Governance Lead Walk rounds and Safe and Secure audit Escalation through nursing structures	Identify actions for walk around results and ensure included on ward improvement plans – **This action is on track.** Escalation of themes identified from the workarounds through nursing and medical structures – **This action is on track.** Re-audit of storage arrangements of medicine management via Governance Lead Walk rounds – **This action is on track.**	31/01/2021 31/01/2021 28/02/2021		Safe and secure audit results Ward Improvement plans Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement.	

27M	Readmission rates for elective admissions		Assurance template completed – **This action is on track.**	28/02/2021		Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	
29M	Medical staffing cover out of hours	Impacted by changes in IAAU	Assurance template being completed – **This action is on track.**	28/02/2021		Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	
30M - SHOULD	The service should improve data submission to, and compliance with, local audits.	Audit team have comprehensive audit plan	Ensure all local audits are logged – **This action is on track.** Achieve improvement on previous financial year – **This action is on track.**	31/01/2021 31/01/2021		Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	
33M - SHOULD	The service should ensure that the leadership team can demonstrate how they use the data collected at ward level to drive forward improvements in patient outcomes.		To collate examples where data has improved care, e.g. NEWS reporting, Pressure Ulcer from paper WAT tools – **This action is on track.** Collate ward manager meetings – **This action is on track.**	31/01/2021 31/01/2021		NEWS data Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	

Surgery and Critical Care

Division	CQC Action	Progress to Date	Further Actions Required / Agreed to provide assurance	Due Date for Completion	Actions to mitigate risk	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Overall Rag Rating
1D – Surgery Division 15S – Surgical care	The Trust must ensure that effective and robust systems are in place to support the management of	Position paper to include Divisional level progress	Adopt Trust documentation for Divisional Governance meetings, Agenda, Action log and Minutes – **This action is on track.** Collate evidence of learning from incidents, complaints, audits, SIs	31/01/2021		Position paper will be submitted detailing improvement made at Divisional level	Likely but also area for continuous improvement.	

17S – Surgical care	governance, risk and performance.		and mortality reviews through the Divisional Governance meeting, 6:1 and Confirm and Challenge meetings. Evidence dissemination and where appropriate improvement activities via newsletter and improvement board on the ward – **This action is on track.** Conduct speciality Business meetings which incorporate governance activities 6 times a year and have an agenda and action log – **This action is on track.** Speciality meetings not to be cancelled unless Tri agreement obtained – **This action is on track.** Review minutes of Governance meetings to ensure that all standing items are being discussed – **This action is on track.** Carry out assessment of need for additional governance support – **This action is on track.**	28/02/2021 30/04/2021 30/04/2021 31/03/2021 28/02/2021				
2D - Surgery Division	Reporting of performance information.		Information collated – **This action is complete.**					
3D – Surgery Division 14S – Surgical care	The Trust must ensure that 85% of complaints are addressed in line with Trust policy.	Position paper being written to show reduction in overdue complaints over last year	Implement new complaints process – **This action is on track.** Close down complaints within old (pre November 2020) process – **This action is on**	30/11/2020 31/01/2021		Position paper to be submitted demonstrating progress	Likely but also area for continuous improvement.	

41CC – Critical care			**track.** Achieve Trust aspiration – 85% of all complaints within the new process being resolved within 60 days – **This action is on track.** Achieve Trust aspiration of 85% of all reopened cases to be resolved within 20 working days – **Data not available** Strengthen the process for learning from complaints, incorporating the proposed monthly report from the Corporate Team, so staff in the Divisions can evidence an understanding of key themes arising from complaints and the resultant learning and improvement action taken – **This action is on track.** Achieve Trust aspiration of 85% of Pals enquiries responded to in 5 working days – **This action is off track.**	31/07/2021 31/12/2020 30/04/2021 31/10/2020				
7S – Surgical care 31S – Surgical care	The service must ensure that consent is gained in accordance with best practice and legal requirements.	Initial audit has been carried out	Review the Trust policy to ensure in line with best practice and national guidance – **This action is on track.** Undertake awareness raising sessions with staff regarding the audit results and agree actions where appropriate – **This action is on track.** Repeat audit – **This action is on track.**	31/01/2021 28/02/2021 31/03/2021	Current policy	Consent policy Audit results Evidence being collated/ Not yet submitted	Likely	

12S – Surgical care	The service must ensure that effective processes are in place to enable access to theatres and that all cases are prioritised appropriately.	Successful informal process in operation	Develop SOP that reflects practice and disseminate – **This action is on track.** Assess impact via ongoing audit and implement feedback loop to support implementation of improvement action as required – **This action is on track.**	28/02/2021 31/03/2021		SOP Audit results Position paper will be submitted.	Likely but also area for continuous improvement.	
16S – Surgical care	The service must ensure that all documentation is reviewed; version controlled and completed accurately to safely document the needs of the patient.	Each ward has at least one individual responsible for versions on the ward	Review documentation audit results for compliance and completeness/accuracy of completion and implement actions where compliance is an issue – **This action is on track.** Audit system of ensuring version control and address any issues – **This action is on track.**	31/01/2021 31/03/2021		Documentation audit results Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement.	
21S – Surgical care	The service must ensure that patients are fasted preoperatively in line with best practice recommendations.	All cancellations have a mini RCA conducted	**This action is completed**					
22S – Surgical care	The service must improve the compliance of documentation of malnutrition universal screening tool (MUST) to identify patients at risk in line with trust policy.	MUST scores are recorded on WEBV	Carry out audit electronic records of MUST scores – **This action is on track.** Implement actions identified from the audit – **This action is on track.**	31/12/2020 28/02/2021		Audit results and action plans Evidence being collated/ Not yet submitted	Likely	
23Sb – Surgical care SHOULD	The service should ensure that there are sufficient qualified, competent, skilled		Describe baseline picture for medical staff – **This action is on track.** Outline actions to improve	31/01/2021 31/01/2021		Evidence being collated/ Not yet submitted	Likely	

	and experienced staff to meet the needs of patients using the service		staffing levels – **This action is on track.**					
24S – Surgical care SHOULD	The service should improve systems for recording venous thromboembolism (VTE) assessments.	Combination of paper and electronic system	Medical staff to complete all VTEs on WEBV and on time – **This action is on track.**	28/02/2021		Evidence being collated/ Not yet submitted	Likely	
25S – Surgical care SHOULD	The service should continue to ensure that effective processes are in place to enable improvement on the number of fractured neck of femur patients who have surgery within 48 hours.	# Neck of femur working group established	Embed # Femur SOP – **This is action on track.** Implement paperwork – **This action is on track.** Continue to monitor performance – **This action is on track.**	31/01/2021 28/02/2021 31/03/2021		# Femur SOP # Femur data Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement.	
26S – Surgical Care SHOULD	The service should continue to improve performance in all national audits and related action plans to improve performance and patient outcomes.	Surgical audit plan	Develop and implement audit plan and monitor progress – **This action is on track.** Identify actions to improve compliance and implement – **This action is on track.** Continue ongoing monitoring – **This action is on track.**	31/01/2021 31/01/2021 31/03/2021		Audit and action plan Evidence being collated/ Not yet submitted	Likely	
27S – Surgical care SHOULD	The service should improve friends and family test response rates and use the outcomes to actively make improvements to patient	Friends and Family stopped during COVID	Collate information from work that has been carried out by the patient experience team – **This action is on track.** Restart Friends and Family – **This action is on track.**	28/02/2021 31/03/2021		Patient experience data Friend and Family data Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement.	

	experience.							
28S - Surgical care	Premises and equipment is properly maintained and suitable		Collate information – **This action is complete.**					
29S – Surgical care SHOULD	The service should ensure that records used in theatres for checking of equipment are completed fully and accurately.	Both theatres have checklists but they are different	Ensure it is clear on checklists if there is not been used rather than just leave a blank – **This action is on track.** Ensure where a problem with equipment is identified subsequent action is also recorded – **This action is on track.**	28/02/2021 31/03/2021	Theatres do have checklists	Evidence being collated/ Not yet submitted	Likely	
30S – Surgical care SHOULD	The service should ensure that in theatre recovery a NEWS score is calculated prior to handover of the patient to ward staff.		Implement new document – **This action is complete.** Audit implementation – **This action is complete.**	31/12/2020 31/01/2021				
34CC – Critical care	The service must ensure there is a dedicated supernumerary care coordinator at all times.	This is monitored through staffing numbers and dependency of patients	Develop and implement mitigatory actions to ensure patient safety is maintained when supernumerary co-ordinator is not available – **This action is on track.**	31/01/2021		Evidence being collated/ Not yet submitted	Likely	
35CC – Critical care 36CC – Critical care	The service must ensure there is a dedicated intensivist for ICU at Scunthorpe General Hospital during the night and weekends	New ways of working have been presented to staff	Gain agreement on new ways of working – **This action is on track.** Agree and implement short term mitigations/actions to address short fall in staffing – **This action is on track.**	31/03/2021 28/02/2021		Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement.	

	ensuring continuity and consistency for patients and their individual plans.							
38CC – Critical care	The service must ensure that the equipment used by the service for providing care or treatment to a service user is safe for such use and used in a safe way.		Ensure staff undertakes competency training for equipment at DPOW ITU and HDUs – **This action is complete.**					
39CC – Critical care	The service must ensure the proper and safe use of medicines		Safe and secure audit action plans created – **This action is on track.** Monitor incidents and outcomes from 15 steps and the WAT tool – **This action is on track.**	31/03/2021 31/03/2021		None	Likely	
40CC – Critical care SHOULD	The service should make improvements to the management of infection control including hand hygiene processes.		Ensure all staff are aware of correct policy and had IPC training – **This action is on track.** Monitor compliance against 95% target and undertake remedial action as required – **This action is on track.**	31/12/2020 31/03/2021		Evidence being collated/ Not yet submitted	Likely	
14WC – Maternity Moved From MATERNITY	The service must ensure a duty anaesthetist is immediately available to cover emergency work on delivery suite, in line with trust policy and national		Develop business case to address requirement for additional tier of anaesthetic staff – **This action is on track.** Continue discussions with CCGs and NHSEI on the need for additional funding to support this activity – **This action is on track.**	31/01/2021 31/03/2021		Included as a business case in the financial paper to be submitted to NHSEI and CCGs	Likely.	

	guidelines.							
27WC – Maternity Moved From MATERNITY	The service must ensure that there is an independent registered scrub nurse able to supervise in theatres at all times, in line with national standards (DPOW).	Independent registered scrub nurse has been implemented at DPOW	Monitor rota and incidents – **This action is on track.**	31/03/2021		Position paper written from Maternity perspective	Likely	
33WC – Maternity Moved From MATERNITY	The service should ensure risks associated with delayed access to an emergency (2nd) theatre are closely monitored &minimised (24/7).		Need to ensure access to obstetric theatre at SGH 24/7 – **This action is on track.**	28/02/2021		Evidence being collated/ Not yet submitted	Likely	

Family Services

Division	CQC Action	Progress to Date	Further Actions Required / Agreed to provide assurance	Due Date for Completion	Actions to mitigate risk	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Overall Rag Rating
1D – Women's & Children Division 24O&G	The trust must ensure that effective and robust systems are in place to support the management of governance, risk and performance.	Significant Divisional level progress	Trust documentation is adopted for Service Governance meetings, Agenda, Action log and Minutes – **This action is on track.** Ensure there is clear evidence of learning from	31/01/2021		Position paper will be submitted detailing improvements made at Divisional level	Likely but also area for continuous improvement.	

			incidents, complaints, audits, SIs and mortality through the Divisional Governance meeting, 6:1 and Confirm and challenge meetings, newsletter and improvement board on the ward – **This action is on track.** All speciality meetings to meet X times a year and have an agenda and action log – **This action is on track**. Speciality meetings not to be cancelled unless Tri agreement – **This action is on track.** Review minutes of Governance meetings to ensure that all standing items are being discussed – **This action is on track.**	28/02/2021 30/04/2021 30/04/2021 31/03/2021				
2D - Women's & Children Division	The Trust must continue its work to improve its reporting of performance information to enable easier oversight and governance and continue its work to improve its digital systems and processes	Maternity dashboard being used Specialty PRIM set up	Paediatric Dashboard developed – **This action is on track.** Evidence of Speciality PRIM including performance – **This action is on track** Evidence of COVID Recovery Plan – **This action is on track** Evidence of performance data used at the frontline – **This action is on track.**	31/03/2021 31/01/2021 31/01/2021 31/01/2021		Paediatric dashboard Speciality PRIM slides COVID recovery plan Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	
3D - Women's & Children Division	The Trust must ensure that 85% of complaints are	Position paper being written, 21 complaints open,	Close down complaints within old (pre - November 2020) process – **This action is on**	30/01/2020		Position paper will be submitted	Likely but also area for continuous	

25O&G	addressed in line with Trust policy	7 out of timescale	**track.** Achieve Trust aspiration - 85% of all complaints - within the new process being resolved within 60 days – **This action is on track.** Achieve Trust aspiration of 85% of all reopened cases to be resolved within 20 working days – Data not available Strengthen the process for learning from complaints, incorporating the proposed monthly report from the Corporate Team, so staff in the Divisions they can evidence an understanding of key themes arising from complaints and the resultant learning and improvement action taken – **This action is on track.** Achieve Trust aspiration of 85% of Pals enquiries responded to in 5 working days – **This action is off track.**	31/07/2021 31/12/2020 30/04/2021 31/10/2020		demonstrating progress	improvement.	
5D - Women's & Children Division	The service must ensure the 62-day cancer waiting times target for appointments is achieved.		Monitor the Cancer PTL 62 days + performance – **This action is on track.**	31/03/2021		Evidence being collated/ Not yet submitted	Likely	
6P – Paediatrics 7P - Paediatrics	The service must ensure that children and young people with a mental health	Agreement with mental health providers on assessment tool.	Implementation of Mental Health A&E tool at SGH – **This action is on track.** Training programme	31/12/2020		Evidence being collated/ Not yet submitted	Likely	

	condition are risk assessed for their mental health needs, self-harm or suicide and are cared for in a safe environment that has been appropriately risk assessed and that staff are appropriately trained in caring for children and young people with mental health conditions.	Support from mental health providers on training	complete on both sites – **This action is on track.** Audit of tool at both sides – **This action is on track.** Monitoring of incidents – **This action is on track.** Electronic alert on patient record indicating a risk assessment is required – **This action is on track.**	31/01/2021 31/03/2021 31/03/2021 31/03/2021				
8P - Paediatrics	The service must ensure that nurse staffing on the Paediatric Assessment Unit meets National guidance.	Remodeling of inpatient beds	Collate evidence of work done – **This action is on track.**	31/01/2021		Evidence being collated/ Not yet submitted	Likely	
13P - Paediatrics	The service should ensure it can demonstrate assurance that the accessible information standard is met, concerning the communication needs of parents/carers.	Electronic document implemented	AIS Information on all wards – **This action is on track.** WebV admission document live – **This action is on track.** Audit – **This action is on track.**	31/01/2021 31/03/2021 31/03/2021		Pictures of boards WEBV document Audit results Evidence being collated/ Not yet submitted	Likely	
14P - Paediatrics SHOULD	The service should ensure actions identified in local audits for sepsis, hand hygiene and paediatric early warning scores	Work has been going on to improve PEWs recording and process of auditing	Local audits in relation to Sepsis, PEWS and hand hygiene are logged on Audit Plan – **This action is on track.** Included on standard agenda at relevant meeting -	31/01/2021 31/01/2021		Local audits Agenda and minutes Evidence being collated/ Not yet submitted	Likely	

	(PEWS) are implemented, embedded and monitored, to provide robust assurance.		progress, results actions etc. – **This action is on track.**					
15P - Paediatrics SHOULD	The service should ensure collected safety information is displayed publicly for children, young people, their families and visitors.		Utilise ambassadors for display boards – **This action is on track.**	31/01/2021		Pictures of boards Evidence being collated/ Not yet submitted	Likely	
17P – Paediatrics 28O&G SHOULD	Abduction Policy and Drill	I child and 1 maternity abduction drills conducted in 2020	Collate evidence of work carried out and insure robust plan for 2021 – **This action is on track.** Review simulations carried out – **This action is on track.**	31/03/2021 30/06/2021		Abduction reports Evidence being collated/ Not yet submitted	Likely	
18P - Paediatrics	Regular checks of resuscitation equipment are completed		Evidence collated – **This action is complete.**					
19P - Paediatrics SHOULD	The service should ensure that medical staff are completing records accurately, in line with guidance.	Documentation audit has been conducted	Review documentation audit results and implement plan (detail to add in) – **This action is on track.**	31/03/2021		Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	
22O&G	The service must ensure a duty anaesthetist is immediately available to cover emergency work on delivery suite, in line with trust		Being delivered by surgery and critical care					

	policy and national guidelines.							
23O&G	The service must ensure all staff have up to date appraisals.	87% 91% 85% 80% 85%	Consistently meet 85% Division overall – **This action is on track.** Consistently meet 85% Additional Clinical Services – **This action is on track.** Consistently meet 85% Administrative and Clerical – **This action is on track.** Consistently meet 85% Medical and Dental – **This action is off track.** Consistently meet 85% Nursing and Midwifery Registered – **This action is on track.** Evidence of escalation of non-compliance – **This action is on track.**	31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/03/2021 31/12/2020		PADR records Evidence being collated/ Not yet submitted	Likely	
30O&G SHOULD	The service should improve maternity record keeping audit assurance and produce a robust action plan to improve performance.	Spot check documentation audit carried out in 2020. Regular audit as part of MT week to be carried out from January 2021.	Previous audits have revealed results which do not align with other audits but also many areas for improvement. To streamline the audit tool to the priority areas (patient safety, Ockenden and CNST requirements) to allow staff to focus on those initially – **This action is on track.** Add consultant for complex pregnancies to monthly check of fresh eyes, WHO check list	31/01/2021		Audit results Action plans Evidence being collated/ Not yet submitted	Likely	

			etc. – **This action is on track.** Introduce monthly auditing through the Mandatory training days – **This action is on track.** Promote the priority areas to staff and need for compliance – **This action is on track.**	31/01/2021 28/02/2021 31/03/2021				
31O&G	The service should carefully monitor and actively seek to reduce the total still birth rate.		Collate evidence – **This action is on track.**	31/01/2021		Evidence being collated/ Not yet submitted	Likely	
34O&G SHOULD	The service should monitor & improve WHO safer surgery documentation checklist compliance.	Monitoring of checklist is happening	Consistently meet 100% compliance – **This action is on track.**	31/03/2021		Evidence being collated/ Not yet submitted	Likely	
35O&G	The service should establish &maintain stable leadership of the service.		Collate evidence – **This action is on track.**	31/01/2021		Evidence being collated/ Not yet submitted	Likely	
36O&G	The service should develop a vision for the maternity service and a strategy to turn it into action.		Collate evidence – **This action is on track.**	31/01/2021		Evidence being collated/ Not yet submitted	Likely	
37O&G SHOULD	The service should consider implementing a baby-tagging alarm system, or similar, at the service.	Mitigation actions in place, Business case not supported	No funding available need to collate evidence on mitigation – **This action is on track.**	31/01/2021	The following mitigatory actions are in place. Ward doors are locked with swipe access to maternity unit.	Evidence being collated/ Not yet submitted	Likely	

					Call bell with video link for patients/visitors to enter the ward. Women and families are advised not to leave babies unattended. Skills drills taking place in relation to baby abduction. Tailgating posters are displayed and daily checks of mums and babies ID during ward rounds. Guidance in place DC096 "Policy for the response in the event of a missing/abducted child/young person"			
7ED	Have 2 RSCN's in ED.	As PEN team managed by paediatrics action moved to here	Submit business case to CCG's and NHSEI – **This action is on track.**	31/03/2021		Business case being written	Dependent of resources	

Community and Therapies

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating
CT1	**MUST** The Trust must ensure that effective and	Much progress made at Divisional and EoL speciality level	Adopt Trust documentation for Divisional Governance meetings, Agenda, Action	28/02/2021		Position paper will be submitted detailing	Likely	

	robust systems are in place to support the management of governance, risk and performance.		log and Minutes – **This action is on track.** Collate evidence of learning from incidents, complaints, audits, SIs and mortality reviews through the Divisional Governance meeting and EoL Strategy group. Evidence dissemination and where appropriate improvement activities via feedback from the Divisions – **This action is on track.** Review minutes of Governance meetings to ensure that all standing items are being discussed – **This action is on track.** Carry out assessment of need for additional governance support – **This action is on track.**	31/03/2021 31/03/2021 31/03/2021 31/03/2021		improvements made at Divisional level		
CT2	**MUST** The Trust must continue its work to improve its reporting of performance information to enable easier oversight and governance and continue its work to improve its digital systems and processes	Variety of information in place that evidences it is disseminating down to frontline staff	Collate evidence of use of data at frontline – **This action is on track.**	31/01/2021		None	Likely	
CT3	**MUST** The service must ensure that patients receive timely assessment		Mechanism in place for accurately reporting all waiting lists – **This action is on track.**	31/01/2021		Evidence being collated/ Not yet submitted	Likely	

	and treatment and put measures in place to address long waits in continence.		Agree new contract with CCG with explicit performance criteria – **This action is on track.**	31/03/2021				
CT4	**SHOULD** The service should ensure that therapy staff in the integrated care networks work closely with other members of the team such as community nursing staff and are included in joint team meetings so that information is shared across all staff to allow more integrated working.		Collate evidence of joint working – **This action is on track.** Formulate a staff survey for feedback in relation to the staff engagement and preferences – **This action is on track.** Deliver joint nursing and therapy development days – **This action is on track.**	31/01/2021 28/02/2021 31/03/2021				
CT6 CT8	**SHOULD** The service should ensure there are enough laptops available for staff working in the community to allow for effective mobile working.	SOP written	Collate evidence of the SOP and dissemination – **This action is on track.**	31/01/2021		Evidence being collated/ Not yet submitted	Likely	
CT7	**SHOULD** The service should ensure staff in the unscheduled care team have access to the equipment they need for clinical assessment of patients including the replacement of tympanic	Equipment audit carried out	Collate evidence	31/01/2021		Evidence being collated/ Not yet submitted	Likely	

	thermometers which do not work in the cold weather.							
CT9	**SHOULD** The service should ensure that all patient group directives are approved, signed and dated by the appropriate person/s in the organisation.	PGDs have been reviewed	Collate evidence	31/01/2021		Evidence being collated/ Not yet submitted	Likely	
CT10	**SHOULD** The service should ensure that staff utilise translation services appropriately and do not reply on patients' relatives to translate on the patient's behalf.	Trust translation services have been communicated to staff	Collate evidence	31/01/2021		Evidence being collated/ Not yet submitted	Likely	
CT11 33EoL	**SHOULD** The service should explore and implement other methods of engaging with patients and use the information to develop and improve services.	Ongoing work as part of the Blue Bell model	To work with Patient Experience to develop focus groups to increase patient feedback across services – **This action is on track.** Carry out patient survey across service – **This action is on track.**	28/02/2021 31/03/2021		Evidence being collated/ Not yet submitted	Likely	
CT12	**SHOULD** The service should take action to ensure that post-operative blood pressure readings are recorded in the dental care records		Collate evidence	28/02/2021		Evidence being collated/ Not yet submitted	Likely	

	for patients undergoing intravenous sedation.							
CT13	The service should take action to ensure staff report significant events and incidents appropriately.		Collate evidence	28/02/2021		Evidence being collated/ Not yet submitted	Likely	
14EoL	**MUST** The service must ensure that mandatory compliance rates are in line with the Trust targets 9for EoL team).	Being managed through the EoL strategy group	Monitor through NLaG EoL Implementation Group – **This action is on track.** Agree actions for managers to manage non-compliance – **This action is on track.**	31/03/2020 31/03/2021		Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	
15EoL	**MUST** The service must ensure that staff are competent for their role and receive appropriate supervision and appraisal (for EoL team).	Being managed through the EoL strategy group	Monitor supervision and appraisal rates of EoL meeting – **This action is on track.** Review quality of appraisals through staff survey – **This action is on track.**	31/03/2021 31/03/2021		Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	
17EoL	Robust oversight and management of incidents. Sharing of incidents across the speciality.		**Action is completed.**					
18EoL	**MUST** The service must ensure that clinical care and treatment are delivered in accordance with national guidance and best practice.		Develop and deliver detailed RESPECT project plan – **This action is on track.**	31/03/2021		Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	

19EoL	**MUST** The service must ensure that robust systems are in place to monitor the effectiveness of care and treatment delivered to achieve good outcomes for patients.	Local KPIs and outcome measures set and monitored through NLAG EoL Implementation Group	Continue to monitor local KPIs and outcome measures and monitor through NLAG EoL Implementation Group – **This action is on track.**	31/01/2021		Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	
20EoL	**MUST** The trust must manage complaints in accordance with Trust policy.		**Action is complete.**					
21EoL	**MUST** The Trust must ensure robust Governance processes are in place to lead, manage, risk assess and sustain effective services.		**Action is complete.**					
22EoL	**MUST** The service must ensure equipment used to deliver end of life and palliative care is used in accordance with Trust policy and best practice.	Ongoing work on the syringe driver training both in content and method of delivery	Continue to monitor compliance rate for syringe driver training across the Trust – **This action is on track.**	31/03/2021		Evidence being collated/ Not yet submitted	Likely but also area for continuous improvement	
23EoL 16EoL 30EoL	**MUST** The service must ensure that there are sufficient staff with the right qualifications, skills and training to keep people free from harm.	Contributed to the NHSEI review	Implement recommendations from the NHSEI review – **This action is on track.** Implement seven-day services in accordance with national guidance – **This action is on track.**	31/03/2021 30/06/2021		Evidence being collated/ Not yet submitted	Likely	

24EoL	**MUST** The service must ensure that patient records are completed to collect evidence consistently and appropriately.	Reviewed Last Days of Life document	Review Last Care of days Life document– **This action is on track.** Propose changes to system – **This action is on track.** Implement workable solution within NLAG – **This action is on track.**	31/03/2021 31/03/2021 30/04/2021		Evidence being collated/ Not yet submitted	Likely	
25EoL	**MUST** The service must ensure safe medicines management in all areas, specifically in relation to reviewing and monitoring of analgesia	Review of tool and policy	Agree pain assessment tools and policy for across the Trust – **This action is on track.** Identify Divisional leads – **This action is on track.** Implement pain assessment tools and audit implementation – **This action is on track.**	31/03/2021 31/03/2021 31/03/2021		Evidence being collated/ Not yet submitted	Likely	
26EoL	**MUST** The service must ensure that staff treat patients with compassion, kindness and respect and take account of individual needs.	Blue Bell model produced	Implement Blue Bell model – **This action is on track.**	31/03/2021		Evidence being collated/ Not yet submitted	Likely	
27EoL	**MUST** The service must ensure version controlled documents are reviewed in line with Trust policy and National guidance.		**Action is complete.**					
28EoL	Safeguarding and mental capacity act		Sub-actions being defined.					

	training is completed							
29EoL	**SHOULD** The service should provide access to written information in community languages for patients and their families.	Poster has been produced	To collate evidence	28/02/2021		Evidence being collated/ Not yet submitted	Likely	
31EoL	**MUST** The service must ensure the Mortuary environment, including the approach, is considerate of those individuals visiting the area.		**This action is complete.**					
32EoL	**SHOULD** The service should develop a local strategy and further develop its services for patients with mental health needs.		Sub-actions being defined.	31/03/2021		None	Likely	

Diagnostics

Division	CQC Action	Progress to Date	Further Actions Required / Agreed	Due Date for Completion	Actions to mitigate	Evidence for assurance/ submitted to CQC	Likelihood of Compliance	Rag Rating
1D - CSS	The Trust must ensure	Significant progress made at	Adopt Trust	31/01/2021		Position paper will be	Likely but also	

Division	that effective and robust systems are in place to support the management of governance, risk and performance.	Clinical Sciences level	documentation for Divisional Governance meetings, Agenda, Action log and Minutes – **This action is on track.** Collate evidence of learning from incidents, complaints, audits, SIs and mortality reviews through the Divisional Governance meeting, 6:1 and Confirm and challenge meetings. Evidence dissemination and where appropriate improvement activities via newsletter and improvement board on the ward – **This action is on track.** Conduct Divisional Governance meetings which incorporate governance activities X times a year and have an agenda and action log – **This action is on track.** Review minutes of Governance meetings to ensure that all standing items are being discussed – **This action is on track.** Carry out assessment of need for additional governance support – **This action is on**	28/02/2021 30/04/2021 31/03/2021 28/02/2021		submitted.	area for continuous improvement.	

			track.					
3D - CSS Division	The Trust must ensure that 85% of complaints are addressed in line with Trust policy.	Implementing new process	Implement new complaints process – **This action is on track.** Achieve Trust aspiration - 85% of all complaints - within the new process being resolved within 60 days – **This action is on track.** Achieve Trust aspiration of 85% of all reopened cases to be resolved within 20 working days – **This action is on track.** Strengthen the process for learning from complaints, incorporating the proposed monthly report from the Corporate Team, so staff in the Divisions they can evidence an understanding of key themes arising from complaints and the resultant learning and improvement action taken – **This action is on track.** Achieve Trust aspiration of 85% of Pals enquiries responded to in 5 working days – **This**	30/11/2020 31/07/2021 31/12/2020 30/04/2021 31/10/2020		Complaint data Position paper has been submitted to demonstrate progress.	Likely but also area for continuous improvement.	

			action is on track.					
4Db - Clinical Sciences	Implementation of the new equipment to help provide capacity to meet the demand.		Additional CT scanner and modular build DPOW – **This action is on track.** Unit housing 1 additional and 1 replacement MRI scanner DPOW – **This action is on track.** Additional MRI scanner SGH – **This action is on track.**	31/01/2021 30/04/2021 31/10/2021		Evidence being collated/ Not yet submitted	Likely	
5D - Clinical Sciences	The service must ensure the trajectory for clearing the backlog of unreported results is monitored and action taken to reduce harm to patients still within the backlog of unreported and delayed results.	Significant improvement of nearly 1000 exams shown compared to previously reported, breaches against internal KPIs continue to be monitored daily and raised where necessary, as do the Everlight outsourced reports when overdue, with no significant issues or breaches to report.	Monitor the number of unreported results and implement actions – **This action is on track.**	31/03/2021		Performance reports Evidence being collated/ Not yet submitted	Likely	
7D - Clinical Sciences	The service should ensure that initiatives to address trust wide shortages of radiologists continue to develop including the development of radiographers' capacity to report on results.		Seek solutions as part of the ICS to address shortfall in staffing – **This action is on track.** Increase capacity of reporting radiographer workforce – **This action is on track.** Working with STP to develop shared reporting platform across HCV, to make best use of available capacity across the	31/03/2021 31/03/2021 31/03/2021		Workforce plan Evidence being collated/ Not yet submitted	Likely	

			STP – **This action is on track.**					
Pharmacy	Safe and secure audit.		Ensure the actions are implemented that address the issues raised in the audit.					
Pharmacy	Incidents		Strengthen the learning from incidents. Raise profile of Safer Medication Meeting.					

January PRIM CQC Action Progress C&T

	ACTION	Old RAG	New RAG
CT1, 21EoL	Ensure that effective and robust governance systems are in place.		
CT2	Reporting of performance information.		
CT3	Timely assessment and treatment and address long waits in continence.		
CT4	Ensure that therapy staff in the integrated care networks work closely with other members of the team such as community nursing staff		
CT5	Sufficient qualified, competent, skilled and experienced staff.		
CT6 CT8	Laptop availability		
CT7	Access to required equipment.		
CT9	PGDs signed and dated		
CT10	Staff utilise translation services.		
CT11, 33EoL	Patient engagement		
CT12	Post-operative blood BPs recorded in the dental care records for pts undergoing intravenous sedation.		
CT13	Incident reporting		
14 EoL	Mandatory compliance rates are in line with the Trust targets.		
15 EoL	Staff are competent for their role and receive appropriate supervision and appraisal.		
17 EoL	Robust oversight and management of incidents and sharing of incidents across the specialty.		
18 EoL	Clinical care and treatment are delivered in accordance with national guidance and best practice.		
19 EoL	Robust systems are in place to monitor the effectiveness of care and treatment.		
20 EoL	Complaints are managed in accordance with the Trust policy.		
21 EoL	Robust governance processes are in place to lead, manage, risk assess and sustain effective services		
22 EoL	Equipment used to deliver end of life and palliative care is used in accordance with Trust policy and best practice.		
23EoL 16EoL 30EoL	Sufficient staff with the right qualifications, skills and training to keep people free from harm.		
24 EoL	Patient records are completed to collect evidence consistently and appropriately.		
25 EoL	Safe medicines management in all areas, specifically in relation to reviewing and monitoring of analgesia.		
26 EoL	Staff treat patients with compassion, kindness and respect and take account of individual needs.		
27 EoL	Version-controlled documents are reviewed in line with trust policy and national guidance.		
28 EoL	Safeguarding and mental capacity act training is completed		
29 EoL	Access to written information in community languages for patients and their families.		
31 EoL	The mortuary environment including the approach is considerate of those individuals visiting the area.		
32 EoL	Local strategy and further develop its services for patients with mental health needs.		

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)035

DATE	2 February 2021
REPORT FOR	**Trust Board of Directors**
REPORT FROM	Neil Gammon, NED / Chair of Finance & Performance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**F&P Committee Highlight Report – January 2021**
BACKGROUND DOCUMENT (if any)	-
PURPOSE OF THE REPORT	Issues from the Finance & Performance Committee meeting requiring escalation by exception to the Trust Board
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The attached highlight report summarises the key issues presented to, and discussed by the Finance & Performance Committee at its meeting on 27 January 2021 and worthy of highlighting to the Trust Board.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	BAF Risks 1, 6, 7
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report and consider the need for any further actions to address issues highlighted in the report.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	2 February 2021
Report From:	Finance & Performance Committee held on 27 January 2021

Highlight Report:

Performance – Access & Flow

- Covid has had significant impact on operational delivery, covering:
    - RTT; increasing waiting list size with both number of incomplete treatments and patients waiting >52 weeks increasing.
    - Follow Up appointments, including Risk Stratification.
    - Diagnostics; increase in diagnostic activity delivering against plan but with reduced capacity in some modalities.
    - A & E; deterioration in 4 hour performance in December 20, with significant number of ambulance handover breaches.

- Relatively short notice of re-starting F & P meetings created shortened report preparation time. Committee noted lack of clarity around actions underway to address performance shortfalls. More detail required in several areas including:
-
    - On how proposed trajectories will improve performance, plus timescales and risks associated with each action.
    - More detail on non-admitted risk stratification.
    - Influence of diagnostic demand and capacity, including impact of removing mobile scanners.

The Committee was not assured as a result of the lack of evidence in the Performance – Access and Flow Report.

Ophthalmology New Medica CCG Contract

- Committee noted that progress is behind plan with this work to 'Lift & Shift' patients from NLAG Ophthalmology waiting lists to New Medica via CCG contract.
- Work in hand to increase New Medica triage capacity, raise New Medica acceptance rates for patients to be transferred to their lists and further negotiate with CCGs and contractor any additional enhancements to increase pace of plan.
- Committee agreed to refer this issue to Q & S Committee to highlight potential patient harm risk cause by delayed treatment.

Finance Report

Committee noted that:

- Trust ahead of Financial Plan at Month 9, caused primarily by Covid-19 impact on activity delivery.
- Forecasting improved deficit of £3.43m vs planned of £4.59m, a £1.17m improvement.
- Planned care capacity will be maximized for remainder of 20/21 to minimise waiting list growth and potential, concomitant patient harm.
- Block income will continue for first quarter of FY 21/22 with planning guidance expected in due course for remainder of 21/22.
- CIP savings forecast to over deliver by £385k; £10.785m vs £10.4m. Will utilize first quarter of 21/22 to confirm savings plans for remainder of year.

Committee was assured with evidence in Month 09 Financial Report.

Estates & Facilities

- Committee approved Estates Strategy 2021 – 2026, subject to amendments to Introduction and Summary sections, and recommends Board approval, subject to those amendments.
- Amendments designed to strengthen urgency of need for capital investment to address estate physical condition, quality of accommodation and non-compliance issues.
- Revised Strategy will return for final F & P scrutiny at Feb 21 meeting.
- Committee deferred NLAG Green Plan until Feb 21 meeting.

Confirm or Challenge of the Board Assurance Framework:

As this was a curtailed meeting with a shortened agenda under Covid-19 protocols, the BAF was not reviewed. However, during debate on item 6.1, Finance Report, it was agreed to review Risk 6 (Risk of not achieving the control total and financial plan) at the 24 February 2021 F & P meeting, with a view to its potential reduction.

Action Required by the Trust Board:

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

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

NLG(21)036

DATE	Tuesday 2nd February 2021
REPORT FOR	Trust Board of Directors Public
REPORT FROM	Jug Johal, Director of Estates and Facilities
CONTACT OFFICER	Jug Johal, Director of Estates and Facilities
SUBJECT	Estates Strategy 2021 – 2026
BACKGROUND DOCUMENT (if any)	N/A
PURPOSE OF REPORT	To approve the Trust's Five Year Estate Strategy
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	List of Consultees Internal • Trust Secretary • Directorate of Finance • Chief Nurse Directorate • Operations Directorate • Medical Directors Office • Directorate of Digital services • Directorate of Strategic Development External • North Lincolnshire Council • North East Lincolnshire Council • East Riding Council • North Lincolnshire CCG • North East Lincolnshire CCG • One Public Sector Estates – Lincolnshire NHSE/I • Humber Vale & Coast PMO Trust Management Board , Approved Finance and Performance Committee, Approved with Recommendations Estates & Facilities Senior Management Team, Approved with Recommendation
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	1. The Five Year Estate Strategy for 2021 – 2026 has been developed to offer an integrated approach to Northern Lincolnshire and Goole NHS Foundation Trust's estate, relative to proposed service models and aligned to both national and local strategies including the Humber, Coast & Vale Integrated Care System. 2. This strategy supports the Trust's ambition to provide

	a range of high-quality, ever-improving services in a dynamic and stimulating environment which attracts the best staff. 3. The strategy describes how assets could change through investment, acquisition or disposal to meet future needs and how the Trust intends to position its estate and infrastructure as a key enabler in the delivery of clinical services that are safe, secure and appropriately located. 4. This strategy document is one of a number of enabling strategies that work in partnership to support delivery of the Trust's Annual Plan and Clinical Services Strategy.

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

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

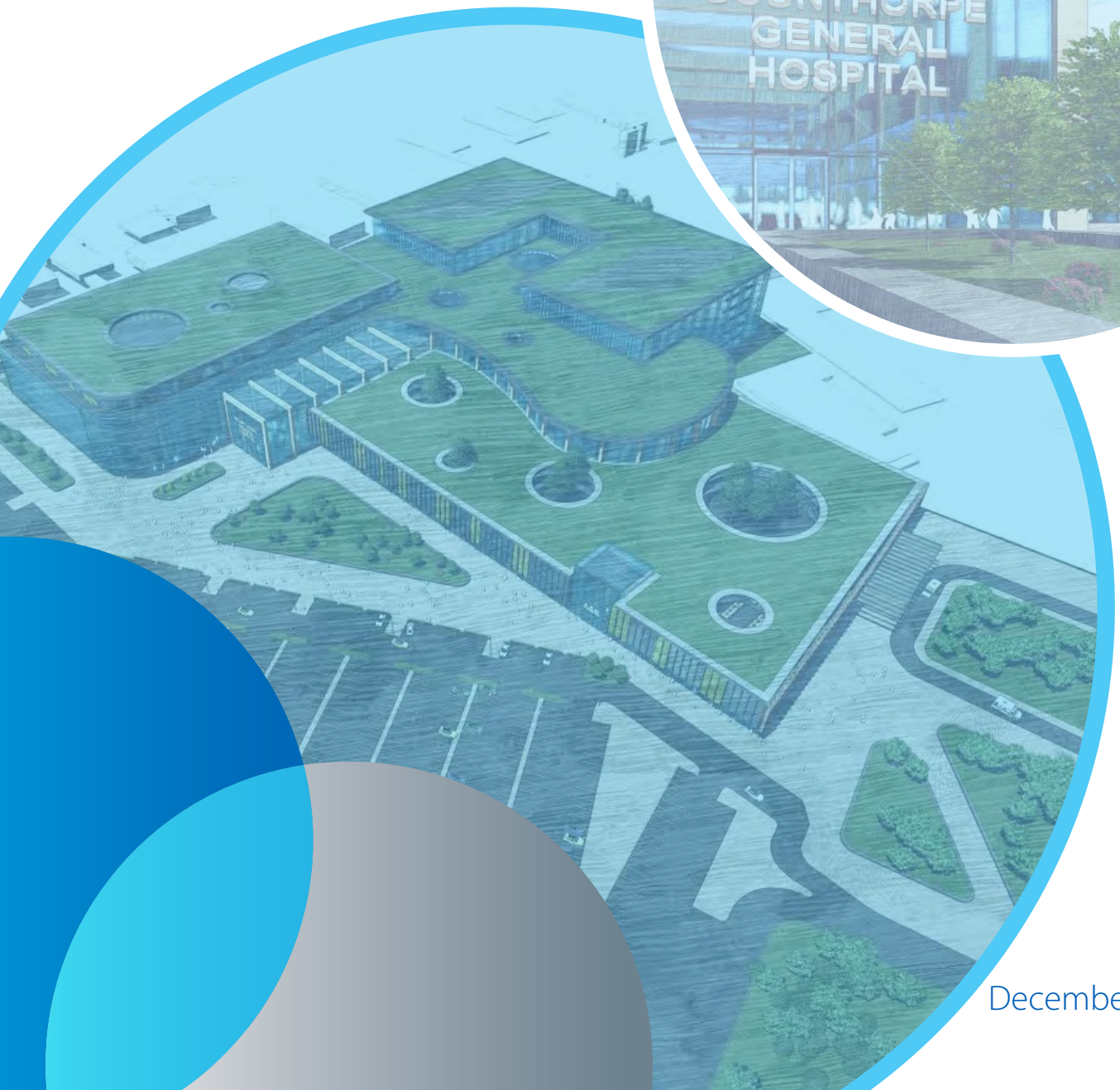
TRUST PRIORITIES -					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	BAF – Risk 7(a) – Estates & Equipment BAF – Risk 7(b) – Estates Sustainability
TRUST BOARD ACTION REQUIRED	The Trust Board is requested to approve the Estates Strategy

Northern Lincolnshire and Goole
NHS Foundation Trust

Five Year Estates Strategy

2021-2026



December 2020


A&E

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Foreword

As we write this healthcare services across the world are facing the Covid-19 pandemic. On top of this they are having to deal with the increasing challenges of complex care - due to patients with comorbidities, finite resources, skilled workforce shortages and the rapid pace of new technology to deliver care and treatments.

Northern Lincolnshire and Goole NHS Foundation Trust provides health services to a population of 450,000 across North, North East Lincolnshire and the East Riding of Yorkshire. To be able to deliver quality care and continue to be responsive to our communities we must develop new models of care and transform our ways of working to meet growing demands.

This Estates Strategy has been developed to offer an integrated approach to Northern Lincolnshire and Goole NHS Foundation Trust's estate, relative to proposed service models and aligned to both national and local strategies including the Humber, Coast & Vale Integrated Care System. It supports the Trust's ambition to provide a range of high-quality, ever-improving services in a dynamic and stimulating environment which attracts the best staff.

Its aim will be to describe the current condition of the estate examining how the existing supply of capital assets meets current service delivery and the needs of the community. The strategy will indicate how assets could change through investment, acquisition or disposal to meet future needs.

In many areas, the physical condition of estate and quality of accommodation for providing services is not fit for purpose and estates are a major financial risk. The majority of the current buildings are not appropriate for delivery of modern healthcare services and the estate backlog maintenance figure is approximately £97.7m after years of under investment.

We therefore need to deliver new, sustainable, buildings fit for modern healthcare service provision, as current accommodation is not fit for purpose. Our focus is on achieving outcomes which improve patient experience, provide safe services and improve the environment to provide excellent clinical care.

As the demands on healthcare grow, with an ageing population and more people facing a life with long term conditions, our new estate will provide the best quality environment to deliver excellent care and will help us face workforce challenges, assisting us in attracting and retaining specialist staff to serve the needs of our population.

We know this will take a lot of collaboration with partners in our region and we are looking forward to exploring our plans with them further. In support of HASR, NLaG will look to secure future funding to develop new hospitals or refurbish and reconfigure Diana Princess of Wales Hospital (Grimsby), Scunthorpe General Hospital and Goole and District Hospital.

As a Trust delivering acute and community services we want to be there when you need us and we want to help you stay well and healthy. Across the NHS, healthcare is being reimagined and we want to play our part in leading the way in creating a healthy workplace for our employees and clinicians while delivering outstanding outcomes for the people we serve.

We are excited about the future for our staff and community and how we can work together to ensure we all benefit from the changes new or updated facilities will bring. This strategy sets out our approach to our Estate.

Terry Moran
Chair

Peter Reading
Chief Executive

1. Executive Summary

1.1 Introduction

This Estates Strategy has been developed to offer an integrated approach to Northern Lincolnshire & Goole NHS Foundation Trust's (hereafter referred to as 'NLaG' or 'the Trust') estate, relative to proposed service models and aligned to both national and local strategies including the Humber, Coast and Vale Integrated Care System (ICS). It supports the Trust's ambition to provide a range of high-quality, ever-improving services in a dynamic and stimulating environment which attracts the best staff.

Its aim will be to describe the current condition of the estate examining how the existing supply of capital assets meets current service delivery and the needs of the community. The strategy will indicate how assets could change through investment, acquisition or disposal to meet future needs.

1.2 Where are we now?

The Estate

NLaG covers a wide geographical area. The Trust has a total of 860 beds with a gross floor area of 142,535m^2. The Trust operates from three main hospital sites and several community premises.

The Three acute hospital sites include:

- Diana Princess of Wales Hospital (DPoW), Grimsby
- Scunthorpe General Hospital (SGH), Scunthorpe
- Goole District Hospital (GDH), Goole.

DPoW and SGH both provide acute hospital care and a range of community services across North and North East Lincolnshire with GDH predominantly providing outpatient, diagnostic, planned surgery and rehabilitation.

NLaG delivers District General Hospital services on the Grimsby and Scunthorpe sites which include Emergency Departments (EDs) and Intensive Treatment Units (ITUs), whereas the smaller Goole District Hospital operates a lesser portfolio of services and has an Urgent Treatment Centre (UTC) rather than a full ED. All three sites provide inpatient, day case and outpatient services.

As part of its community provision, NLaG delivers adult, dental and end of life community health services across North Lincolnshire.

In the financial year 2019/2020, within an operating expenditure of £421m, NLaG:

- Received 148,500 ED attendances
- Delivered 4,077 babies
- Performed 77,900 surgical operations
- Received 112,200 inpatient admissions
- Received 397,100 outpatient attendances

The Trust holds freehold for all three sites. SGH is located within a residential area of Scunthorpe, is surrounded by residential properties and the Trust lease a nature reserve to North Lincolnshire Council. It is therefore landlocked with no opportunity for expansion. The GDH site includes a Primary Care Centre (not owned by the Trust) and has significant space for future expansion should it be required. In addition, the Trust occupies 15 community premises where staff are either delivering, or supporting acute or secondary care services, or where community clinical services are provided by the Trust.

Six Facet surveys were completed early in 2020 and they identified backlog maintenance costs of c£97.7m in order to get the estate up to the required condition as detailed below:

Table 1 - Backlog Maintenance Costs as at 2020/21

Site	Total Facet Survey Costs (works cost only)
SGH	£60,182,971
DPoW	£27,689,248
GDH	**£9.830,912**
TOTAL	**£97,703,131**

The estate was ranked in accordance with the Department of

Figure 1 - Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) acute sites

Diana, Princess of Wales Hospital, Grimsby (DPoW)

Scunthorpe General Hospital (SGH)

Goole & District Hospital (GDH)

Health's estate code whereby all buildings should be ranked as condition B (or above) – Sound, operationally safe and exhibits only minor deterioration. The physical condition facet of a multi-facet survey categorises each element and sub-element of the building into the following six categories:

Table 2 - Estate Code Physical Condition Facet Rankings

Ranking	Description
A	As new (that is built within the last two years) and can be expected to perform adequately over its expected shelf life
B	Sound, operationally safe and exhibits only minor deterioration
B/C	Operationally safe however falling into Condition C within 1 year.
C	Operational but major repair or replacement will be needed soon, that is, within three years for building elemental and one year for engineering elements.
CX	Operational but major repair or replacement will be needed soon, that is, within three years for building elemental and one year for engineering elements. Item will require total rebuild or relocation.
D	Runs a serious risk of imminent breakdown.
DX	Runs a serious risk of imminent breakdown. Item will require total rebuild or relocation.

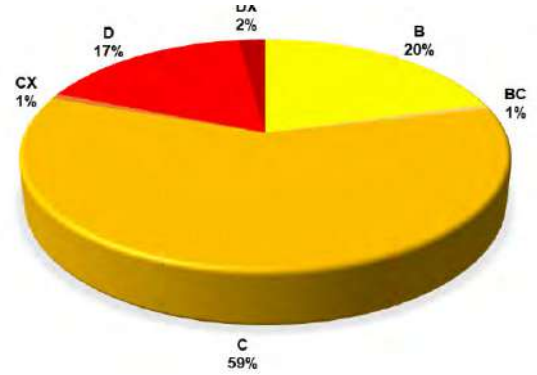
The results of the six facet surveys for each site are summarised as follows:

Diana, Princess of Wales Hospital, Grimsby (DPoW)

The costings associated with the DPoW estate six facet surveys are detailed in the below table, the pie chart illustrates the physical condition.

Table 3 - DPoW Six Facet Survey Costs and Physical Condition Chart

Physical Condition	£21,129,452
Statutory Compliance	£845,386
Quality	£415,200
Functional Suitability	£259,210
Environmental	£5,040,000
Space Utilisation	£0
TOTAL	**£27,689,248**



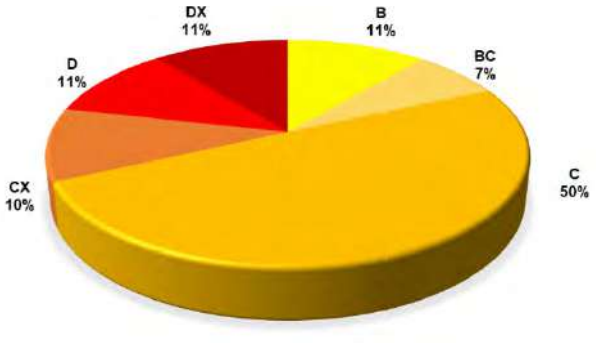
- 19% of the total investment required to bring the estate up to a satisfactory condition is classified for elements '***running a serious risk of imminent breakdown***' (Category D and DX
- 60% of the estate requires major repair or replacement works (Category C and CX)
- Within one year an additional 1% of the costs will also fall into this category (Category B/C) resulting in **a total of 61% of the estate requiring major repair or replacement works**
- The three sites requiring the **most significant investment** are the '*Main Block*', '*Industrial Zone*' and '*D Block*' which collectively covers 42,817m^2, totalling approximately **82% of the overall surveyed site area.**

Scunthorpe General Hospital (SGH)

The costings associated with the SGH estate six facet surveys are detailed in the below table, the pie chart illustrates the physical condition.

Table 4 - SGH Six Facet Survey Costs and Physical Condition Chart

Physical Condition	£47,633,491
Statutory Compliance	£1,343,880
Quality	£6,687,600
Functional Suitability	£2,718,000
Environmental	£1,800,000
Space Utilisation	£0
TOTAL	**£60,182,971**



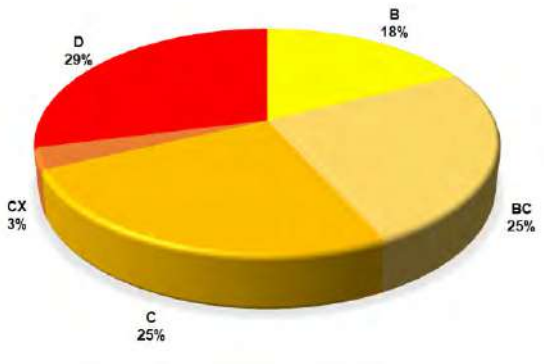
- 22% of the total investment required to bring the estate up to a satisfactory condition is classified for elements '***running a serious risk of imminent breakdown'*** (Category D and DX)
- Out of the remaining 78%, 60% of the cost is for elements requiring major repair or replacement works (Category C and CX)
- **Within one year an additional 7% will fall into this category** (now Category B/C). This will then total 67% of costs on elements requiring major repair or replacement works .

Goole & District Hospital (GDH)

The costings associated with the GDH estate six facet surveys are detailed in the below table, the pie chart illustrates the physical condition.

Table 5 - GDH Six Facet Survey Costs and Physical Condition Chart

Physical Condition	£7,813,472
Statutory Compliance	£889,440
Quality	£738,000
Functional Suitability	£102,000
Environmental	£288,000
Space Utilisation	£0
TOTAL	**£9,830,912**



- Overall, there were six blocks surveyed at the GDH Site
- 29% of the total investment required to bring the estate up to a satisfactory condition is classified for elements '***running a serious risk of imminent breakdown'*** (Category D)
- 28% of the costs are for elements requiring major repair or replacement works (Category C and CX)
- Within one year an additional 25% of costs will fall into this category (Category B/C)
- This will then total 53% of the costs for elements requiring major repair or replacement works.

It must be noted that if investment is not made in the estate then maintenance

costs will increase year on year and the investment will only address safety critical issues. Investment in backlog maintenance will not ensure that the estate will provide modern, fit for purpose buildings which will support the safe and efficient clinical service which the Trust wishes to deliver to meet future requirements.

In many areas, the physical condition of estate and quality of accommodation for providing services is not fit for purpose and estates are a major financial risk. Significant fire safety issues were identified in relation to evacuation of patients due to the layout of the Coronation Building at SGH. In October 2018 following routine random sampling, major water infrastructure issues were identified, leading to the closure of two wards and two laminar flow theatres.

Between 2017 and 2020, NLaG has seen a 28% rise in delivered unit energy costs. The rise in energy and water prices is likely to continue for many years and therefore energy efficiency and reduction measures are increasingly vital. Significant opportunities for emission reductions can be seen in energy use in buildings, waste and water, and new sources of heating and power generation.

NLaG will actively work with relevant bodies to utilise funds directed towards the UK wide target towards net zero. This potentially includes accessing substantial funding through the government's decarbonisation grant and other salix finance opportunities.

The majority of the current buildings are not appropriate for delivery of modern healthcare services. For example, they do not meet standards for en-suite facilities in ward bays or for sufficient single cubicle capacity. A high-level summary is as follows:

- Estates backlog – c.£97.7m after years of under investment of which c.£51.1 m is critical infrastructure plus VAT, fees, equipment, IT and other non-works enabling costs these costs will be significantly higher
- The physical condition of the estate and quality of accommodation is below modern and safe standards
- Non-compliance with fire standards and water infrastructure issues have led to the closure of clinical areas
- Aged estate
- Clinical equipment deficits – i.e. requirement for additional scanners
- Staff accommodation at SGH is in very poor condition.

Ongoing transformation schemes to support patient flow through the hospital within the developments of the Acute Assessment Unit (AAU), and new builds to increase Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scanning capacity, will ultimately help configure the estate to support the clinical capacity in fit for purpose facilities. This is a key enabler for infrastructure programmes to take shape, increasing the Trust's clinical footprint thereby improving its Carter Metric. The Trust is currently developing plans to deliver new ED/AAU facilities at both DPoW and SGH to a value of £54.86m.

To address the high risks, the Trust is working in collaboration with the ICS and progressing with a strategic outline case in readiness for to secure large scale capital through the national Health Infrastructure Plan (HIP) through the Humber Acute Services (HAS) to form potential opportunities of rebuilding our hospitals.

Clinical services are provided across all three hospital sites as shown in the diagram below; alongside various services provided in the community such as district nursing and therapies in North Lincolnshire, End of Life and palliative services, community paediatrics and rehabilitation elsewhere.

The Trust set out five key quality priority themes to focus on in 2019/2020

Table 6 - Services Delivered across the three Acute Sites

	DPoW	SGH	GDH
Emergency Department	✓	✓	
Stroke	✓	Hyper acute	
Cardiology	✓	✓	✓
Gastroenterology	✓	✓	
Respiratory	✓	✓	
Haematology	✓	✓	
Oncology	✓	✓	
Dermatology	✓	✓	✓
Diabetes / Endocrinology	✓	✓	
General Medicine	✓	✓	
Neurology	✓	✓	
Rheumatology	✓	✓	
Elderly Medicine	✓	✓	
Radiology / Imaging	✓	✓	✓
Pathology	✓	✓	✓
Rehabilitation	✓	✓	✓
Palliative Medicine	✓	✓	✓

	DPoW	SGH	GDH
Critical Care	✓	✓	
Trauma	✓	✓	
General Surgery Acute(all)	✓	✓	
Anaesthetics	✓	✓	✓
Orthopaedics	✓	✓	✓
General Surgery Elective	✓	✓	
Colorectal	✓	✓	✓
Upper GI	✓	✓	
Urology	✓	✓	✓
ENT	✓	✓	
Ophthalmology	✓	✓	✓
Maxillofacial/Oral	✓	✓	✓
Breast	✓	✓	
Gynaecology	✓	✓	✓
Obstetrics	✓	✓	Home from home
Paediatrics	✓	✓	
Neonatal	✓	✓	

financial year. These themes, and the Trust's performance against each of these themes, are summarised below:

Table 7 - NLaG Quality Priorities 2019/20

Ref	Quality Priority	
1	**Safety** Specific focus on pressure ulcers, recognition of the deteriorating patient and mortality indicators	Overall, during the latter half of 2018/2019, improvement has been seen against the quality indicators used to measure this quality priority theme. • **Pressure ulcer incidence** has shown significant reductions during the 2018/2019 period within the Trust's acute hospitals • **Early Warning Scores recorded on time** has shown progress during the year, following the change in systems used to record this, from paper based to electronic recording. • **Mortality performance** has been measured during 2018/2019 using the national '***Summary Hospital Level Mortality Indicator***' (SHMI), which includes deaths within the hospital and those within 30 days following hospital discharge; and the '***Hospital Standardised Mortality Ratio'*** (HSMR). The Trust's performance against these indicators during 2018/2019 has shown improvement, with the '***official'*** SHMI indicator reducing and the HSMR reducing to demonstrate '***as expected'*** performance against the national average. • **Falls** within the Trust have been decreasing as demonstrated by the trending over time. • **Infection prevention and control indicators**, specifically the number of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile infections resulting from a lapse in clinical care, has demonstrated that systems in place are effective. NLaG has not had a Trust apportioned case of MRSA in the last 18 months. Gram Negative Blood Stream Infections (GNBI) is a newly measured indicator during 2018/2019 and demonstrated a higher than target number of infections. • **Venous Thromboembolism (VTE)** is an indicator demonstrating the percentage of patients admitted who have documented evidence that their risks of acquiring VTE have been assessed, leading to preventative treatment. The Trust's performance during 2018/19 has demonstrated improvement towards the 95% target, but performance during December and February has slipped.
2	**Safe Emergency Care** With specific focus on access to non-elective care and flow through NLaG's hospitals	• The Trust's performance against the **A&E 4-hour target** has not yet achieved the 90% goal; performance should be considered in the context of a growing demand on the Trust's urgent and emergency care services. • Patients who have been in hospital for long lengths of stay are referred to as **super stranded**, if in a hospital bed for more than 21 days. NHSI set a target for the Trust to achieve 61 days length of stay working as part of its local system. Trending data demonstrates reductions during 2018/19. Whilst not yet achieving the target, there have been reductions which support the wider hospitals' ability to cope with increased demands. • Following a switch in the systems used to record and track patient's **early warning score (NEWS)** being recorded on time, performance has seen significant improvement across the Trust. In urgent and emergency care, performance with this indicator has remained static.

Ref	Quality Priority	
3	**Safe Planned Care** With specific focus on cancer care, 52 week waits, overdue follow up appointments and clinical harm reviews	• The Trust has been focused on delivering significant improvements against the **62-day GP referral to treatment (RTT) for cancer** during 2018/19. Progress has been made and performance during the year has been improving as measured by this target. Recent work has reduced the number of patients waiting 62 days or more by 50% with a similar reduction for those waiting between 42-62 days. • The **Maximum 6-week wait for diagnostic procedures** is not yet meeting the target set (>99%). This reflects the wider diagnostic challenges the Trust is facing, for which some investment has been successful in CT scanners and in endoscopy. • **Patients on an incomplete RTT pathway waiting more than 52 weeks** has seen significant improvement during 2018/2019 towards the Trust's quality aim of having zero patients waiting in excess of 52 weeks by the 31 March 2019 and zero patients waiting more than 40 weeks by 31st March 2020. • **Patients on an incomplete referral to treatment (RTT) to be less than the Trust's March 2018 reported figure** is a national target aiming to focus on reducing waiting lists across the NHS. The Trust has demonstrated a reducing waiting list. • At the end of 2017/2018 it was a key priority for the Trust to establish and embed an effective process to integrate clinical harm reviews into the Trust's focus on waiting list improvement. This was initiated and overseen by an external **clinical harm review** group. The principal focus of this group's work was to establish a clinical harm review process for a snapshot of patients who, at the 8th August 2017, had waited in excess of 40 weeks for treatment; or who waited more than 6 months after their due follow-up date; or who had waited more than 104 days on a cancer tracking pathway. The Trust has now assessed and seen all these patients.
4	**Safe Maternity Care**	• The **ratio of midwives to births** data is currently unavailable as this is being validated against standard definitions to ensure accuracy of reporting. • The Trust chose a priority indicator linked to the commencement of **cardiotocography (CTG)** to ensure that women who needed such investigations had no delays in accessing. Performance has remained above 89% during 2018/2019. Linked to this, **fresh eye reviews** are designed to reduce the risk of misinterpretation of a CTG trace. This was found to be effective in reducing the incidence of errors. The Trust has been focused on ensuring that CTGs are reviewed by more than one person during the period of CTG monitoring, to reduce the risk of errors and harm to women in the Trust's care. NLaG has maintained consistently high performance, exceeding 93% during 2018/2019. • The proportion of still births in the Trust is low and in line with the England average. Whilst public health and social factors affect the risk of still births, the Trust has been focused on identifying the risk of **still birth** due to small for gestational age (SGA) and fatal growth restriction (FGR) in the use of **individualised growth charts**. The Trust uses the Perinatal Institute tool for this purpose and is performing above the UK average.

Ref	Quality Priority	
5	**Safe Staffing and improved staff engagement**	• **Safer staffing fill rates** is a measure of the extent to which rota hours on ward areas are being filled by registered nurses, midwives and unregistered care staff to enable ongoing monitoring of safe staffing for the Trust; and to provide reassurance to local people that wards are safely staffed. The trending data demonstrates an increased fill rate by registered nurses and midwives. Un-registered carer staff has also exceeded the target set following a targeted recruitment programme during the latter part of 2018 which has led to a decrease in carer vacancies across the Trust. • **Registered nursing staff vacancy rates** - During 2018/2019 NLaG set a vacancy target of <6% for registered nurses and <2% for unregistered nurses carer staff. During the year these had been increasing, largely as a result of the Trust rebasing its establishment needs for ward areas (i.e., reviewing the demands on each ward and resetting the number of trained nurses needed in that location) so, in effect, deciding that more staff were needed, rather than this being solely in relation to nursing staff retention rates. During November 2018 the vacancy rates reduced significantly towards the target. • **Medical staff vacancy rate** - At the beginning of 2018, the Trust set an improvement target to reduce the medical staff vacancy rate to less than 15%. In February 2019 NLaG reduced its Medical vacancy rate to fewer than 14% and has maintained this trajectory to close the 2018/2019 financial year and thus achieve the target set. • **Staff engagement, satisfaction and feedback** – This has been supported during 2018/2019 as the Trust continued to focus on several work streams designed to improve engagement and support to staff within the organisation. These have resulted in several very positive outcomes; however, the Trust recognises that more time is needed to evaluate the outcomes from these programmes. • **Patient voice and listening to the feedback of patients and service users** - Work was undertaken during 2018 to listen more acutely to patient feedback and, as a result, some improvements were made.

The CQC, the independent regulator of health and social care, rated the Trust as '***Requires Improvement'*** in their last inspection report, published in February 2020. A summary of performance is shown in the table below.

Figure 2 - CQC Performance Summary

@ Feb 2020	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Inadequate ↓	Requires improvement → ←	Good → ←	Requires improvement → ←	Requires improvement → ←	Requires improvement → ←
Community	Requires improvement → ←	Requires improvement ↓	Good → ←	Requires improvement → ←	Requires improvement → ←	Requires improvement → ←
Trust Overall	Inadequate ↓	Requires improvement → ←	Good → ←	Requires improvement → ←	Requires improvement ↑	Requires improvement → ←

Following the February report, the Trust's over-riding priority is to improve its rating for safety. Whilst the Trust is rated '***Good***' for caring, the CQC identified areas for improvement in the '***effective, responsive and well-led'*** domains.

Whilst the majority of the improvement priorities identified, are being addressed at clinical divisional level and are transactional in nature, there are other key themes which require transformational change both at organisational and system level. These include:

- Outpatient care
- RTT waiting times
- Cancer waiting times
- Access to diagnostics
- End of Life care

The challenges in addressing identified areas for improvement include the uncertainty of COVID-19 both in terms of patient uptake of services, changing regulations and the potential of a further spike, an inability of capacity to meet demand, the ability to recruit and retain highly skilled staff, and the ability to sustain a financial balance.

Innovative models of service delivery and workforce utilisation across the Trust and in partnership with other organisations will be integral to address these challenges and is underpinned by developing a culture of continuous improvement.

Performance

The required NHS constitutional performance standards have shown a sporadic picture predominantly for the A&E 4 hour wait, cancer waiting times for 62 days to treatment from GP referral and the 18 week wait RTT targets. Prior to March 2020, improvements to waiting times and some of the performance domains were heading in the right direction such as the over 40 weeks and 52 weeks waiting times.

NLaG saw pre COVID, a significant improvement in RTT waiting time performance. The Trust is now beginning to see an increase in patients waiting over 40 and 52 week waits as treatment was paused in line with national guidance due to COVID.

The A&E four hour wait was starting to show improvements mid-year but unfortunately declined due to the impacts of winter and the rising demand in attendances. Pre-COVID the performance significantly improved in March 2020.

Cancer waiting times have been a significant challenge for the Trust throughout 2019/2020. This is an urgent priority to transform cancer services to ensure quicker diagnosis and treatment.

The current position for performance delivery is even more constrained with the impacts of COVID and therefore accelerates the need to address the way clinical services are delivered through service transformation.

Workforce

There is a national shortage of specialist staff – doctors, nurses, radiographers etc. and NLaG is competing to attract staff. Many of them want a lifestyle which is better offered by living in, or close, to larger cities. As these areas have larger teaching hospitals, they also offer staff the opportunity to work in more specialised services.

Staff who do work in NLaG's hospitals are under pressure because of these shortages and the Trust needs to make their hospitals better places to work so that they do not leave. NLaG's current model of trying to run similar services across multiple sites, 24 hours a day and seven days a week, stretches the existing staff base thinly, which is not fair on staff or patients.

Covid -19

The current pandemic has accelerated changes to the estate as a result of the requirement for zoning and social distancing and keeping patients safe through compliance with infection prevention control standards. There is an urgent need to ensure all hospitals have increased single cubicle capacity on our wards and appropriate space in waiting areas.

This will include the need to separate emergency and elective pathways wherever possible and use digital processes by default as a way of minimising patient contact wherever appropriate and practicable.

Challenges

NLaG is facing challenges across workforce, quality of care, operational issues and Estates and Facilities; ultimately leading to financial unsustainability.

Significant work has been done to address these challenges in recent years. Proactive international recruitment, operational and quality improvements, and financial measures have been put in place, resulting in multiple improvements but there is still a long way to go to achieve improvements to the services provided to deliver the optimal patient experience. This includes:

- Standards for urgent care, cancer care and routine waiting times
- NLaG is unable to meet all four priority standards for providing consistent access to high quality emergency care
- The Trust has reached a critical point which means that it can no longer operate some services as they are
- The need to work with primary care, to enable the needs of local people to be managed at place, bringing expertise to the community, especially considering the needs of frail elderly residents
- The need to recognise when people are at the end of their lives and ensure those who have reached the end of their life receive a high standard of quality care and compassion
- The scale and long-standing nature of the workforce, service sustainability, and estates challenges across the region suggest that it will take more than the efforts within each individual organisation to address threats to the Trust
- It requires Trusts to work together in a range of ways to secure the future for key services. It is believed that joint working across the Humber could help bridge the workforce gaps, address some of the quality and financial issues, and protect fragile services from failing, avoiding emergency reconfigurations
- The challenges are even more significant within current circumstances of COVID-19 with strains on staffing, capacity and PPE to continue delivering safe services in response to COVID-19.

1.3 Where do we want to be?

Our estate will support clinical models to maximise patient safety and efficient staffing. We want an efficient, well-utilised estate that offers an excellent and safe environment for patients, staff, carers and visitors. Our estate must be sustainable in environmental and financial terms and we need to ensure that any investment is central to these aims.

At the same time, we need to align with wider proposals at the national and regional level, which impact the projects or timeline in our estate improvements.

Local Context

Trust Strategic Framework – 2019-2024

NLaG's Trust Strategy (Strategic Framework) 2019-2024 complete with other supporting strategies will provide the framework within which operational planning will take place over the next five years. It not only addresses existing challenges but is also in alignment with national and regional objectives. It describes how the organisation will achieve the vision and values within defined principles to achieve their six key priorities. This will be achieved through a system-wide approach, working in collaboration with key stakeholders, to align key assumptions over the next five years.

Figure 3 - NLaG Strategic Framework 2019-2024

At a high level the strategy is focused on delivering the following outcomes which will address current challenges facing the Trust:

- Improved patient experience
- Improved clinical outcomes
- Reduced waiting times
- Equity of access for patients
- Safe services.

Strategic Priorities

The strategy states that by 2024 the Trust will deliver its six priorities as follows:

Table 8 - NLaG's Strategic Priorities

Ref	Priority	
1	**Integrated Urgent & Emergency care**	• The creation of an urgent and emergency care service which means patients are seen by the right staff members in the best place for them and as quickly and efficiently as possible. Often this means patients are not seen or treated in the A&E department (as they have been for many years) but in other, more appropriate services. In order to achieve this the Trust will, over the next five years: • Develop and implement community-based assessment for frail patients • Achieve the integration of UTCs • Create multidisciplinary assessment models combining surgical and medical assessment • Ambulatory care and short stay services to reduce length of stay and avoid admissions • Achieve the reconfiguration of existing infrastructure through allocated capital funding to combine the above services into appropriately located multidisciplinary assessment units • Deploy allocated capital funding to locate the above services together.
2	**Transformed outpatient services**	• The NHS 10 Year Plan sets out the national vision for outpatient's services. It is ambitious and talks about reducing visits to hospitals for these appointments by about a third, using technology to achieve this. The plan also talks about finding better ways for different healthcare services to share information about patients. In order to make sure the Trust can meet these ambitions it will, in the next five years, work to: • Implement advice and guidance across all specialities to improve referral flow and reduce demand • Achieve virtual clinics to avoid the need to attend hospital • Develop and implement shared care plans with other healthcare professionals • Develop digital systems to deliver a third of outpatient attendances out of hospital.
3	**Worked in partnership with Primary Care Networks**	• Working more closely with primary care, i.e., GPs and their surgeries, is another key element of the NHS 10 Year Plan. This makes sense to share resources – people and money – and to share getting the best out of them through shared training, recruitment and retention approaches. In the next five years the local health system will change through the development of PCNs. Each network consists of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. The Trust will work with these networks to: • Explore opportunities to join resources with primary care • Strengthen clinical recruitment and training across the healthcare system • Work to share skills and knowledge across the primary care system.
4	**Reconfigured specialties on to one site where appropriate**	• Through the HASR the Trust will ensure all services are reviewed and assessed to provide optimal care for the population in the right place and at the right time with a particular focus on: • Development and implementation of a Cardiology Strategy • Review of maternity and paediatrics to meet the required standards and ensure we have the right pathways and service support in place • Development and implementation of a Medicine Strategy • Development and implementation of a Surgery Strategy.

Ref	Priority	
5	**Restructured cancer services**	• Cancer services are one of the areas where the Trust needs to improve: to make sure patients get access to diagnostics quickly and, where cancer is identified, treatment can start as soon as possible. The Trust does not have access to skilled and experienced cancer specialists and needs to change what it does to make sure it provides the best possible care to every patient. It will look to do this by working with other Trusts and hospitals which do have the experienced staff as well as the facilities to provide the very latest treatments. To ensure this happens in the next five years the Trust will: • Review and assess tumour site services to provide best care • Explore and develop new models of care to ensure faster diagnosis is delivered in 28 days and treatments provided to time • Expansion of MRI and CT scanning through capital funding to implement new scanners.
6	**Create a sustainable hospital at Goole**	• The Trust wants to create three vibrant hospitals to serve its local communities, this means focusing on Goole as well as Grimsby and Scunthorpe. In 2019/2020 the Trust set a priority to move more planned care to GDH. This was the start of a longer-term piece of work to create a sustainable hospital in the town. In the following years the Trust will: • Increase the elective/day case planned surgery provision to its full potential • Through wider integration, develop opportunities to create a base for a centre of excellence i.e. rehabilitation services.

Quality Priorities

The Trust's local priorities were set following a review of performance during the year and reflection of where further improvement or assurance is needed. The Trust has agreed six quality priority areas for 2020/2021which are shown in the table below along with the list of measures of success against them:

Table 9 - NLaG's Quality Priorities

Ref	Priority		
1	**Patient Experience**	Waiting lists	**QP1**: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups
2	**Clinical Effectiveness**	Mortality and End of Life	**QP2:** Reduce mortality rates and strengthen end of life care
3	**Patient Safety**	Management of Diabetes	**QP3:** Improve the management of diabetes
4	**Patient Experience & Clinical Effectiveness**	Cancer Pathways	**QP4:** Improve the effectiveness of cancer pathways focussing on time to diagnosis
5	**Patient Experience & Clinical Effectiveness**	Quality and Timeliness of safe Flow & Discharge	**QP5:** Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon
6	**Patient Experience**	Patient Feedback	**QP6**: Improve the quality and timeliness of complaints responses using a more individualised approach

A More Productive and Efficient Estate

In addition to understanding the organisational objectives and strategies impacting the estate, evaluation of its current position in terms of finance and performance has highlighted the need for improvements on a number of levels. These include;

- Improving utilisation of clinical space to reduce inefficiency and maximise the use of the highest quality assets for optimal income generation
- Reducing the amount of estate used for non-clinical activities and incentivise efficient use
- Improving the efficiency of long-term assets through disposal, demolition or reconfiguration
- Supporting the provision of a technology led and enabled environment to enhance productivity and utilisation of resources (including space)
- Adopting a set of metrics which show both the cost and performance of built assets to support service line management principles
- Reducing operating costs through effective use of resources, robust management and environmental performance improvements
- An implementation plan which is capable of being delivered in phases, each of which can 'stand-alone'
- Being productivity enabling whilst achieving return on investment
- Ensuring the physical condition of the estate is based on health and safety and business risk assessments
- Provide easily accessible services and facilities
- Reflects the Trust's desired image and reputation.

A number of priorities in terms of schemes have already been identified for inclusion in this current Estate Strategy and are being progressed. These are highlighted further within the '***How do we get there?***' section of this Estate Strategy.

These were developed ***b***y taking into consideration the Objectives of the Trust and the Estates Department in connection with local, regional and government strategies, our current position and estate performance and the available funding,

Supporting Strategies

Workforce Transformation

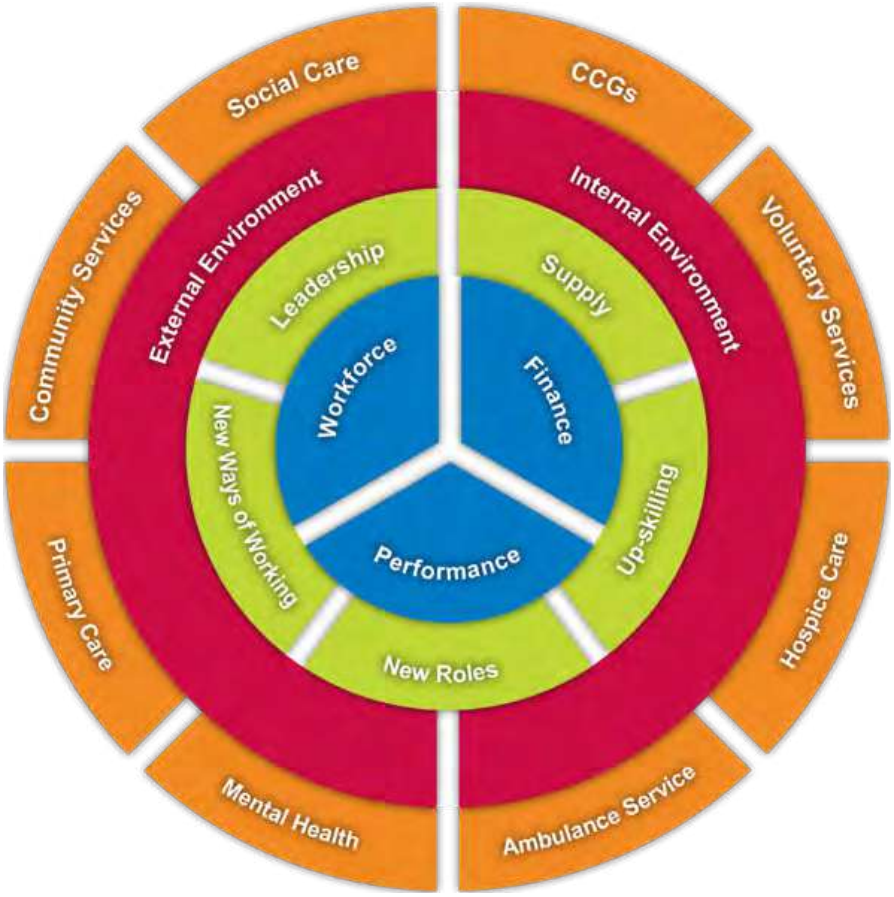
The Trust's vision for internal and external workforce transformation supports a more systematic and effective approach to workforce redesign in support of the long-term plan, quality priorities and transformation changes. This includes transformation for current and future workforce by working with partner agencies, introducing new roles and new types of workers and alternative models of care.

Strategic transformation will be achieved by reducing demand on current acute services through changing the way we work together as described in the transformational schemes.

This is both internally and externally, across the whole local health and social care economy; thereby creating a portable and flexible local workforce.

This will be responsive to change, through new models of care, increased use of digital and other technology delivered through a collaborative approach.

Figure 4 - Workforce Transformation



Digital Strategy

Trusts which have embraced technology are realising efficiencies in administrative processes, safer care delivery and improved quality of care and outcomes for patients. It has also driven shared responsibility for health by patients and care providers and contributed to attracting and retaining a workforce that wants to work with the cutting-edge technology.

While a Digital Strategy is about the business, it is equally about people and culture. To be successful, it will require everyone to lead and model the behaviours of a '***digital hospital***'. By adopting a digital first approach, patients, families, and care providers can expect:

- Better, more connected tools for frontline providers
- Greater data access for patients
- Digital inclusion
- Digital workforce
- Data integration and predictive analytics
- Strengthening of community linkages to broaden the circle of care
- More virtual care options to enable 'care where I am'
- Introducing innovation.

The Trust also needs to consider the digital element of a safe and sustainable infrastructure to enhance Estates and Facilities inter-operability, e.g., improved Building Management System (BMS) telemetry, automation control systems.

The National Context

Key national policies and directives which set out ambitions for the NHS include:

- NHS 10 Year Plan
- Interim NHS People Plan
- Primary Care Five Year Forward View
- NHS Five Year Forward View Delivery Plan 2017
- Delivering a 'Net Zero' National Health Service.

In response to these national policies, local changes are taking place, and these are reflected in this updated strategy. There is particular focus on innovative and co-operative working; leading to strong, effective collaboration and partnerships.

COVID-19

The Impact of COVID-19 on the working practices of the NLaG estates and the services delivered has been a positive step forward enabling a number of staff to be able to work remotely while also potentially enabling a left shift of certain services into the community, freeing up valuable clinical space within the acute sites.

It is anticipated that NLaG will continue to deliver these services out in the community in line with future the strategic direction of the Trust.

The Regional Context

Humber, Coast & Vale Health & Care Partnership

NLaG is part of the Humber, Coast & Vale Health & Care Sustainability Transformation Partnership (HCV STP), which later became an ICS in April 2020, after its application for ICS status was ratified by NHS England and NHS Improvement.

The scale of the ICS creates opportunities to share resource in areas where services are stretched, providing a better service to patients and a better experience for the staff who work within those services. Across the area support services such as finance can also be shared to reduce costs and improve efficiency. The principle aim of the partnership is to improve the health and wellbeing of the population it serves, as well as the quality and effectiveness of services.

Humber Coast and Vale Health and Care Partnership (HCV HCP) is adopting a unique approach to its capital investment programme to ensure that it serves as a catalyst for economic and social revitalisation on a much grander scale, transforming the lives and welfare of people and communities across the Humber region.

Plans include the:

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

The partnership's plans encompass the following unique vision, spanning the region's economy, healthcare services, buildings, workforce, digital infrastructure, sustainability, research and development, and long-term prosperity.

By driving a collaborative, region-wide approach to investment planning and implementation between Local Authorities (LAs), NHS organisations, Local Enterprise Partnerships (LEPs), universities, and private and public sector organisations, the partnership can achieve its bold ambitions and deliver a lasting legacy of transformative health improvements across the Humber, building great places to live, learn and work for generations to come.

Table 10 - HCV HCP Vision for Humber's Future

• **HCAV HCP s Vision for Humber s Future**	What we'll do **Power collective prosperity through healthcare investment by building great places to live, learn & work.**
	What we'll achieve • **A thriving economy** – inclusive long-term economic growth which benefits everyone in our region, through **strategic expansion in key sectors**, from health and care, to ports and logistics, green energy and sustainability, and data, research and innovation • **Thriving organisations** – growth and expansion of local private and public sector organisations, through **closer collaboration, shared use of resources** and extending regional prosperity • **A Thriving population** – sustained improvements in health and wellbeing for local people through the provision of better jobs, housing, education, cultural opportunities and community assets • **Levelled up communities** – reduce inequality across our region, through targeted community development and a collective focus on creating opportunities and raising aspirations.
• **Building better prosperity**	What we'll do Unlock the potential of our region and its people through **investment in healthcare infrastructure.**
	What we'll achieve Healthcare facilities that re fit for the future by: • **Transforming or replacing our existing hospitals to provide new state-of-the-art health and care campuses,** using leading edge design. This will significantly improve patient care whilst also promoting research, innovation and greater employment prospects. • Sustained and inclusive economic growth by: • Maximising the benefits of our investment programme for local people through **forging new cross-sector partnerships** • Supporting inclusive opportunities and prosperity by driving a **collaborative approach** to developing our investment proposal • Growing our workforce by **working with education partners** to equip people with the skills and knowledge to build long-term healthcare careers • Boosting our economy through **partnering with local suppliers** and leveraging the buying power of NHS organisations • Optimising investment potential by taking a creative approach to funding opportunities, achieving financial stabilisation across Humber organisations and **being more efficient with our assets** • Shaping regional corporate, operational and workforce plans around maximising the long-term economic and social benefits of **capital investment** • Evaluating the impact of the investment on the region using financial modelling.
• **Building better services**	What we'll do Create a network of vibrant healthcare campuses to meet the changing needs of our communities.
	What we'll achieve Expanded provision of care by: • Enabling people to get advice and treatment more easily by **improving access to routine care in community settings** and offering more digitally enabled care • Helping more people access high quality treatment by **improving the way our hospitals work together** • More efficient management of services by: • Helping hospital staff make the best use of resources by implementing a **networked approach to care planning and delivery** • Streamlining and accelerating treatment by **investing in fully connected services**, underpinned by common ways of working, pooled resources and shared records • Reducing risks to the delivery of safe and effective care through **implementing sustainable service models** that maximise positive results.

• **Building better infrastructure**	What we'll do Future proof our healthcare buildings to ensure long term service quality.
	What we'll achieve Significantly improved standard of care by: • Maximising the prevention and control of infection by **developing state-of-the-art healthcare hubs** • Helping staff to provide exceptional specialist treatment by **developing networked services** across our five sites • Widening access to care by taking a collaborative approach to estate management • Sustainable and adaptable infrastructure by: • Making best use of resources by seamlessly blending new and retained buildings • Ensuring our healthcare hubs can be **upgraded** to incorporate the latest technologies and ways of working through utilising **intelligent, flexible design** • Capitalising on local expertise in **modern methods of construction** to build high quality, sustainable buildings fit for the future.
• **Building our future workforce**	What we'll do Create opportunities for our population to thrive by offering rewarding careers and nurturing future talent.
	What we'll achieve A flexible and diverse workforce that meets our needs by: • Investing in, nurturing and training our current and future workforce, equipping them to provide the highest quality healthcare and looking after their mental and physical wellbeing • Introducing more flexible roles and **enabling staff to move between organisations** and sectors with ease • **Creating vibrant and dynamic places to live and work**, attracting the brightest and best to work in our organisations • Encouraging and supporting our staff to be innovative and lead the design of **new ways of working** A region of opportunity where everyone can thrive by: • Working with schools and colleges to promote careers in health and care, remove barriers to entry and raise aspirations of our young people • Offering flexible career pathways that enable people at all stages of life to reach their full potential • Tackling discrimination, encouraging diversity and creating a sense of belonging • Collaborating with universities and private sector organisations to generate employment opportunities in other related industries.

• **Building better connected services**	What we'll do Use digital technology to power our services and create better connected people and communities.
	What we'll achieve Improved health and care for local people by: • Empowering people to take charge of their own wellbeing by giving communities access to support through dedicated apps and websites • Ensuring everyone can benefit from digital opportunities by working with partners to take a proactive approach to digital inclusion • Enabling more patients to access round the clock care by empowering staff to digitally connect with people from anywhere, at any time • Driving innovation through continually upgrading our infrastructure and services and designing new buildings that are fully digital enabled. More effective, data driven decision making by: • Empowering staff and patients to make better healthcare choices by pooling data across organisations into one accessible, centralised digital source • Increasing access, visibility and accuracy of patient information by storing data in one centralised place, utilising the Yorkshire and Humber Care Record • Enabling practitioners to make better choices about care through sharing data across organisations to give them a rounded view of patients' needs • Keeping our data fully secure by investing in the latest cyber-security technology.
• **Building better research opportunities**	What we'll do Create outstanding and diverse learning environments to position the Humber as a centre for life changing research.
	What we'll achieve Expanded research, training and innovation capabilities by: • Increasing collaboration and aspiration in healthcare research through strengthening partnerships between our academic, public and private partners • Working with the University of Lincoln and the University of Hull to develop an ambitious collaborative research and development programme • Giving our workforce the resources they need to pioneer new ideas by **investing in our state-of-the-art healthcare hubs** • Cementing the Humber as a national driver of cutting edge advancements in health and care by building a culture of innovation across the region • Delivering on our ambitious plans for growth in clinical and applied healthcare research. Increased expertise across our workforce by: • Establishing the University of Hull's **Health Campus as a centre of excellence** in clinical and applied healthcare research • Increasing opportunities for local healthcare professionals through expanding and developing regional clinical academic careers • Broadening understanding of the role of research in enhancing and transforming healthcare services.

• **Building sustainable futures**	What we'll do Put environment sustainability at the heart of our investments to maximise long term benefits for our region and the planet.
	What we'll achieve More eco-friendly services by: • Reducing carbon emissions and single use plastics across our healthcare campuses • Making better use of digital technology across our services and communities to reduce the environmental impact of healthcare delivery. More sustainable infrastructure by: • Incorporating cutting edge innovation into our development plans, combining the latest academic and industry expertise • Leveraging the assets, knowledge and expertise in green energy within the Humber to play our part in reducing the region's carbon footprint.

Humber Acute Service Review (HASR)

The Humber Acute Services programme was established to create a Humber wide response to the challenges faced in delivering healthcare across a large geographic area which has high levels of health inequalities, deprivation and experiences significant issues in recruiting staff in some areas.

The review will look at how the ICS can provide the best possible hospital services for the people living in the area, whilst making best use of the money, staff and buildings that are available. Due to the COVID-19 outbreak and national lockdown, certain aspects of the HASR were paused or delayed so that resources can be focused on the frontline. The outcome of the HASR and transformation of primary care will dictate the anticipated activity and location of services across the region. This will have a direct impact on the reconfiguration of the estate and how the estate can support the Trust and regional objectives.

HASR has made the following progress:

Table 11 - Progress to Date of HASR

October 2019 **Developing Outline Ideas** **(Public engagement)**	A review team, led by an independent clinical lead, engaged with local clinicians to look at a range of possible ways of delivering services for each of the following key service areas: • Maternity and paediatrics • Urgent and emergency care • Planned care These possible approaches were displayed along a continuum from least to most change. Patients and their representatives were consulted at a series of events (throughout October 2019) about their views on these approaches. The review wanted to know what patients thought about the different ideas and whether they would have a positive or negative effect on them and their families.
November 2019 **Refining Service Models** **(Citizens' Panel Meeting)**	• Feedback from patient and public workshops, clinical design group meetings as well as a range of other engagement activities with clinical and non-clinical staff members and other stakeholders was used to refine the outline ideas into possible service models. The Citizens' Panel meeting in November 2019 reviewed the possible service models for the key clinical areas individually.

December 2019 – February 2020 **Combining Service Models** **(Clinical Design Group)**	• The Clinical Design Group was asked to review whether each possible clinical model would be sufficient to address the issues set out in the Case for Change (i.e., would the change be enough to solve the problems that the system currently faces, and be enough to provide safe and effective care for local people). • Looking at sufficiency enabled the Clinical Design Group to rule out a number of (theoretically possible) models. The next stage was for clinicians to review all the possible service models and combine them together into '***whole hospital***' models. Clinical colleagues felt strongly that it made most sense to start with urgent and emergency care and build planned care models around this. There are strong links (interdependencies) between urgent and emergency care services, maternity and paediatrics and therefore these have been combined first to create viable '***whole hospital***' models. • Across Hull and East Riding, these service areas are largely consolidated onto a single site and therefore the focus of this element of the review work is on the sites on the south bank of the Humber. Planned care will be brought back in at a later stage. The Clinical Design Group looked at the clinical interdependencies that might apply to determine which models could be safely put together on a single hospital site. The Clinical Design Group reviewed multiple iterations of the possible combinations and discussed the different interdependencies and the viability of the different models.
February to March 2020 **Evaluating Clinical Models** **(Clinical Design Group/Citizens' Panel)**	• The next stage of the process was to evaluate the different clinical models against the evaluation criteria set out at the start of the review as listed below: **Figure 5 - HASR - Evaluation Criteria** **Quality** Clinical Outcomes — Will the service give me the best possible chance of being well? Patient experience and satisfaction — Will the service meet my needs? Will I have a good experience? Embracing technology — Will the service use up-to-date technology? Working together to ensure patient safety — Will the services I need link up in the best way for me? **Operational Delivery** Performance — Will I receive my treatment within the agreed waiting times? Getting there and parking — Will I be able to get there? **Sustainability** Staffing — Will there be the right staff there to provide the care I need? Buildings and equipment — Will there be the right buildings and equipment to provide the care I need? Cost effectiveness — Will it be cost effective and within budget?

At its February meeting, the Clinical Design Group evaluated the four models set out above against two of the criteria (where they were best placed to exercise their professional judgement) – **workforce/staffing** and **clinical outcomes**.

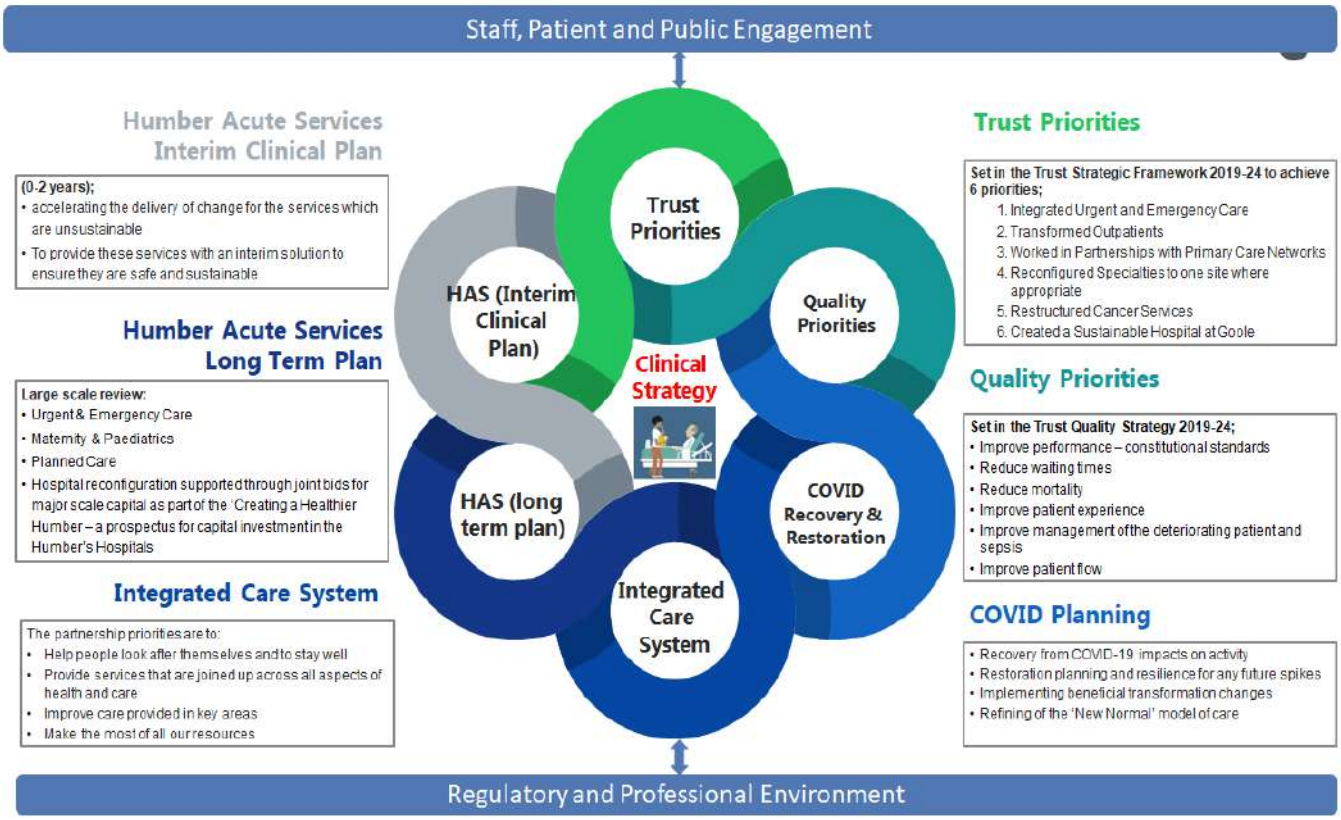
It was then proposed that the Citizens' Panel would use their judgement and the information gathered through the patient feedback events to assess the four models against two further criteria – **access & transport** (getting there and parking); and **patient experience & satisfaction**.

Alignment

There are multiple evolving journeys in progress to achieve these outcomes, all of which need to closely align to ensure the most optimal result. The clinical strategy aims to reflect an end state of ultimately achieving safe, effective and sustainable services.

The diagram below reflects the key areas of alignment:

Figure 6 - Strategic Alignment



By taking into consideration the objectives of the Trust and the estates department in connection with local, regional and government strategies, our current position and estate performance and the available funding, a number of priorities in terms of schemes have already been identified for inclusion in this current Estates Strategy and are currently being progressed.

1.4 How do we get there?

This section sets out the major projects that are proposed or underway to achieve our estate vision. Some projects only affect the NLaG estate; others have a wider effect on health services in the region and therefore will require a collaborative response between stakeholders.

NLaG Estates Masterplan 2020-2050

NLaG's 2020-2050 Masterplan, developed in early 2020 as a precursor to the production of this 2020–2025 Estates Strategy, identified existing and potential future development options with regard to the physical condition, quality, utilisation and location of the whole Trust estate.

This was developed without fully taking into account the latest national, regional and Trust strategic priorities described within this Estates Strategy. The schemes noted in the 2020-2050 Masterplan were proposed to address the following site risks and issues:

- Pockets of aged buildings unfit for clinical use across all sites, along with significant, safety critical infrastructure backlog maintenance
- Specific need to address old estate at SGH – potential need for wide scale redevelopment and provision of a new clinical centre of excellence
- Potential alleviation of bed pressures following reconfiguration and refurbishment of existing departments
- High demand for imaging facilities at DPoW and SGH – works underway to increase capacity
- Residential accommodation at SGH is poor and fails to attract interest from staff. Potential for redevelopment
- Option to provide assisted living facility and land sale for private residential accommodation at the SGH site to reduce non-clinical footprint in response to the Carter report. (A similar scheme has already been completed at DPoW).

Current/Planned Schemes

The table below highlights the status and value of current, planned schemes the Trust has, or is seeking, funding for:

Table 12 - NLaG's Current/Planned Capital Schemes

Project	Est. Value	Funding	Site Operational
Major Capital Still to be approved			
New SGH Development - Pre-Consultation Business Case (PCBD) SOC	c.£400m	TBC	Post 2030
Wave 5 National ICS/STP Bidding to incl. DPoW/GDH	c.£150m	DHSC/NHSE/I	TBC
Trust Approved			
ED/AAU (ED x 2 & AAU x 2)	£54.86m	ETP & ED Funding	ED - 2021/22 AAU – 2022/23
SGH MRI	£4.88m	STP Wave 4/Trust Capital	2021/22
DPoW MRI	£8m	DHSC Loan	2021
DPoW CT	£1.9m	DHSC Loan / Core	Dec 2020/Jan 2021
Critical Care	£1.4m	NHSE/I	Dec 2020/Jan 2021
Critical Infrastructure Risk (CIR)	£3.6m	NHSE/I	Mar 2021
COVID Equipment	£1m	COVID	Delivered
Awaiting Approval			
Goole Energy Scheme	£2.3m	Central Gov.	TBC
Infection Prevention Control (IPC) - Phase 3/COVID/Winter)	£24m	NHSE/I	Winter 2020/21
Digital Accelerator	£5m	NHSE/I	TBC
Approved Core Capital & Completed Schemes			
Back Log Maintenance (BLM)	£1.8m	Core	March 21
IM&T	£1.4m	Core	March 21
Equipment	£1.3m	Core	March 21
Mental Health & Mortuary - CQC	£0.9m	Core	TBC
Endoscopy JAG Accreditation	£0.037m	Core	2021/22
SGH Ward 29	£2m	Core	Completed/Open

These options are to be further developed and considered taking into account NLaG's emerging Clinical and other supporting strategies e.g., Workforce and Digital Strategies; the outcome of the HASR, the ICS and the transformation of Primary Care through the PCN.

Short to Medium Term Options

Strategic Priority One – Integrated Urgent & Emergency Care

There is a requirement to develop facilities within the HCV region to support and enable the roll out of a standardised front door Urgent & Emergency Care Clinical Assessment Service Model including Same Day Emergency Care (SDEC). The aim is to create an Urgent Care Hub that brings together the ED, a priority admission area, alongside an AAU (including assessment, SDE), frailty and short stay areas that span all specialities.

To this end NLaG have developed plans to create new A&E Departments and AAU at both DPoW and SGH. The new facilities will allow transformation of the service and see Urgent and Emergency care come together in a multidisciplinary assessment area co-locating surgical and medical assessment with same day emergency care.

When developing and finalising its designs and Outline Business Case (OBC) in readiness for NHSE/I approval for this scheme, the Trust was notified of an opportunity to access additional funding of circa £30m for the renewal of A&E departments at both sites which the Trust was successful in securing.

Long Term Development Options

Strategic Priority Two

Transformed Outpatients/ Building Better Services (HCAV HP's Investment Plan)

The programme will be delivered by enabling the use of technology, innovation and efficiency to support operational teams to maximise capacity in outpatients and deliver the transformational change of clinical pathways across primary and secondary care.

This programme has been accelerated through the COVID-19 period, due to the need to move to virtual assessment and review where safe to do so. The establishment of a referral assessment service (RAS) across the system in April 2020 and agreement of clinical pathways to support this has resulted in the beneficial achievement of the NHS Plan objectives to move to virtual review from years to a matter of weeks. There does remain a significant challenge to ensure that these changes are now embedded through recovery.

A realistic implementation programme is required that will deliver outpatient services in the community and other settings. It is anticipated that the outcome of the HASR and the more developed future strategic direction of the HCAV HP will identify those services which can be amalgamated regionally and delivered across the whole regional health economy. It is only by working together that efficiencies can be made in terms of digital technology, estate use and patient pathways.

Strategic Priority Three

Work in Partnership with Primary Care Networks

In the next four years the local health system will change through the development of PCNs and the Trust will be working closely with primary care to bring the right skills to the networks, developing a greater partnership between acute and primary care services. Clinical networks across all sectors will support new ways of working.

The conditions we will focus on will vary from place to place depending on local circumstances; however, across HCV there will be a focus on supporting people with **diabetes**, **respiratory conditions** and **cardiovascular disease** because these are areas where significant improvements can be made by working together at scale.

The system will also improve the coordination of end of life care so that more people can be supported to die in their chosen place and not be rushed into hospital unnecessarily.

The right estate in the right place will play a key role in helping to facilitate the Transformation of Primary care.

Strategic Priority Five

Restructured Cancer Services

Cancer services are one of the areas where the Trust needs to improve: to make sure patients get access to diagnostics quickly and, where cancer is identified, treatment can start as soon as possible. The Trust does not have access to skilled and experienced cancer specialists and needs to change what it does to make sure it provides the best possible care to every patient. It will look to do this by working with other Trusts and hospitals which do have the experienced staff as well as the facilities to provide the very latest treatments. To ensure this happens in the next five years the Trust will:

- Review and assess tumour site services to provide best care
- Explore and develop new models of care to ensure faster diagnosis is delivered in 28 days and treatments provided to time
- Expansion of MRI and CT scanning through capital funding to implement new scanners.

To support the improvement of cancer services capital investment in imaging services is required.

The demand for MRI and CT scanning has dramatically increased over recent years causing significant capacity issues in the ability to meet the demand and scan patients within acceptable timescales. The Trust has invested, and continues to invest, in much-needed additional scanning capacity and has been successful in receiving capital funding to install CT and MRI facilities at Diana, Princess of Wales Hospital and an MRI suite at SGH.

Whole Site Transformational Long Term Options

Strategic Priority Four

Reconfigure Specialities to One Site where appropriate

This Trust strategic priority also addresses **HCAV HP's Investment Plan Visions**, **Building Better Prosperity and Building Better Infrastructure**.

Underpinning the need for service change is the dependency on infrastructure and estate and the ability for existing buildings to adhere to the required clinical standards. Given this is one of the main challenges the Humber is facing, there is a commitment to creating a healthier Humber through significant capital investment. Put simply, we want to provide 21st Century infrastructure which will attract top talent to our hospitals and provide the best care for our patients.

HCAV HP's investment plan to unlock the potential of our region and its people through investment in healthcare infrastructure will be achieved by transforming or replacing existing hospitals to provide new, state-of-the-art health and care campuses, using leading edge design. This will significantly improve patient care whilst also promoting research, innovation and greater employment prospects. This will enable the future proofing of healthcare buildings in the region to ensure long term service quality.

Capital investment in our hospitals will act as a catalyst for the continued regeneration of the region, because the opportunity a cash injection brings in terms of employment, education and mental and physical well-being for local people. It also provides an opportunity to build on the region's skills and expertise in green energy to develop a lower carbon future for our healthcare facilities and support the development of green jobs in the region.

In support of HASR, NLaG will look to secure future funding to develop new hospitals or refurbish and reconfigure DPoW (Grimsby), SGH and GDH. Options for these new hospital developments were proposed in the NLaG 2020-2050 Masterplan produced in early 2020. The reconfiguration of specialities to one site is identified as a HASR strategy.

The Trust are therefore developing proposals to build a brand new hospital on a new site in the Scunthorpe area which would enable a faster, cheaper and much more efficient construction process. These findings have led to four new potential sites being identified by the Trust which are currently under evaluation.

The master planning and subsequent work undertaken by NLaG feeds into the wider HASR and during Summer 2020, preparatory work was undertaken to develop high level plans for a programme of major capital developments across the ICS area.

The NHSE/I Regional Team has identified the redevelopment of Scunthorpe Hospital and re-provision of the tower block at Hull Royal Infirmary as top priorities for inclusion within the national Health Infrastructure Plan (HIP) programme. Prior to the start of the COVID-19 pandemic it had been expected that an expansion of the HIP programme would be confirmed by the government before the end of the calendar year. Given the very high level of support being provided by the Regional Team, it had been anticipated that the Scunthorpe/Hull major development would be selected for inclusion in the expanded HIP programme.

This proposed solution will significantly improve the standard of care by maximising the prevention and control of infection, helping staff to provide exceptional specialist treatment by developing networked services across all five sites included with the HASR, and widening access to care through a collaborative approach to estate management.

In addition, the creation of vibrant and dynamic places to live and work will attract the brightest and best talent to work within the organisation. The new hospital will provide this workforce with the resources they will need to pioneer new ideas and cement the Humber as a national driver of cutting edge advancements in health and care, building a culture of innovation across the region.

Figure 7 - Artist's Impression of Proposed new Hospital in Scunthorpe

Strategic Priority Six

Create a Sustainable Hospital at Goole

In 2019/2020 the Trust set a priority to move more planned care to GDH. This site also offers real potential in terms of the ICS and future models of care. This was the start of a longer-term piece of work to create a sustainable facility in the town.

A long-term scheme proposed in NLaG's 2020-2050 Masterplan would be the redevelopment of GDH. GDHs physical condition facet survey results highlight that the whole site (all five blocks surveyed) are either '*very poor facilities' or "less than acceptable facilities'* and *'requires capital investment or replacement'*.

Implementation Plan

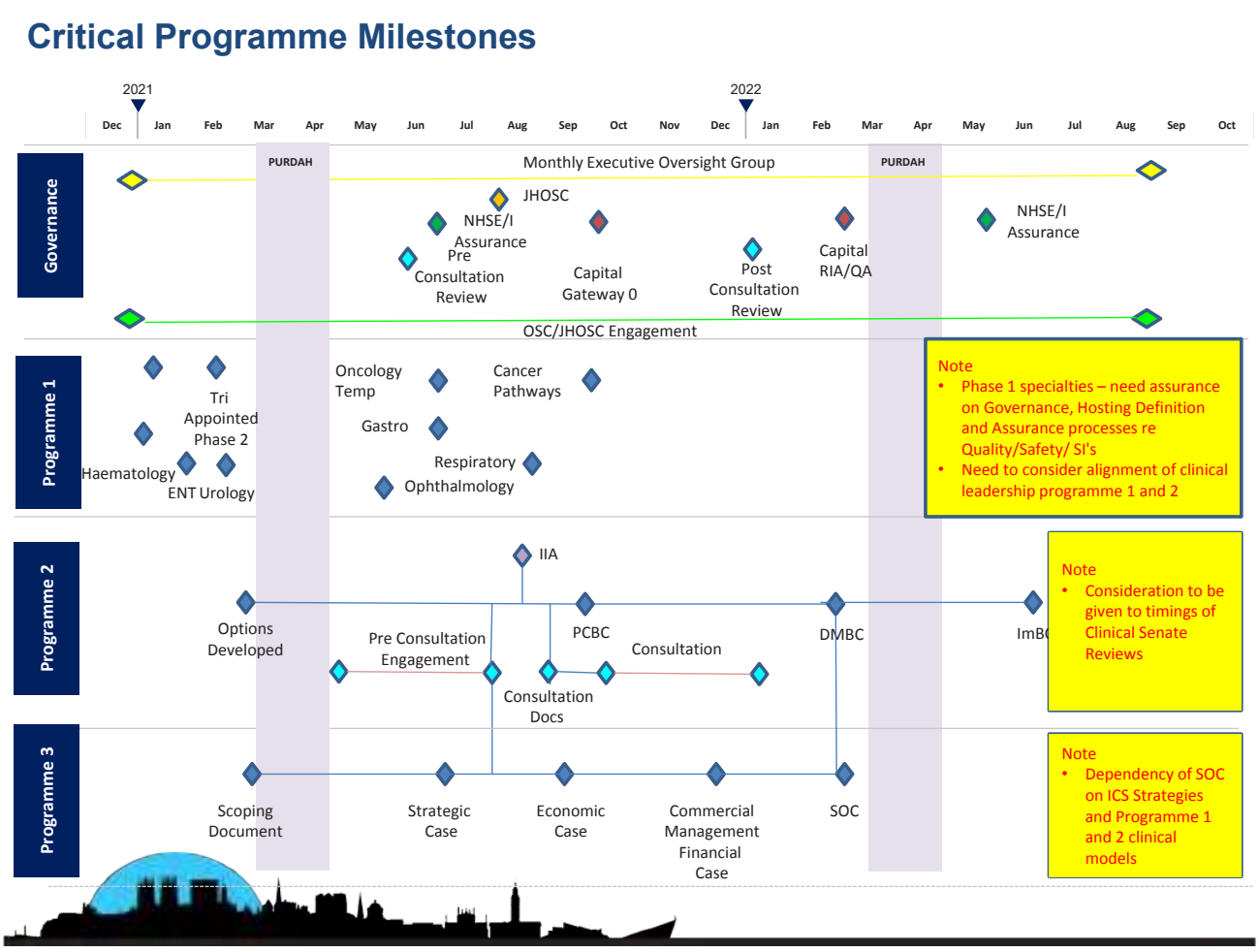
In order to be able to deliver the whole scale transformation, which is required to continually provide, "Right care, right place, right time", NLaG must have a clear implementation plan. This Estates Strategy (and the approval of other supporting strategies) represents the first phase of this plan and the diagram below identifies the subsequent steps necessary to deliver an estate which will meet current demands whilst also being able to respond to future needs.

Sustainability

Opportunities to co-locate Trust facilities with other organisations, both within the NHS, private health sector, and non-health public and private sector organisations could deliver:

- Cost efficiencies and sustainability benefits of using, leasing or funding a single building rather than several enabling us to "live withing our means"
- Provision of integrated services (Linked to Strategic Priority 3 & 4)
- A greater opportunity for a '*one stop'* service delivery, this should reduce the time taken to procure healthcare and reduce travel (Linked to Strategic Priority 4)
- NLaG will give careful consideration to the design of the estate and recognises that creative renovation will improve service quality, energy efficiency and will reduce the impact on the environment. The re-use, remodelling and refurbishment of the estate will contribute to sustainability objectives by:
- Reducing pressure to develop on previously undeveloped land, particularly the open countryside
- Improving the viability of public and other services in urban areas, particularly by procuring as much as possible in the local economy, and employing as many local people as possible
- Assisting in urban regeneration which could potentially improve the quality and vitality of the urban environment and urban living
- Application of BREEAM (Building Research Establishment Environmental Assessment Method).

Figure 8 - NLaG's Estate Strategy Implementation Plan/Critical Programme Milestones



NLaG's Green Plan

As detailed in NLaG's Green Plan, the Trust will continue to make direct interventions to tackle climate change while delivering high quality care and improving public health. These interventions have been identified as:

Table 13 - NLaG Green Plan Interventions

Areas for Action	What this means	What we are doing at NLaG
Sustainable consumption & production	• Achieve more with less • Look at how goods and services are produced and the impacts of products and materials across their lifecycle • Reduce inefficient use of resources	• The Trust is reviewing all tender documentation including pre-qualification questionnaires (PQQs) and Invitation to Tenders (ITTs) to ensure that sustainable issues are considered within future procurement decisions • Consideration of life cycle costing • Increase recycling and review waste segregation • Seek opportunities to improve water efficiency • Reduce single use plastics
Climate change & energy	• The effects of climate change can already be seen, and scientific evidence points to the release of greenhouse gases into the atmosphere by human activity as a primary cause of this • Decarbonisation of our estates and facilities • Prepare for the climate change that cannot now be avoided	• Future Energy performance contracts across our sites to guarantee meeting of carbon targets and production of savings • New Sustainable Energy Centre at Goole & District Hospital • Installation of carbon reducing technologies across the sites • Purchase of 100% REGO backed renewable energy • Increase implementation of AMR and energy monitoring
Protecting natural resources & the environment	• Natural resources are vital to the existence of all • Develop a better understanding of environmental limits, environmental enhancements and recovery	• Maintenance of green spaces around the sites • Seeking ways to improve the air quality at our sites
Creating sustainable communities	• Create sustainable communities that embody the principles of sustainable development at a local level • Working in partnership to get things done	• Working in partnership with Local Authorities, other NHS organisations and the voluntary sector e.g., Heat Networks and Travel Plans

Funding

Several capital funding options might be available. As part of the identification of the best way forward, detailed calculations will be required covering availability of reserves, the annual capital resource limit (CRL), the Trust's prudential borrowing limit (PBL) and the impact on the Trust's long-term financial model (LTFM).

Although the costs associated with developing a guideline compliant SOC would be covered by national NHS funding, there may be scope to secure funding from non-NHS sources including Towns Deal funding, One Public Estate funding and external investor funding.

STP Funding

A new approach to NHS capital funding was introduced in 2020/2021, the main purpose of which is the allocation of a capital envelope for each STP/ICS. The aim of this is to provide greater clarity and confidence on the level of capital resource available; support system working and discussion on capital priorities; and enable faster access to national capital funding for critical safety issues.

Health Infrastructure Plan (HIP) Funding

In October 2020 the government confirmed that 40 hospitals will be built by 2030 as part of a package worth £3.7bn, with eight further new schemes invited to bid for funding. It is anticipated that a bidding process for the remaining 8 places will take place in Spring 2021.

Trust Capital

Trust capital is limited and could provide an initial investment to kick start transformation of the estate. Whilst capital money is not readily available, and a portion of this capital is required to maintain statutory compliance across the estate whilst the transformation plan is being implemented.

Decarbonisation Fund

NLaG will be applying for a significant amount of this funding to deliver a range of energy efficiency technologies and heat decarbonisation schemes within our estate. This will help support a new Energy Performance Contract (EPC) predominantly aimed at SGH and DPoW.

In addition, GDH has been chosen as one of the four pathfinder projects forming part of the Modern Energy Partners (MEP) Catapult programme. BEIS will help fund a new sustainable energy centre at the site replacing coal boilers with a CHP and high efficiency gas heating system. Along with other strategic energy efficiency technologies, these measures, which are planned to be completed by September 2021, will reduce the carbon footprint of GDH by over 60% delivering substantial cost savings to the Trust.

Constraints & Barriers

As with all large-scale strategic development there will be a number of constraints and barriers which will impact implementation which include, but are not limited to, the following:

- Previous lack of investment in buildings and critical infrastructure
- Availability of funding for whole scale transformation
- Ability to work successfully with other Trusts, CCGs and wider STP partners
- Co-operation of NHS PS and other landlords
- Willingness of other parties to support vision
- Future commissioning plans
- HR Policies, Procedures and required Management changes
- Workforce
- Technology
- Appetite.

All constraints and barriers identified throughout this process will be considered in more depth at Business Case Stage. However, plans to prevent some of these being a barrier to the transformation of the estate can be set in motion now.

Risk

The aim of this estate's strategy is to eliminate, minimise or adequately control risks associated with the built environment and to ensure that any investment decisions are affordable, represent value for money, provide added value and support the Trust's financial plans.

Risk, individual to the schemes identified within this estate's strategy will be analysed in more detail through the business case process.

The Trust have an overarching Governance and Risk Management Strategy 2019-2024. The Governance and Risk Management Strategy is an integral part of the Trust's approach to continuous quality improvement and is intended to support and assist the organisation in delivering the key objectives within the Trust's Quality Strategy as well as ensuring compliance with external standards, duties and legislative requirements including those relating to the Trust's License with NHS Improvement (NHSI) as a Foundation Trust.

Benefits

The strategic development of the estate will provide a number of tangible benefits for patients, staff, visitors, and commissioners and the wider health and social care economy and support the Trust to deliver its strategic framework. The estates anticipated high level benefits will include:

- A cost-effective quality estate which is safe, sustainable, efficient, and fit for purpose delivering services in the right place at the right time, which are patient centred and allows us to "live within our means"
- Alignment with Trust, regional and national objectives including the reduction of out of area placements, strengthening of community services and development of specialist services in preparation for further development of the STP and new models of care
- Alignment with the expectation of regulators e.g., NHSI/E, CQC, HSE
- An estate that better meets the current and future needs of the population served, which will allow service transformation and whole system thinking
- Improved flexibility to respond to new service developments or minimise the impact of service or activity retractions
- A working partnership with other providers and partner organisations across the region including working in partnership with PCN's
- Increased level and an enhancement of services in the community to ensure they are delivered in the right place at the right time
- An estate which meets national targets such as those indicated in the Carter Review and Carbon Reduction Commitment, the NHS Net Zero Carbon Plan etc.
- Demonstrable improvements in quality and patient experience linked to the delivery of the Trust's quality priorities
- A reduction in the frequency and severity of adverse incidents
- Improved environmental performance (including carbon reduction).

Recommendations

It is recommended that the Trust Board approve this estates strategy in conjunction with other supporting strategies and show commitment to progress with the alignment of this estates strategy with the outcomes from the HASR and share with the HCV HCP in order to commence discussions and negotiation with the wider health economy. This will begin the process of a system wide transformational change which will ultimately deliver a sustainable, cost effective, safe and fit for purpose estate integrating health and social care services to support and improve health outcomes.

This will involve supporting the development of a Strategic Outline Case (SOC) to secure HIP funding which has been identified as being available to the Trust subject to robust plans.

2. Introduction

This Estate Strategy sets out how NLaG intends to position its estate and infrastructure as a key enabler in the delivery of clinical services that are safe, secure and appropriately located. This strategy document is one of a number of enabling strategies that work in partnership to support the Trust's Annual Plan and Clinical Strategy.

Figure 9 - How an Estates Strategy supports overall strategy

The suite of documents as a whole reflects the Trust's vision, values and strategic objectives to provide a range of high-quality, ever-improving services in a dynamic and stimulating environment that attracts the best staff.

This Estates Strategy has been developed in accordance with the Department of Health and Social Care (DHSC) guidance document 'Developing an Estates Strategy', and is structured to reflect the following three key questions:

- **Where are we now?**
- **Where do we want to be?**
- **How do we get there?**

Its aim will be to describe the current condition of the estate, (identifying its suitability, occupancy, tenure, physical condition, service and organisational constraints, capital investment decisions and occupancy costs), highlighting how the existing supply of capital assets meets current services and the needs of the community.

This will be in line with the Humber, Coast and Vale Partnership Long Term Plan, 2019/2024, showing how assets could change through investment, acquisition or disposal to meet future needs.

The Estate Strategy will also identify the steps which can be taken by the Trust to maximise the use of those assets in order to provide a productive, efficient, safe, and fit for purpose estate which will support existing and future clinical requirements; while demonstrating how value for money can be achieved.

Drawing on a number of examples of estates strategy development and best practice guidance, a recent Kings Fund review of strategic estate development has identified the following as important core components to a robust estate strategy document:

- **A strategic overview** – estates strategies should align with and reflect the aims of any wider organisational or strategic planning
- **Alignment with clinical strategy** – as part of the above, estates strategies should align with the clinical strategy (at all levels), rather than being developed in isolation, driven by cost concerns, or based on existing buildings
- **Customer focus** – a clear understanding of what '*customers*' require and value. This includes those who currently use the estate and those who may use the estate in the future
- **Clear case for change** – linked to the above, and key to implementation
- **Understanding of the estates value** – an understanding of the role and value of the estate within the context of other strategies, e.g. funding and sustainability, social value, value to the taxpayer
- **Flexibility** – any estates strategy needs to be able to respond to potential changes in demand or requirements over time. Where this does not happen, the estate becomes a constraint
- **Understanding risk** – understanding the risk appetite of the stakeholders involved
- **Governance** – a strategy should include clear systems of governance and responsibilities. This includes relevant government, and organisational bodies
- **Clarity on outcomes** – estates strategies should include desired outcomes (specific and wider benefits) and set out the approach that will be used to measure performance

The traditional approach to producing an estates strategy has been taken and developed further to incorporate the aforementioned core components which will result in a strategic document that not only reflects national guidance but is fit for purpose in the modern era.

3. Where are we now?

3.1 Estate Overview

NLaG covers a wide geographical area. The Trust has a total of 860 beds with a gross floor area of 142,535m^2. The Trust operates from three main hospital sites and several community premises.

Key Sites

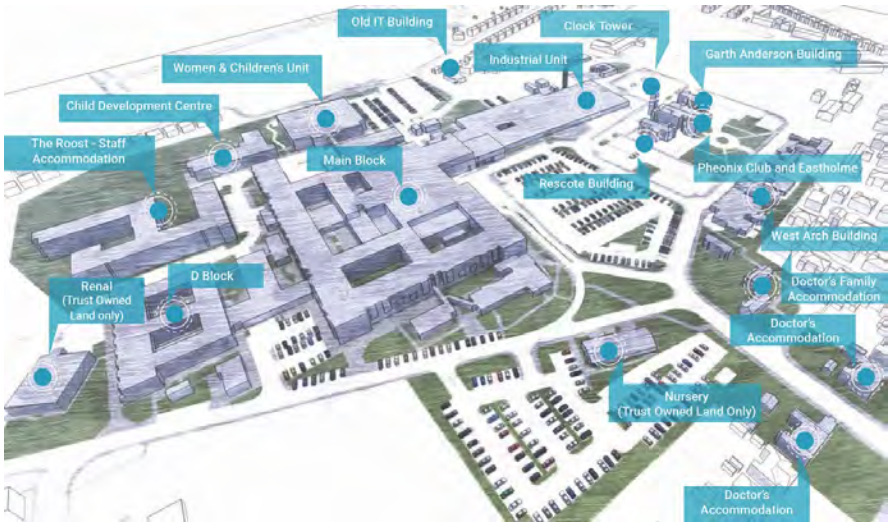
Diana Princess of Wales Hospital (DPoW), Grimsby

NLaG holds freehold for the DPoW site which has a gross floor area of 72,136m^2 and covers a land area of 14.54 hectares. The Trust has already disposed of 6.71 hectares of surplus land to the South side of the hospital, which significantly reduced future expansion opportunities.

The Trust owns staff residential accommodation on this site, providing accommodation for members of staff in training as well as trained staff.

Accommodation is provided on site through a number of flats and semi-detached houses and a new accommodation block called 'the roost' consisting of 96 student units and 124 studio apartments.

Figure 10 - Existing Plan of DPoW, Grimsby



Scunthorpe General Hospital (SGH), Scunthorpe

The Trust holds freehold for the site which has a gross floor area of 54,642m^2 and covers a land area of 10.82 hectares. The site has two access roads from Cliff Gardens and two from Church Lane and has extremely limited parking on site.

The Trust owns an adjacent plot of land where additional off-site staff parking is provided, however some of this is a nature reserve which is leased to North Lincolnshire Council and it is unlikely that this land would be available for further development.

The site is within a residential area of Scunthorpe and is surrounded by residential properties. It is therefore landlocked with no opportunity for expansion.

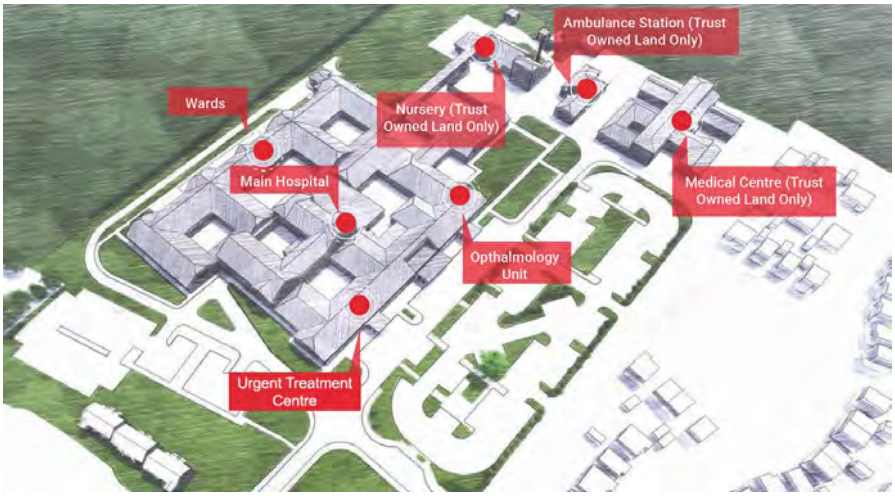
Figure 11 - Existing Plan of SGH, Scunthorpe (South West View)

In January 2015 NLaG purchased staff accommodation back from Riverside Ltd. The total stock equates to 108 units made up of self-contained flats with en-suite.

Goole and District Hospital (GDH), Goole

NLaG holds freehold for the site which has a gross floor area of 15,757m^2 and a land area of 5.91 hectares. The site includes a Primary Care Centre (despite not being owned by the Trust) and has significant space for future expansion should it be required. The site has a single entrance and a single exit point onto Woodland Avenue.

Figure 12 - Existing Plan of GDH, Goole



Community Premises

The Trust occupies 15 community premises where staff are either delivering, or supporting acute or secondary care services, or where community clinical services provided by the Trust are located.

- Ironstone Centre
- Ashby Clinic (Dental & The Birches Medical Practice)
- Barnard Court
- Cottage Beck Road
- Global House
- Monarch House
- Cleethorpes Primary Care Centre
- Cromwell Road Primary Care Centre
- Freshney Green Primary Care Centre
- Louth Hospital (Blocks 07 & 17)
- Pilgrim Primary Care Centre
- Scartho Health Centre
- St Nicholas House
- Weelsby View Primary Care Centre
- New Beacon House

The majority of the community estate was inherited as part of the '*Transforming Community Services*' programme in April 2011 due to the transfer of a number of services from NHS North Lincolnshire.

As such the properties occupied for the delivery of community services vary in size, condition, location and are numerous.

Ownership of these properties is mixed, with the Trust occupying space owned or leased by a number of organisations including:

- NHS Property Services Ltd
- Local Authorities
- General Practitioners (GPs); and
- Private landlords.

The Trust's 2015/2020 Estates Strategy identified the need to consider the following with regard to the Community Estate:

- From which properties does NLaG deliver services?
- Are the properties efficient, safe, and sustainable, fit for purpose (in line with Estate Code) and are they providing value for money?
- Are the properties appropriately strategically positioned and aligned to the Trust Clinical Strategy?
- Are properties used or able to be utilised flexibly and in the most efficient manner?
- Are appropriate agreements in place with property owners?
- Do opportunities exist to rationalise the community estate by surrender or co-location of services or with other public sector bodies?

There is an ongoing review with regard to the community estate to support the ongoing community clinical strategy and service review. However, this Estates Strategy focuses on the three main acute sites, being cognisant of the fact that some services, currently being provided by the acute hospitals, could relocate into the community estate as part of the future direction of the Trust and the outcome of the Humber Acute Services Review (HASR).

Age Profile

A significant percentage of the estate was built prior to 1994 as detailed in the table below and Figures 13-15:

Table 14 - Age Profile of the Estate

Age Profile	DPoW	SGH	GDH	Community
Age profile - 2015 to 2024	10%	0%	0%	5.89%
Age profile - 2005 to 2014	1%	3%	0%	24.58%
Age profile - 1995 to 2004	14%	0%	0%	11.24%
Age profile - 1985 to 1994	2%	53%	100%	46.97%
Age profile - 1975 to 1984	67%	14%	0%	0%
Age profile - 1965 to 1974	3%	4%	0%	0%
Age profile - 1955 to 1964	0%	11%	0%	0%
Age profile - 1948 to 1954	0%	0%	0%	0%
Age profile - pre 1948	3%	15%	0%	11.32%
TOTAL	**100%**	**100%**	**100%**	**100%**

- 73% of DPoW site is over 36 years old
- Almost half (44%) of SGH is over 36 years old
- 100% of GDH was built between 1985 and 1994
- Over 11% of the community estate, while not owned by the Trust pre-dates 1948. However, Trust services operate from these aging buildings

Figure 13 - SGH – Age Profile of Estate

Figure 14 - DpoW – Age Profile of Estate

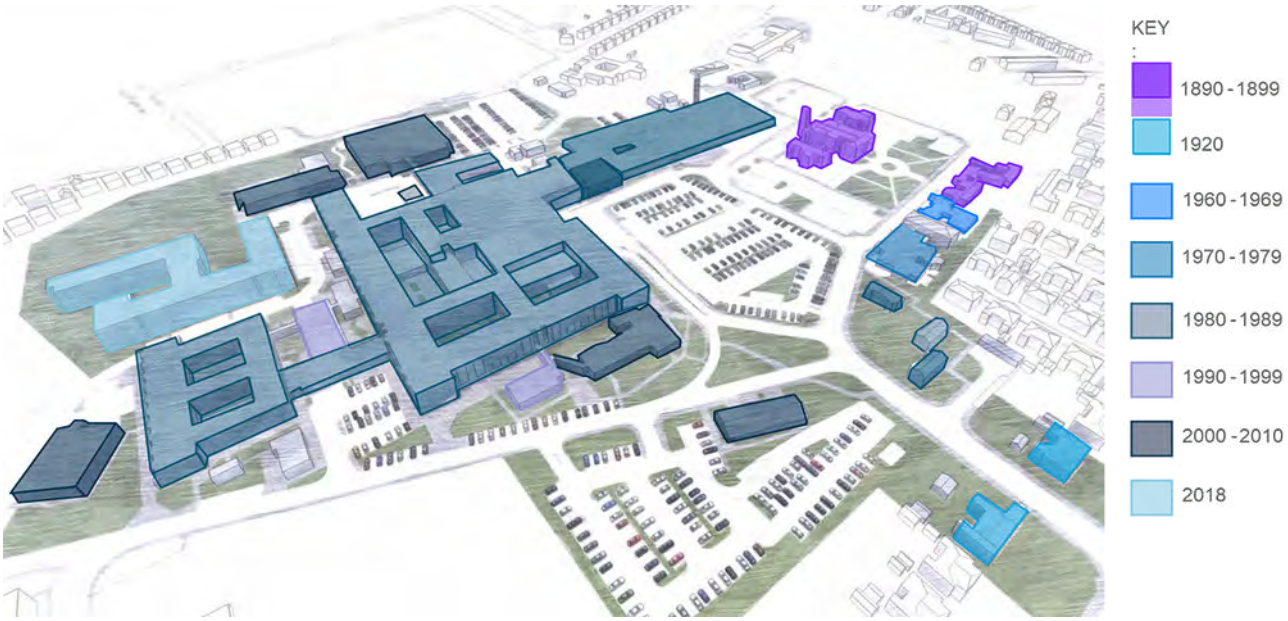
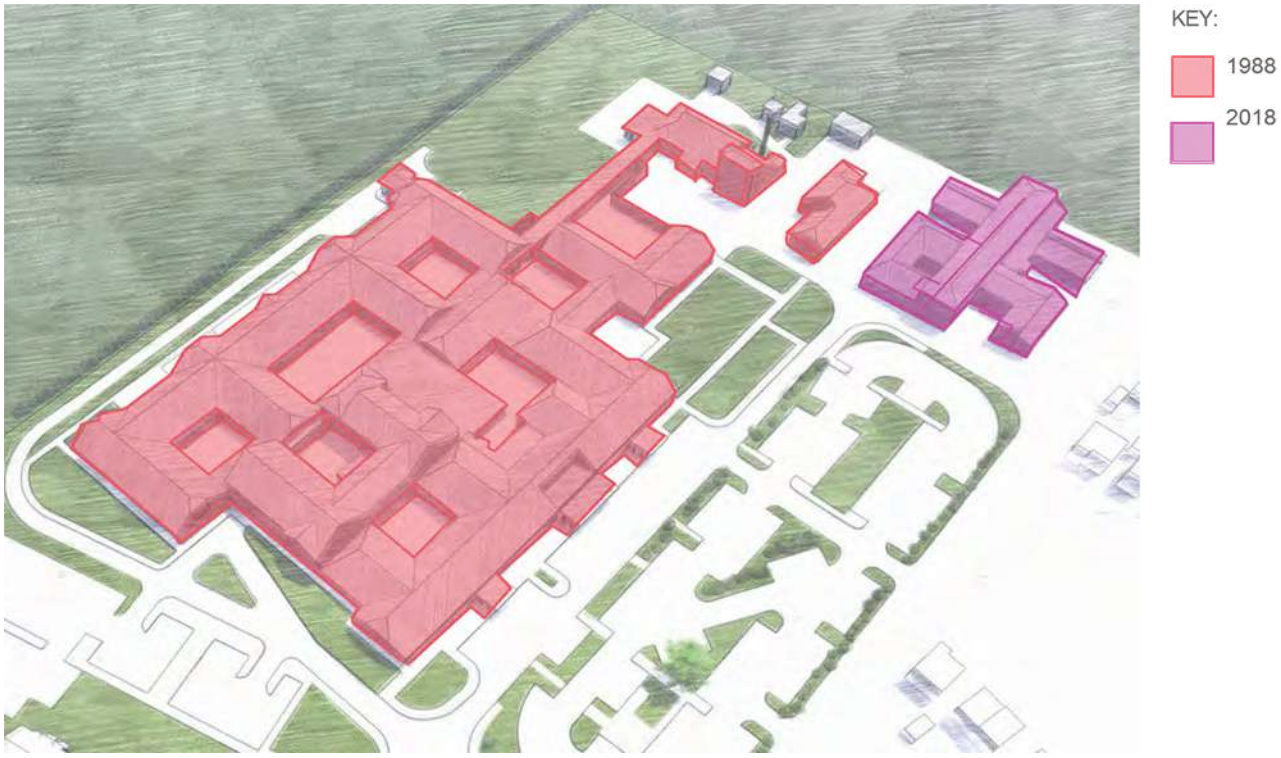
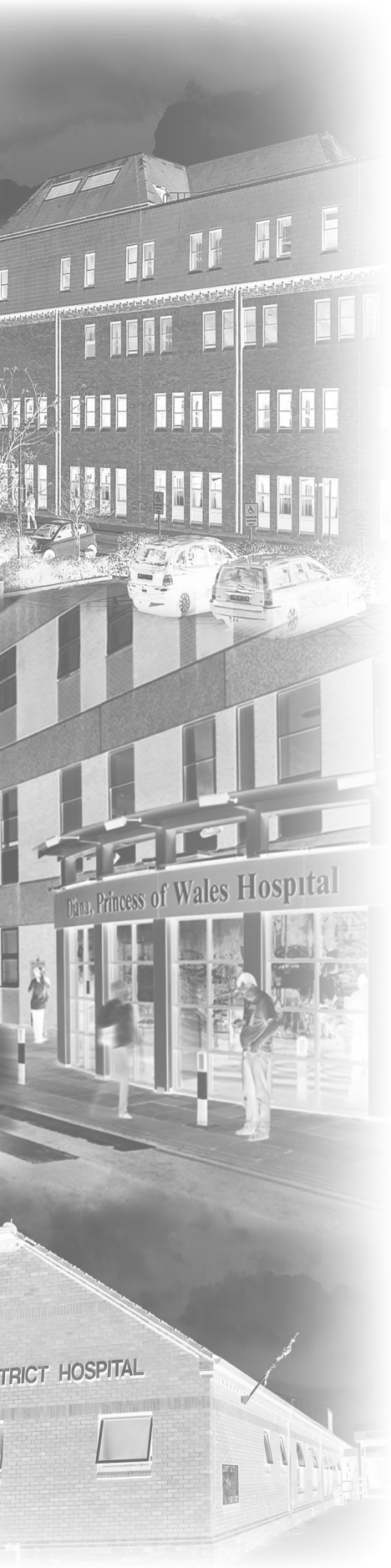


Figure 15 - Goole Hospital – Age Profile of Estate





3.2 Occupancy Costs

The Occupancy Costs for each of the three acute sites has been broken down and included in the Table below. This data is based on the 2019/2020 financial year.

Table 15 - Acute Site Occupancy Costs

Cost	DPoW	SGH	GDH
Facilities Management (FM) Services	£10,159,670	£7,105,059	£1,780,449
Energy	£1,713,994	£2,048,307	£351,128
Water	£207,529	£281,242	£35,888
Waste	£471,841	£439,440	£39,206
Hard FM Totals	£12,553,034	£9,874,048	£2,206,671
Car Parking	£450,927	£516,907	£197,154
Cleaning	£2,795,843	£2,379,276	£453,370
Inpatient Food Services	£2,044,274	£1,745,912	£248,201
Laundry & Linen	£599,791	£500,391	£52,628
Portering	£1,092,709	£1,157,347	£154,043
Soft FM Totals	£6,893,544	£6,299,833	£1,105,396
TOTAL	**£19,536,578**	**£16,173,881**	**£3,312,067**

A reduction in occupancy costs, particularly with regard to Hard FM, can be made through new developments, where buildings will be more operationally efficient, particularly given the NHS Net Zero Carbon conditions which will now need to be considered during development.

In addition, new builds would be designed to new models of care/patient pathways which will reduce inefficiencies leading to a smaller floorplate and less adjacent/supporting accommodation.

3.3 Six Facet Surveys

Introduction

A Six Facet property appraisal was carried out on the three acute hospitals sites between February and May 2020. The survey covered the physical condition of the properties, (including the fabric of the buildings, fixtures and fittings and the electrical and mechanical installations), critical infrastructure, space utilisation, functional stability, quality, statutory compliance and environmental management.

The survey results were reviewed and validated by the Trust. The following section details the findings and the investment required in order to bring the Trust estate up to estate CODE condition B compliance, where condition B is defined as:

'A facility requiring general maintenance investment only', which in terms of physical condition is 'sound, operationally safe and exhibits only minor deterioration' and in terms of compliance, the estate 'complies with all necessary mandatory fire safety requirements and statutory safety legislation with minor deviations of a non-serious nature'.

The survey covered the entire estate including all buildings and associated infrastructure including M&E installations and site grounds. In accordance with the Department of Health's Estate CODE, all properties should be ranked estate CODE condition B or above in order for them to be safe and efficient, and not in need of any capital investment. Overall average building conditions can be summarised as:

Table 16 - Physical Condition Facet Condition General Summaries

Ranking	Description
A	A facility of excellent quality
B	A facility requiring general maintenance investment only
C	A less than acceptable facility requiring capital investment
D	A very Poor facility requiring significant capital investment or replacement

Physical Condition

In order to ascertain the physical condition of the estate in accordance with Estate CODE, the surveyor based their findings on information provided by the Trust as detailed on their Computer Aided Facilities Management (CAFM) System. This system allows the Trust to track, manage, report and plan facilities operations and the benefits of using CAFM can be organised into quality of life, cost reduction, cost avoidance and information improvement. These surveys were part of ongoing plans to help update asset management and maintenance across the Trust contributing to the CAFM system. However, due to timescales, a measured survey of internal elements was not undertaken on site. Instead, to calculate the building fabric elements and non-critical mechanical and electrical items, a percentage of the floor area was used. External building fabric elements and critical plant however was quantified and measured on site to give more accuracy to key areas. Statutory information was also gathered from the estates CAFM system; however, as the available information was limited it did not provide a full statutory assessment.

The appraisal was carried out addressing each of the main physical elements as indicated below. The scope covered all building, M&E elements including infrastructure and external works.

Table 17 - Physical Estate Elements reviewed in accordance with Estate CODE

• Ceiling Finishes • Communication Security & Control Systems • Disposal Installations • Electrical Installations • External Services • External Walls • Fire & Lightning Protection • Fittings Furnishings & Equipment
• Floor Finishes • Frame • Fuel Instillation/Systems • Grounds Maintenance • Heat Source • Internal Doors • Internal Walls & Partitions • Lift & Conveyor Installations/ Systems • Roof
• Space Heating & Air Conditioning • Stairs and Ramps • Substructure • Upper Floors • Ventilation Systems • Wall Finishes • Water Installations • Windows & External Doors

The list of elements/sub-elements recorded varied from building to building dependent upon the identified condition of the asset.

The physical condition facet of a multi-facet survey categorises each element and sub-element of the building into the following six categories:

Table 18 - Physical Condition Facet Ranking

Ranking	Description
A	As new (that is built within the last two years) and can be expected to perform adequately over its expected shelf life
B	Sound, operationally safe and exhibits only minor deterioration
B/C	Operationally safe however falling into Condition C within one year.
C	Operational but major repair or replacement will be needed soon, that is, within three years for building elemental and one year for engineering elements.
CX	Operational but major repair or replacement will be needed soon, that is, within three years for building elemental and one year for engineering elements. Item will require total rebuild or relocation.
D	Runs a serious risk of imminent breakdown.
DX	Runs a serious risk of imminent breakdown. Item will require total rebuild or relocation.

Condition, costs and risk levels were compiled from a survey of each room together with associated building and engineering services infrastructures.

Condition B sub-elements were only recorded where costs were required within the forthcoming financial year to maintain the sub-element in condition B.

Condition B(C) sub-elements do not have associated backlog costs as, at the time of the survey, they were recorded as being in condition B. A backlog cost was assigned at a point in the future at which it was predicted the sub-element would fall below condition B.

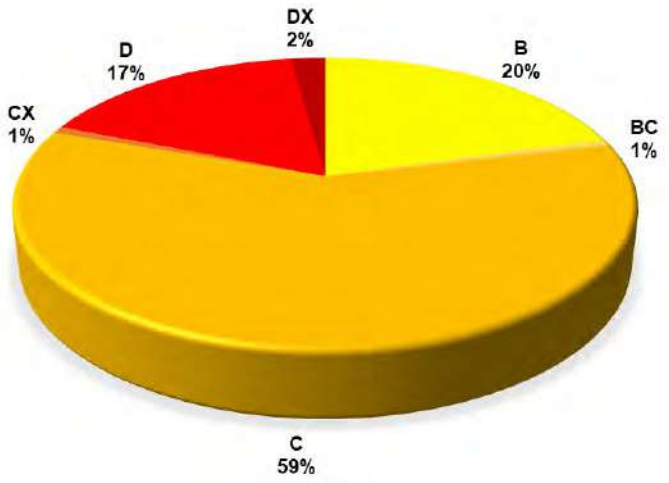
The remaining life of the building/block was based upon its assessed remaining life during the survey and/or the remaining life provided by the District Valuer.

The physical condition for each of the main sites are summarised below:

Diana, Princess of Wales Hospital (DPoW)

The following pie chart illustrates the condition of the DPoW estate:

Figure 16 - DPoW - Physical Condition of Site

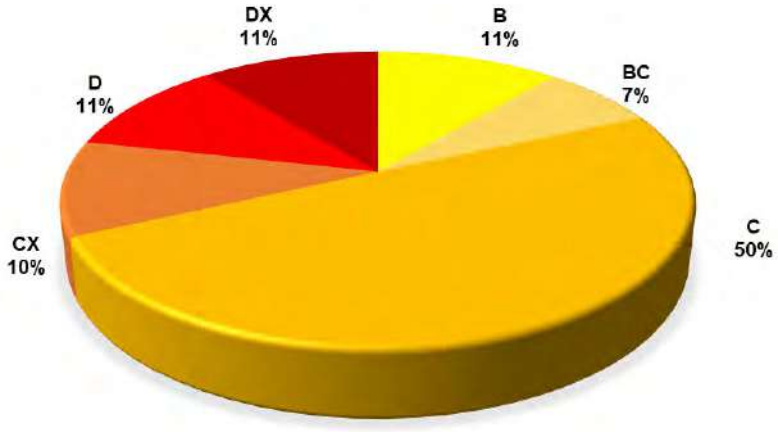


- Overall, there were 41 blocks surveyed at the DPoW Site
- The total cost associated with the physical condition of DPoW is £21,129,452 (net cost)
- 19% of this total cost is classified for elements '***running a serious risk of imminent breakdown***' (Category D & DX):
- 2% of this 19% is the cost for total rebuild or relocation (Category DX)
- The additional 81% of these costs are associated with elements that are classified as operational, (Category B, B/C, C & CX)
- 60% of which require major repair or replacement works (Category C & CX)
- Within one year an additional 1% of the costs will also fall into this category (Category B/C) resulting in a total of 61% requiring major repair or replacement work
- All these repairs, replacement, rebuild or relocation works are required either within three years for building elements or one year for engineering elements
- The three sites requiring the most significant investment are the 'Main Block', 'Industrial Zone' and 'D Block' which collectively covers 42,817m2 of the estate, totalling approximately 82% of the overall surveyed site area

Scunthorpe General Hospital (SGH)

The following pie chart illustrates the condition of the SGH estate:

Figure 17 - SGH - Physical Condition of Site

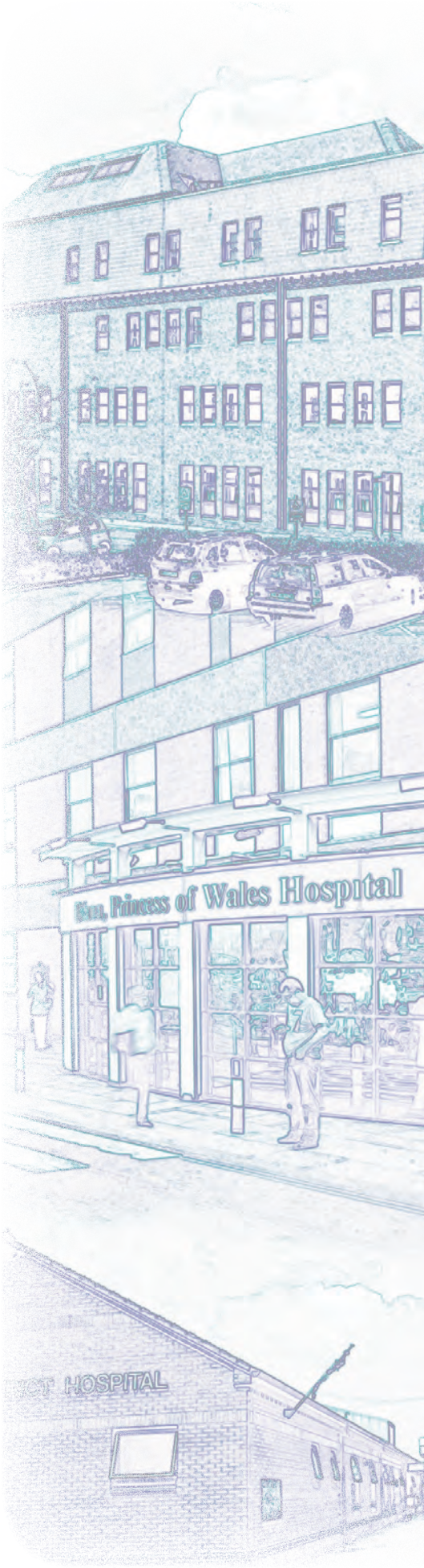


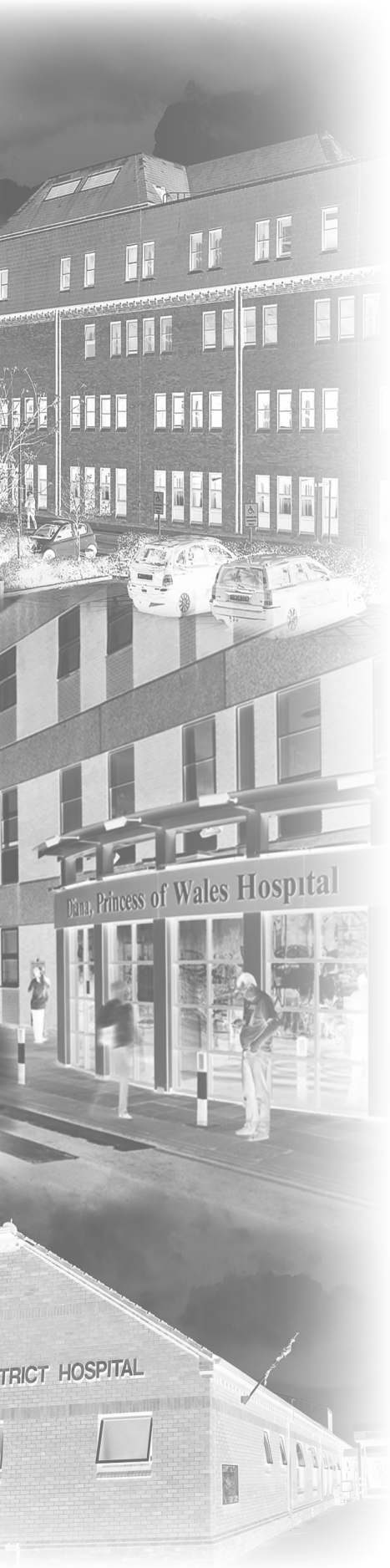
- Overall, there were 40 blocks surveyed at the SGH Site
- The total cost associated with the physical condition of SGH is £47,633,491 (net cost)
- 22% of this total cost is classified for elements '***running a serious risk of imminent breakdown***' (Category D & DX):
- 11% of this 21% is the cost of elements requiring total rebuild or relocation (Category DX)
- The additional 78% of these costs are on elements classified as operational (Category B, B/C, C & CX)
- However, out of this 78%, 60% of the cost is for elements requiring major repair or replacement works (Category C & CX)
- Within one year an additional 7% will fall into this category (now Category B/C). This will then total 67% of costs on elements requiring major repair or replacement works
- All these repairs, replacement, rebuild or relocation works are required either within three years for building elements or one year for engineering elements

The top five blocks on this site which require significant investment for either major repair or replacement in order to bring these properties up to Estate CODE Condition B are:

- The Boiler House;
- Outpatient Departments 1 & 2;
- Coronation Block
- Queens Building;
- The Service Centre.

The boiler house is a significant issue due to the fact that if the infrastructure goes down such as the heating systems etc., then this will impact all of the associated properties at the SGH site and ultimately potentially prevent services from being delivered.

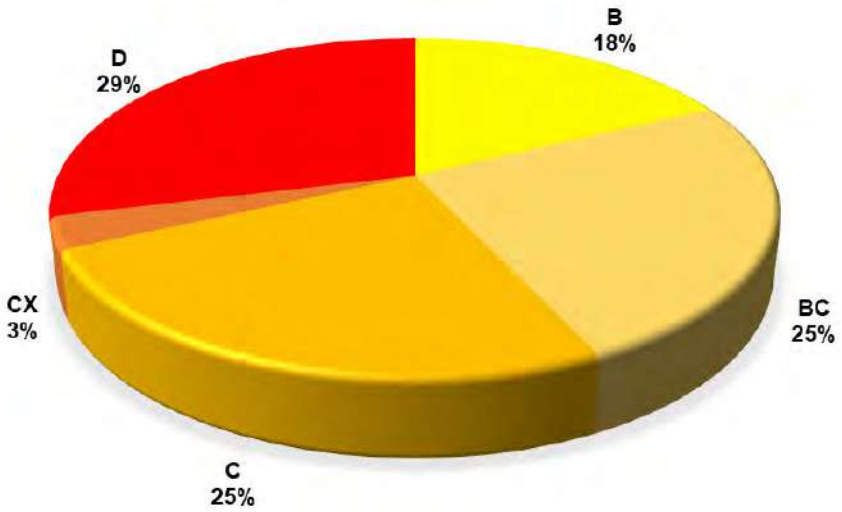




Goole & District Hospital (GDH)

The following pie chart illustrates the condition of the GDH estate:

Figure 18 - GDH - Physical Condition of Site



- The total cost associated with the physical condition of GDH is £7,813,472 (net cost)
- 29% of the total cost is classified for elements '***running a serious risk of imminent breakdown***' (Category D). The additional 71% of the costings are for elements classified as operational
- However, out of this 71%, 28% of the costs are for elements requiring major repair or replacement works (Category C and CX)
- Within one year an additional 25% of costs will fall into this category (Category B/C)
- This will then total 53% of the costs for elements requiring major repair or replacement works
- All these repairs, replacement, rebuild or relocation works are required either within 3 years for building elements or one year for engineering elements

Out of these six blocks the two that require the most significant investment, for either major repair or replacement, in order to bring these properties up to Estate CODE Condition B are:

- Main Block
- Ward Block

Further detail on the overall capital investment required to address backlog is detailed later in section 5.6.

Space Utilisation

The space utilisation element of the facet survey was undertaken at a very high level only and shows the space use of a property purely at the time the property was surveyed.

A more detailed space utilisation survey would allow for several visits to the same location over a period of time visiting the property at different times on different days of the week.

This would give a more useful understanding of the efficiency of the estate.

It should also be noted that the survey detailed below was completed during the lockdown period of the global pandemic. Since the start of COVID-19 where members of staff have been able to work from home they have; elective services were suspended, and a number of services have temporarily changed their model of care to reduce the number of patients visiting the acute hospitals. This has led to a new way of thinking regarding maximising the utilisation of the current estate. The impact of COVID-19 is discussed further in the '*Where do we want to be?*' section.

The space utilisation survey results for each of the NLaG acute sites have been summarised as follows. This data is based on each of the overall Block Rankings.

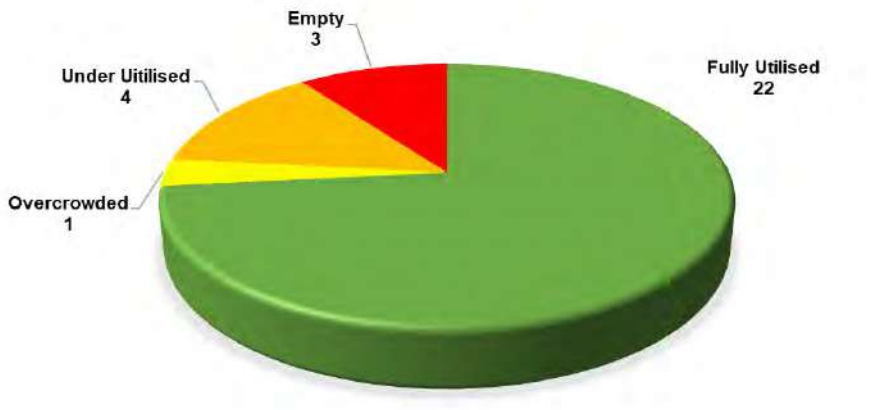
Table 19 – Space Utilisation Facet Ranking

Ranking	Description
F	Fully Utilised
O	Overcrowded
U	Underused
E	Empty

Diana, Princess of Wales Hospital (DPoW)

The high-level space utilisation survey for the DPoW estate, was completed between 23rd March and 4th June 2020. The results are indicated in the pie chart below:

Figure 19 - DPoW - Space Utilisation per Block



Most of the blocks (22) are fully utilised, with four blocks being under-utilised, one block was overcrowded, and three blocks were empty. The total area noted as underutilised was 6,403m² which is 12.24% of the total area surveyed for space utilisation at DPoW. It is understood that the under-utilised and empty blocks were noted as a result of COVID-19 rather than under-utilisation which may or may not have been the case prior to the pandemic.

The one overcrowded block was Restcote which mainly houses the finance function.

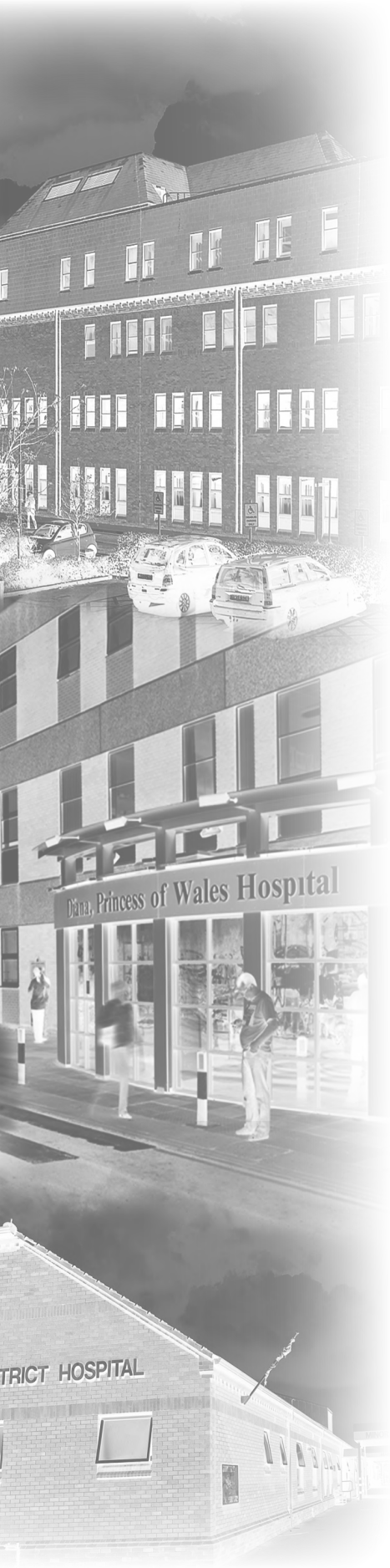
Scunthorpe General Hospital (SGH)

The high-level space utilisation survey for SGH's blocks was completed between 24th February and 14th July 2020. The results are indicated in the pie chart below:

Figure 20 - SGH - Space Utilisation per Block

20 blocks were fully utilised with 12 blocks being under-utilised, and one (the Hospital Radio block) being empty at the time of the survey.

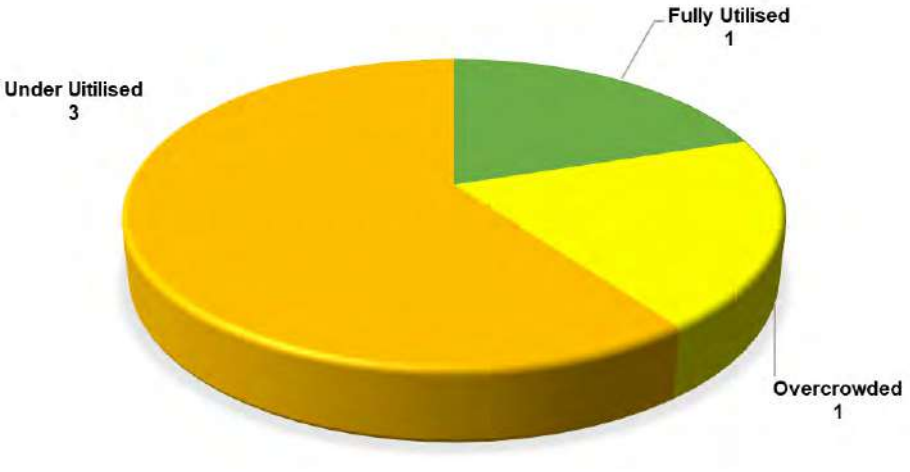
The total area noted as underutilised was 12,665m² which represents 30.9% of the total area surveyed at SGH. Again, the under-utilised and empty properties were noted as such due to the impact of COVID-19. These properties will need to be reviewed in order to understand if they will be re-occupied.



Goole & District Hospital (GDH)

The high-level space utilisation survey for GDH was completed on 5th February 2020. The results are indicated in the pie chart below:

Figure 21 - GDH - Space Utilisation per Block



Despite not being used by the Trust the Ambulance Station was the only block noted as being fully utilised. The Workshop Boiler House was noted as overcrowded. The remaining three blocks (the Main Block, Ward Block and Catering, and Stores) were all underutilised.

The total area noted as being underutilised was 14,454m^2 which is 91.8% of the total area surveyed for space utilisation at GDH.

Functional Suitability

The Functional Suitability survey undertaken reviewed the following elements:

- Internal Space Relationship
- Support Facilities
- Location

Each of these elements were categorised for each block using the multi-facet survey rankings, along with notes and associated costs. It is important to note that the rankings were provided on the basis of the current use/occupancy of these areas and does not take into account any future service changes.

Diana, Princess of Wales Hospital (DPoW)

The functional suitability survey for DPoW was completed between 30th March and 4th June 2020. The survey was based on whether the facilities were functionally suitable for the services delivered at this present time.

The survey does not take into account whether the facility is functionally suitable for other services which may be delivered in the future.

The results were:

Table 20 - DPoW – Functional Suitability Ranking (against current service provision)

Ref	Block	Internal Space Relationships	Support Facilities	Location
01A	Main Block	B	B	B
01B	Diabetes Centre	B	B	B
01i	Cardiology	B	B	B
02	Chapel	B	B	B
02A	D Block	B	B	B
03A	Industrial Zone	B	B	B
04A	CSSD Sub Station	B	B	B
05A	Main Intake Sub Station (AP Office,TXs Gens & LV)	B	B	B
05B	Main Intake Sub Station (HV Switch Rooms and Meters)	B	B	B
07A	Boiler House Sub Station	B	B	B
08A	Chemical Store	B	B	B
10A	Bike Store	B	B	B
12A	Child Development Centre	B	B	B
27A	138 SCARTHO ROAD	B	B	B
35A	Osler Building - Education Centre	B	B	B
36A	Meers Building	B	B	B
37A	West Arch Front Office Area	B	B	B
37B	West Arch Rear Office Area	DX	DX	B
37C	West Arch Meeting Room Area	B	B	B
37D	Lodge	B	BC	B
46A	Oil Tanks	B	B	B
46B	VIE Plant	B	B	B
51A	Training and Development	B	B	B
63A	IT Services	DX	DX	C
64A	Gas House	B	B	B
67A	Restcote	B	C	B
68A	Eastholme	B	CX	B
68B	Phoenix Club Sports and Social	DX	DX	C
72A	Assisted Living Centre (Sexual Health)	B	B	C
73A	Assisted Living Centre (Community Clinic)	B	B	C

The total cost for the required works associated with the internal space relationship, support facilities and location at DPoW Hospital is £259,210 (net cost).

The five blocks that have the highest associated costs are:

Table 21 - DPoW - Blocks requiring Significant Investment (against current service provision)

Block	Functional Suitability Cost to Condition B (Net cost)
Phoenix Club Sports and Social	£96,000
IT Services	£60,010
Eastholme	£36,000
Restcote	£30,000
West Arch Rear Office Area.	£24,000
TOTAL WORKS COST*	**£246,010**

Although the Phoenix Sports and Social Club is well located close to main areas of the Hospital, extensive renovation is required as the block has been noted as unused for a number of years. Both the internal space and support facilities require full internal replacement.

The IT Services block has the second highest associated cost. The space relationships and location are adequate with close proximity to the main hospital; however, major renovation and internal upgrades are required.

Whilst Eastholme is located close to main car parks and has adequate space within critical rooms that are fully functional, with adequate storage and meeting space; the property has inadequate toilet facilities for the staff with no disabled access to the first floor. Stair access would only be improved through the installation of an accessible lift.

Although Restcote is also close to main hospital departments and car park areas and has critical rooms which are adequately sized, the toilet accommodation is insufficient for the amount of staff present in the building, and again there is no lift access to the first floor. This lack of vertical access restricts the opportunities to relocate certain services and is not in accordance with current regulations regarding accessibility.

West Arch Rear Office Area is located away from the main hospital block, the support facilities are inadequate and overall, the property is old, deteriorated, poorly maintained and not fit for occupation. There is a potential opportunity to demolish this property to allow for a reconfiguration of the DPoW estate.

Scunthorpe General Hospital (SGH)

The functional suitability survey for SGH was completed between 24th February and 14th July 2020. The survey was based on whether the facilities were functionally suitable for the services delivered at this present time. The survey does not take into account whether the facility is functionally suitable for other services which may be delivered in the future. The results are indicated in table below:

Table 22 - SGH - Functional Suitability Ranking (against current service provision)

Ref	Block	Internal Space Relationships	Support Facilities	Location
01D 080	OPD 1 and 2	B	B	B
01G 086	Flammable Store	B	B	B
01H 070	Dermatology, Medical Rec., Intake Sub Station SS1	B	B	B
02B 100	A&E Dental X-Ray	B	B	B
02C 060	Chapel	C	C	C
03A 131 132 050	War Memorial Block	BC	B	C
03B 380	Lindsey Blue Sky Imaging Suite	B	C	B
03C 320	Courtyard Block	CX	B	B
03E 170	Hospital Radio	B	B	B
03F	Sub Station SS4 Blue Sky Imaging Suite	B	B	B
04C 161	Workshops Stores and Medical Engineering	B	D	B
04D 162	Modular Office Building	B	C	B
04F 210	118 & 120 Cliff Gardens (Occupational Health)	CX	CX	D
05A 190	Butterwick House (Includes HYMS)	C	B	B
05B 191	Training and Development Centre	B	C	B
05C 230	IT Services	B	C	B
05D 242	Belton House	B	B	B
06A 120	Service Centre	B	B	C
06B 124	Medical Gas Store	B	B	B
07A 110	Coronation Block	B	DX	B
09A 180	GP Ward Block	B	B	B
09B 181	Ward 18 Renal Unit Haematology Oncology	B	B	B
N/A	10 F Alkborough	C	C	B
N/A	10 H Saxby House	B	C	B
N/A	10 G Keelby House	B	C	B
N/A	05 E Croxton House	B	C	B
N/A	05 F Elsham House	B	C	B
N/A	10 E Edward Jenner	B	C	B
N/A	10 D Edward Jenner	B	C	B
N/A	10 B Edward Jenner	B	C	B
N/A	10 C Edward Jenner	B	C	B
N/A	10 A Edward Jenner	B	C	B

The total cost for the required works associated with the internal space relationship, support facilities and location at Scunthorpe General Hospital is £2,718,000 (net cost).

The three blocks that have the highest associated costs are:

- Coronation Block;
- War Memorial Block;
- 118 & 120 Cliff Gardens (Occupational Health)

Table 23 - SGH - Blocks requiring Significant Investment (against current service provision)

Block	Functional Suitability Cost to Condition B
Coronation Block	£1,200,000 (Net Cost)
118 & 120 Cliff Gardens (Occupational Health)	£612,000 (Net Cost)
War Memorial Block	£336,000 (Net Cost)
Other	£570,000 (Net Cost)
TOTAL WORKS COST	£2,718,000 (Net Cost)

The Coronation Block support facility has been surveyed as '***Not suitable to be used as a ward [clinical purposes]***' and a rebuild should be considered as a refurbishment may not be cost or time efficient. This alone has an associated net construction cost of £1,200,000 which is nearly 50% of the total functional suitability costs for SGH. It is recommended that 118 & 120 Cliff Gardens (Occ. Health) be demolished and rebuilt primarily because:

- Facilities on the first floor are inaccessible
- Clinical rooms on the ground floor are undersized
- There are an inadequate number of electrical sockets to meet requirements
- It is in a poor location for people with mobility issues

Alternatively, this building could be sold off or removed altogether.

The War Memorial block is to be demolished as part of an approved scheme. The remaining cost of £294,000 (net cost) is split between the other blocks that have categorisations below category B.

Goole & District Hospital (GDH)

The functional suitability survey for GDH was completed on 5th February 2020. The results are shown below:

Table 24 - GDH - Functional Suitability Ranking (against current service provision)

Ref	Block	Internal Space Relationships	Support Facilities	Location
10A	Ward Block	B	B	B
11A	Main Block GDH	B	B	B
12A	Catering and Stores	B	B	B
13A	Workshop/Boiler House/Crèche	C	D	C
14A	Ambulance Station (Trust does not occupy this building)	B	B	B

The total cost for the required works associated with the internal space relationship, support facilities and location at GDH is £102,000 (net cost).

The main functional suitability issues within the GDH site sit within the Workshop/Boiler House/Crèche block. These issues, associated with internal space relationships, support facilities and location include:

- The storerooms and plant rooms lead onto the main corridor and may present a fire risk. These rooms are identified as hazard rooms and it is believed that they therefore have the required 30 or 60 minute fire rating in accordance with the relevant HTM
- Inadequate storage – both in size and number
- It is well located for works; however, the works area is shared with a crèche which presents a safety risk whereby carers with young children will be accessing the same area as workmen carrying materials and equipment

The overall cost associated with these issues is £96,000 (net cost).

Quality

The quality survey was based on the following three elements:

- Amenity
- Comfort Engineering
- Design

The scoring against each surveyed block for each of these elements were used to create overall quality block rankings.

The Quality facet survey results for each of the NLaG estate sites are as follows:

Diana, Princess of Wales Hospital (DPoW)

The overall block rankings for the DPoW site quality facet were:

Nine of the blocks are categorised as less than acceptable facilities. These blocks cover an area of 39,633m^2, which is 76% or the area surveyed.

Within one year this could also include a further two blocks, which covers an additional 1,064m^2 increasing the total area categorised as less than acceptable to 78% of the entire estate.

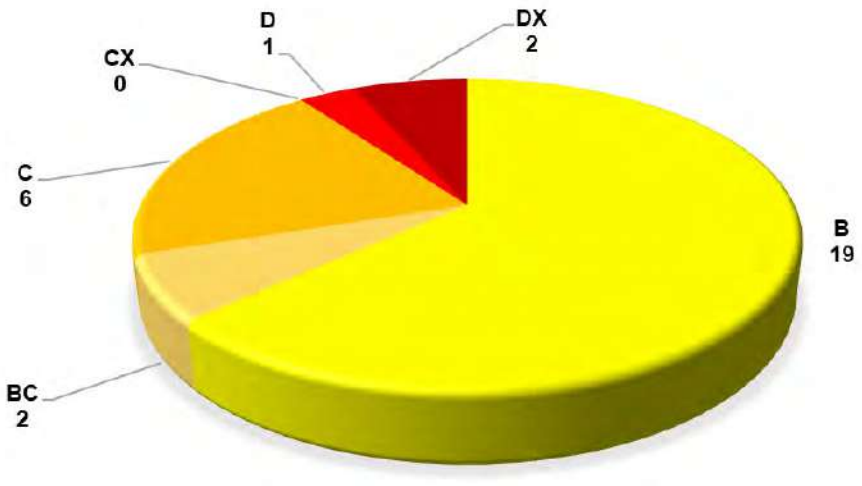
Despite 21 of the blocks currently being within acceptable standards, these blocks only equate to an area of 12,666m^2 which is only 24% of the area surveyed.

Overall, a total investment of £415,200 (net cost) has been estimated in order to improve the quality of the estate. The five blocks that require the greatest capital investment are:

- Phoenix Club Sports and Social
- Restcote
- Industrial Zone
- Eastholme
- IT Services

The above findings reflect the outcomes of both the Space Utilisation and Functional Suitability surveys.

Figure 22 - DPoW - Quality Assessment by Block



The main key issues highlighted for each of these blocks are summarised below:

Table 25 - DPoW - Investment Required to improve Quality (amenity, comfort engineering & design)

Block	Comments	Investment Required (Net Cost)
Phoenix Club Sports & Social	Requires major renovation in response to all three elements.	£66,000
Restcote	Further toilet accommodation and kitchen space is recommended, the UPVC windows throughout the block are dysfunctional, condensation present and there is a draught blowing through into the office space. In addition, an accessible lift is recommended for ease of access.	£66,000
Industrial Zone	Several amenities in key areas of this block are ageing and in need of a short-term lifecycle replacement, and It has ageing space heating in sporadic areas throughout the block, affecting room temperatures throughout the year.	£54,000
Eastholme	Despite adequate comfort engineering and internal temperatures, the Block requires improvements to the toilet areas and provision of more facilities. Further improvement is required to the kitchen area to fulfil the user's needs, and the floor and ceiling finishes require lifecycle replacement throughout. In addition, an accessible lift is recommended to the first floor.	£42,000
IT Services Block	It is structurally sound however as it has not been used for many years it requires major upgrades in all areas.	£42,000)
TOTAL WORKS COST		**£270,000**

It must be noted that it is only worth investing in the quality of the buildings if there is an identified use for the building as part of the strategic estate development.

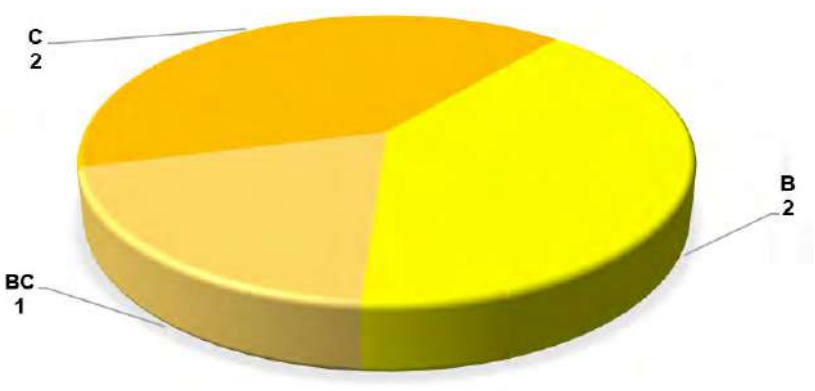
Scunthorpe General Hospital (SGH)

The overall block rankings for the SGH site quality facet are summarised right:

Access to the Queen's Building, Pathology, HV Sub-Station and Boiler House was not available at the time of the survey and therefore these properties aren't included within the results noted above.

19 of the blocks across the SGH site were categorised as having less than acceptable facilities. These blocks cover 52% of the area surveyed.

Figure 23 - SGH - Quality Assessment by Block



Within one year this could increase by an additional four blocks which would cover an additional area of 9,826m^2 resulting in a 73% of the total area of the estate categorised as less than acceptable.

In general, significant investment is required to improve the quality of the estate. This has been estimated at a cost of £6,687,600 (net cost). The two main blocks that require capital investment are the Coronation Block and the Service Centre. The main key issues highlighted for each of these blocks are detailed in table 26.:

Table 26 - SGH - Investment Required to Improve Quality

Block	Comments	Investment Required (Net cost)
Coronation Block	Elderly wet pipe system and is not currently suitable to be a ward	£3,600,000
Service Centre Restaurant	Additional mobility toilet facilities could be added and a service lift and a ground floor kitchen are required to reduce traffic as the stores and kitchens are currently sited on the upper floor.	£1,236,000
Other	Various	£1,851,600
TOTAL WORKS COST		**£6,687,600**

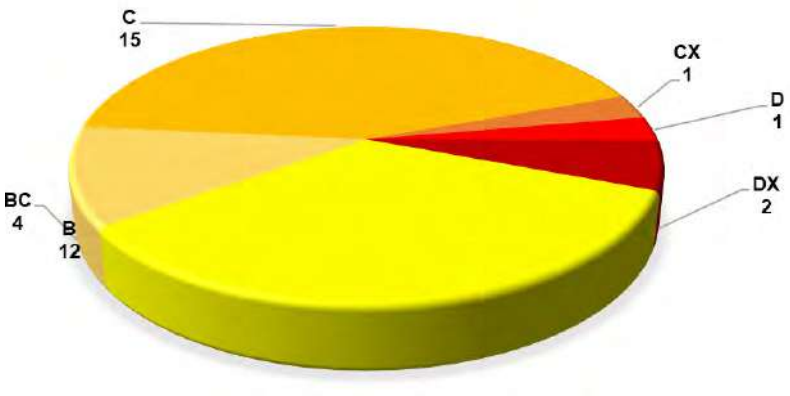
The £3**,600,000 (net cost) investment** noted to improve the quality of the Coronation Block **is approximately 54% of the overall total.**

Goole & District Hospital (GDH)

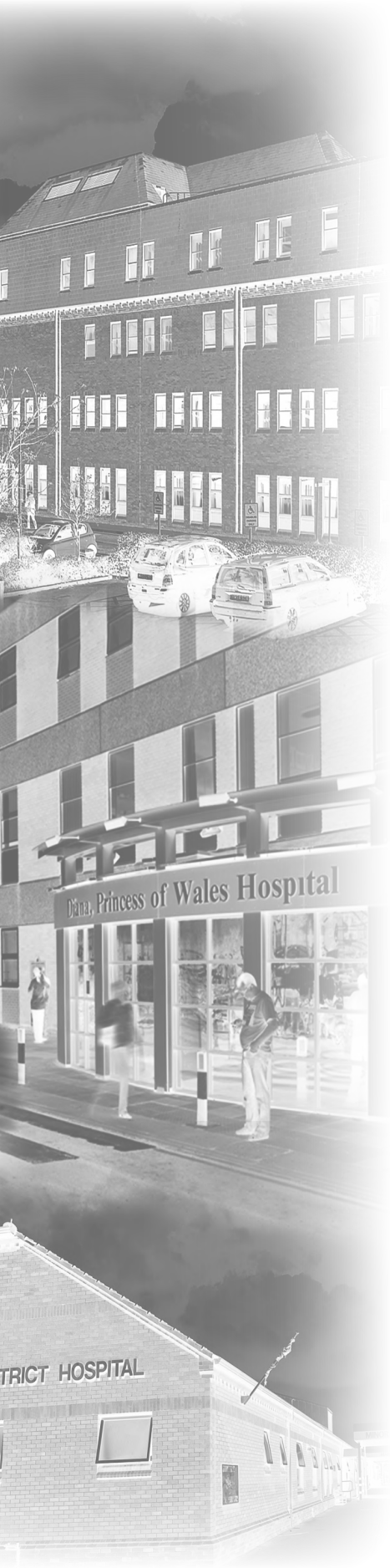
The overall block rankings for the GDH site quality facet are shown in the pie chart right:

Out of the five blocks surveyed, two of the blocks (the '***Main Block'*** and 'the ***'Ward Block'***) are categorised as less than acceptable facilities. These two blocks equate to 84% of the surveyed site covering an area of 13,181m^2. While the remaining blocks are currently considered acceptable, the '***Catering and Stores***' block is likely to fall below this threshold within one year which will increase the total area deemed less than acceptable as 92% of the whole estate.

Figure 24 - GDH - Quality Assessment by Block



Overall, a total investment of £738,000 (net cost) is required in order to improve the quality of the estate. Most of these costs fall within the ***'Comfort Engineering'*** element of the survey. This includes an issue regarding several air handling equipment units which are not operational, and manually adjusted heating in the Main Block. £612,000 (net cost) has been costed against this block alone which is circa 81% of the total investment required.



Statutory Compliance

The statutory compliance facet survey for each of the NLaG sites was based on the following:

Table 27 - Statutory Compliance Criterion

No.	Criteria Question
1	Are notice boards, communication material & HSAWA Posters displayed?
2	Is waste suitably stored?
3	Is there suitable storage for COSHH?
4	Are any dangerous substances clearly marked with suitable symbols?
5	Are flammable & explosive substances suitably stored?
6	Is there a suitable means of cleaning for any food preparation & cooking areas?
7	Is the workplace well maintained & free of any potential slip trips & falls?
8	Are noise levels to a suitable standard?
9	Are roof man safe systems routinely inspected?
10	Is there evidence of inspection of water storage tanks & when was the last inspection?
11	Is there evidence current legionella testing?
12	Is there suitable ventilation to the kitchens & toilet areas
13	Is there any evidence of fungal growth to the building structure?
14	Do boiler rooms have suitable ventilation?
15	Are gas systems routinely inspected & records available?
16	Are air conditioning systems routinely tested - F Gas Leak Inspections?
17	Are there any issues with surface temperatures of heat emitters?
18	Is there evidence of inspection of fuel storage tanks & when was its last inspection?
19	Have all dampers been inspected?
20	Is the property in a region of risk of radon?
21	Has radon monitoring been undertaken?
22	Is any known asbestos clearly identified or encapsulated?
23	Is there an asbestos survey/management plan available on site?
24	Are there records for testing/recording for lead based products, such as paint, pipework?
25	Has the building got an up to date fire risk assessment?
26	Have all actions been undertaken from the fire risk assessments?
27	Is there an up to date fire strategy plan?
28	Is there evidence of fire compartmentation checks
29	Are fire alarm systems routinely tested?
30	Have all means of firefighting been routinely inspected?
31	Is there an access audit available for the property?
32	Have all actions been undertaken from the access audit?
33	Have 5-year fixed wire electrical tests been undertaken?

It should be noted that at the time of the survey not all of the statutory compliance documents were reviewed therefore caution should be noted with regard the identified costs as they may be under-estimated.

The results of this survey are summarised as follows:

Diana, Princess of Wales Hospital (DPoW)

Statutory compliance facet surveys were completed for the DPoW site on 1st June 2020.

The overall estimated statutory compliance associated costs against DPoW is £845,386 (net cost) as shown below. £775,784.05 (net cost), which is approximately 92% of the overall DPoW statutory compliance cost, is specific to three blocks. These blocks are the Main Block, D Block and the Industrial Zone.

Table 28 - DPoW - Main Statutory Compliance Costs

Ref	Block	Overall Estimated Total Costs
01A	Main Block	£513,496.62 (Net Cost)
02A	D Block	£143,030.56 (Net Cost)
03A	Industrial Zone	£119,256.88 (Net Cost)
N/A	Other	£69,601.95 (Net Cost)
TOTAL WORKS COST		**£845,386.01 (Net Cost)**

The table below displays the statutory compliance issues against each of these blocks in relation to the criteria questions detailed above. Where evidence could not be provided for the criteria a '**?**' was marked against the question. The areas highlighted in red show areas where the above costs are applied, this is predominantly around fire and water safety.

Table 29 – DPoW - Statutory Compliance Summary

		Criteria Question Number																														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
Block	MAIN BLOCK ,DPoWH 01A	?	?	?	?	?	?		?	?	?		?				?	?	?	?							?					?	?	
	D BLOCK ,DPoWH 02A,		?	?	?	?	?	?	?	?	?		?				?	?	?	?							?		?			?	?	
	INDUSTRIAL ZONE,DPoWH 03A		?	?	?	?	?	?	?	?	?		?				?	?	?	?							?	?				?	?	

Scunthorpe General Hospital (SGH)

The SGH statutory compliance facet surveys were completed on 16th April 2020 (main site) and 14th July 2020 (domestic properties). The following table displays the estimated statutory compliance costs noted. The five blocks with the greatest significant statutory compliance related costs are '*A&E Dental X-Ray*', '*the Queens Building*', '*Ward 18 Renal Unit Haematology Oncology*', '*Medical Gas*' and the '*Underfloor Ducts and site*'.

Table 30 - SGH - Main Statutory Compliance Costs

Ref	Block	Overall Estimated Total (Net) Costs
02B 100	A&E Dental X-Ray	£144,000.00
08A 370	Queens Building	£216,000.00
06A 120	Service Centre	£9,600.00
09B 181	Ward 18 Renal Unit Haematology Oncology	£240,000.00
06B 124	Medical Gas	£192,000.00
N/A	Underfloor Ducts and site	£149,880.00
N/A	10 F Alkborough	£48,840.00
N/A	10 H Saxby House	£42,840.00
N/A	10 G Keelby House	£42,840.00
N/A	05 E Croxton House	£45,240.00
N/A	05 F Elsham House	£46,440.00
N/A	10 C Edward Jenner	£33,240.00
N/A	10 E Edward Jenner	£33,240.00
N/A	10 D Edward Jenner	£33,240.00
N/A	10 B Edward Jenner	£33,240.00
N/A	10 A Edward Jenner	£33,240.00
TOTAL WORKS COST (NET)		**£1,343,880**

The table below displays the statutory compliance issues against each of these blocks with the greater statutory compliance costs, in relation to the criteria questions detailed above. Where evidence could not be provided for the criteria a *'?'* was marked against the question. The areas highlighted in red show areas where the above costs are applied, this is predominantly around fire and water safety.

Table 31 – SGH - Statutory Compliance Summary

		Criteria Question Number																												
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
Block	A&E Dental X-Ray	?	?	?	?	?	?		?	?	?		?				?	?	?	?							?	?	?			?	?	?
	Queens Building	?	?	?	?	?	?		?	?	?						?	?	?	?								?	?			?	?	?
	Service Centre	?	?	?	?	?	?		?	?	?		?				?	?	?	?							?	?	?			?	?	?
	Ward 18 Renal Unit Haematology Oncology	?	?	?	?	?	?		?	?	?		?				?	?	?	?							?	?	?			?	?	?
	Medical Gas	?	?	?	?	?	?		?	?	?		?				?	?	?	?							?	?	?			?	?	?
	Underfloor Ducts and site	?	?	?	?	?	?		?	?	?		?				?	?	?	?												?	?	?

Goole & District Hospital (GDH)

Statutory compliance facet surveys for GDH were completed on 5th February 2020.

The following table details the overall estimated cost against each of the GDH surveyed properties/blocks. Most of the costs fall within the *Main Block* and the *Ward Block* which would be anticipated, as the GIFA of both these blocks totals 13,181m2 which equates to 98% of the total estate.

Table 32 - GDH - Main Statutory Compliance Costs

Ref	Block	Overall Estimated Total (Net) Costs
11A	Main Block	£412,860
14A	Ambulance Station	£10,260
10A	Ward Block	£426,660
13A	Workshop/Boilerhouse/Crèche	£63,660
TOTAL WORKS COST		**£889,440**

The table below displays the statutory compliance issues against each of these blocks in relation to the criteria questions detailed above. Where evidence could not be provided for the criteria a '*?*' was marked against the question. The areas highlighted in red show areas where the above costs are applied.

Table 33 – GDH - Statutory Compliance Summary

		Criteria Question Number																												
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
Block	Main Block GDH																																	
	Ambulance Station																																	
	Ward Block																																	
	Workshop Boiler House Creche																																	

Although there are several highlighted issues against each block in the above table, there are two issues which form the bulk of the overall estimated cost of £889,440 (net cost).

This involves criteria question 26 in particular which is *'Have all actions been undertaken from the fire risk assessments?'* Even though all the GDH surveyed properties/blocks are non-compliant, the main block and the ward block both have associated costs of over £400,000 (net cost) each which is approximately 81% of the overall total cost estimate.

Environmental

The environmental facet surveys for each of the acute sites reviewed the following:

- Energy Performance
- Energy Documentation
- Water Consumption
- Water Documentation
- Waste Management Online
- Waste Management Documentation
- Transport Management Onsite
- Transport Management Documentation

The environmental facet survey results are summarised below.

Diana, Princess of Wales Hospital (DPoW)

Table 34 - DPoW - Environmental Facet Rankings & Cost Summary

Function		Category	Cost (Net)
Energy	Performance	**C**	£600,000
	Documentation	**C**	£3,000,000
Water	Consumption	**D**	£120,000
	Documentation	**D**	£1,200,000
Waste	Management Online	**B**	£0
	Documentation	**B**	£0
Transport	Management Onsite	**C**	£120,000
	Documentation	**C**	£0
TOTAL WORKS COST			**£5,040,000**

As highlighted above, the three areas that are '*less than acceptable*' at DPoW are the Energy, Water and Transport elements.

The main issues are in relation to the Water function as there are leaks to pipes and there are no saving schemes which means that new pipework is required. Although the Water function is categorised as being in the worst condition, it doesn't hold the greatest cost.

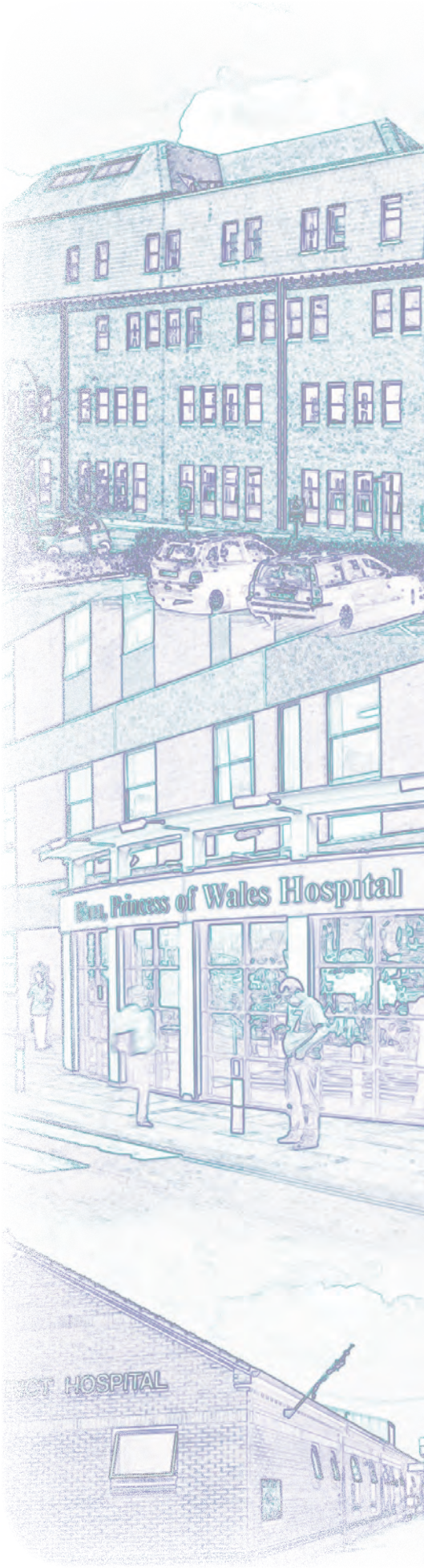
The greatest cost falls with the Energy function as there are currently few renewable energy sources on site. Whilst some renewable technologies are not feasible for hospital sites, e.g., heat pumps etc., solar energy systems are being investigated as part of decarbonisation plans. Onsite renewable generation will reduce our need to import expensive grid energy.

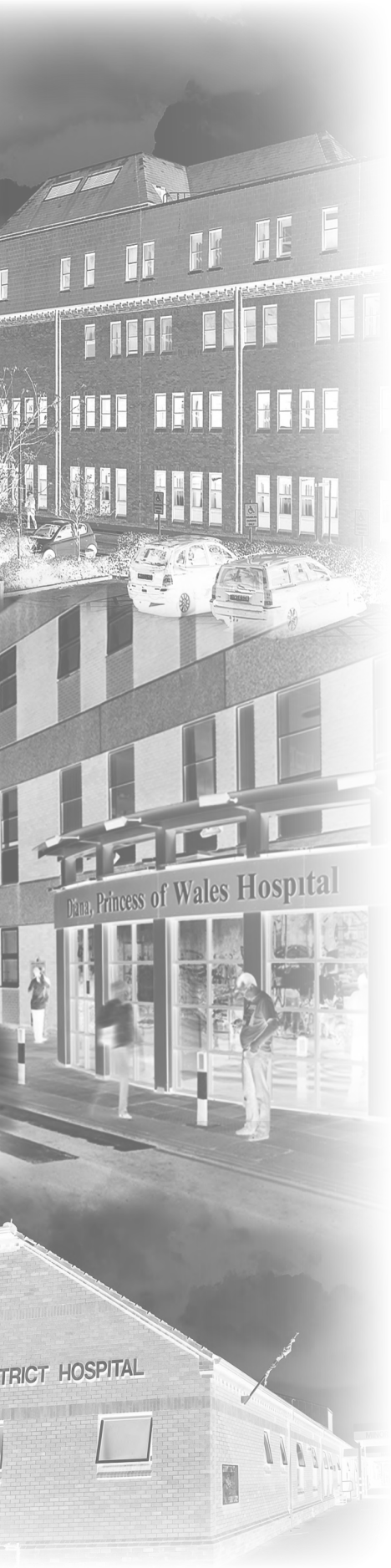
Scunthorpe General Hospital (SGH)

Table 35 - SGH - Environmental Facet Ratings & Cost Summary

Function		Category	Cost (Net)
Energy	Performance	**C**	£148,000 (Net Cost)
	Documentation	**C**	£148,000 (Net Cost)
Water	Consumption	**D**	£148,000 (Net Cost)
	Documentation	**D**	£1,224,000 (Net Cost)
Waste	Management Online	**B**	£0
	Documentation	**B**	£0
Transport	Management Onsite	**C**	£148,000 (Net Cost)
	Documentation	**C**	£0
TOTAL WORKS COST			**£1,800,000** (Net Cost)

With the exception of the 'Waste Management Online & Documentation' elements, all other statutory compliance elements at SGH are '*less than acceptable*'.





As highlighted in table 35 on the previous page,, the greatest issue falls with the '*Water Consumption and Documentation*' elements, which equates to approximately 78% of the total cost. It must be noted, however, that the costs associated with energy may be higher than estimated as the survey was not able to review all associated information and were not able to undertake a detailed survey.

Goole & District Hospital (GDH)

Table 36 - GDH - Environmental Facet Ratings & Cost Summary

Function		Category	Cost (Net)
Energy	Performance	**D**	£240,000
	Documentation	**B**	£24,000
Water	Consumption	**C**	£24,000
	Documentation	**B**	£0
Waste	Management Online	**B**	£0
	Documentation	**B**	£0
Transport	Management Onsite	**B**	£0
	Documentation	**B**	£0
TOTAL WORKS COST			**£288,000**

As highlighted above, the two elements that are considered to be '***less than acceptable'*** are Energy Performance and Water Consumption. In addition, the Energy Documentation function although ranked '*category B*' also holds an associated cost.

The greatest issue falls with the 'Energy Performance' element, which totals £240,000 (net) equating to nearly 83% of the total environmental costs for GDH. This cost is due to the current poor performance of coal fired boilers, local controlled heating and aged windows. As with Scunthorpe General Hospital a detailed energy survey was not undertaken. NLaG's estate team is aware of the need to replace coal boilers and therefore believe the associated cost to be significantly higher than recorded.

3.5 Summary

The findings of the multi-facet surveys are summarised as follows:

Diana, Princess of Wales Hospital (DPoW)

Table 37 - DPoW - Multi-Facet Survey Results

Property	Physical Condition	Functional Suitability	Space Utilisation	Quality	Statutory Compliance	Environmental
138 SCARTHO ROAD, DPoW27A	B	B	F	B	B	C
Assisted Living Centre (Community Clinic), DPoW 73A	B/C	B	F	B	B	C
Assisted Living Centre (Sexual Health), DPoW 72A	B/C	B	F	B	B	C
Bike Store, DPoW 10A	N/A	B	F	B	B	C
Boiler House Sub Station, DPoW 07A	C	B	F	B/C	C	C
Cardiology, DPoW 01i	C	B	F	B	C	C
Chapel, DPoW 02B	B/C	B	F	B	B	C
Chemical Store, DPoW 08A	B	B	F	C	B	C
Child Development Centre, DPoW 12A	B/C	B	F	B	B	C
CSSD Sub Station, DPoW 04A	C	B	F	B	C	C
D Block, DPoW 02A	CX	B	U	B	C	C
Day Surgery Unit, DPoW 01H	B	N/A	N/A	N/A	B	C
Diabetes Centre, DPoW 01B	D	B	F	C	B	C
Eastholme, DPoW 68A	D	C	F	C	C	C
Family Services Building, DPoW 13A	B/C	N/A	N/A	N/A	C	C
Gas House, DPoW 64A	B	B	F	B	B	C
Grounds	N/A	N/A	N/A	N/A	B	C
Industrial Zone, DPoW 03A	CX	B	F	C	CX	C
Inflammable Store, DPoW 06A	B/C	N/A	N/A	N/A	B	C
IT Services, DPoW 63A	C	DX	E	D	C	C
Lodge, DPoW 37D	DX	B	F	BC	C	C
Macmillan Nurses, DPoW 01D	B/C	N/A	N/A	N/A	B	C
Main Block, DPoW 01A	CX	B	F	C	CX	C
Main Intake Sub Station (AP Office,TXs Gens & LV), DPoW 05A	D	B	F	B	C	C
Main Intake Sub Station (HV Switch Rooms & Meters), DPoW 05B	B/C	B	F	B	C	C
Meers Building, DPoW 36A	DX	B	U	B	B	C
Multi Location (More than one Block or Building), DPoW 00800	C	N/A	N/A	N/A	N/A	C
Oil Tanks, DPoW 46A	N/A	B	F	B	B	C
Osler Building - Education Centre, DPoW 35A	C	B	U	B	B	C
Phoenix Club Sports and Social, DPoW 68B	D	DX	E	DX	B	C
Renal Unit, DPoW 25A	B	N/A	N/A	N/A	B	C
Restcote, DPoW 67A	D	B/C	O	C	C	C
Training and Development, DPoW 51A	C	B	U	B	C	C
VIE Plant, DPoW 46B	B	B	F	B	B	C
West Arch Front Office Area, DPoW 37A	DX	B	F	B	C	C
West Arch Meeting Room Area, DPoW 37C	DX	B	F	B		C
West Arch Rear Office Area, DPoW 37B	DX	DX	E	DX	C	C
11F Residential Block 6 Laurel Close	D	N/A	N/A	N/A	N/A	C
23A Doctors House No 1	D	N/A	N/A	N/A	B	C
23B Doctors House No 2	D	N/A	N/A	N/A	B	C
23C Doctors House No 3	D	N/A	N/A	N/A	B	C
23D Doctors House No 4	D	N/A	N/A	N/A	B	C
23E Doctors House No 5	D	N/A	N/A	N/A	B	C
23F Doctors House No 6	D	N/A	N/A	N/A	B	C

Scunthorpe General Hospital (SGH)

Table 38 - SGH - Multi-Facet Survey Results

Property	Physical Condition	Functional Suitability	Space Utilisation	Quality	Statutory Compliance	Environmental
118 and 120 Cliff Gardens (Occupational Health)	DX	CX	F	DX	N/A	C
A&E Dental X-Ray	C	B	F	B	B/C	C
Belton House	D	B	F	B	N/A	C
Boiler House	D	N/A	N/A	N/A	N/A	C
Butterwick House (Includes HYMS)	D	B/C	F	C	N/A	C
Chapel	DX	C	U	C	N/A	C
Coronation Block	D	C	U	DX	N/A	C
Courtyard Block	C	B/C	F	B	N/A	C
Dermatology, Medical Records, Intake Sub Station SS1	CX	B	F	B/C	N/A	C
Flammable Store	B/C	B	F	B	N/A	C
GP Ward Block	DX	B	U	B	N/A	C
Hospital Radio	DX	B	E	B	N/A	C
IT Services	DX	B/C	F	C	N/A	C
Lindsey Blue Sky Imaging Suite	C	B/C	F	B/C	N/A	C
Medical Gas Store	CX	B	F	C	B/C	C
Modular Office Building	D	B/C	F	C	N/A	C
OPD 1 and 2	DX	B	F	BC	N/A	C
Pathology HV Sub Station SS 2	C	N/A	N/A	N/A	N/A	C
Queens Building	CX	N/A	N/A	N/A	B/C	C
Reservoir	C	N/A	F	C	N/A	C
Robert Holme Hall Social Club	C	N/A	U	D	N/A	C
Service Centre	B/C	N/A	N/A	CX	B	C
Sub Station SS4 Blue Sky Imaging Suite	B/C	N/A	F	B	N/A	C
Training and Development Centre	C	B/C	U	B	N/A	C
War Memorial Block	C	B/C	F	C	N/A	C
Ward 18 Renal Unit Haematology Oncology	B/C	B	F	B	B/C	C
Workshops Stores and Medical Engineering	B/C	C	F	B	N/A	C
Underfloor Ducts	D	N/A	N/A	N/A	B/C	C
Grounds Maintenance	B/C	N/A	N/A	N/A	N/A	C
10 F Alkborough	N/A	C	F	C	N/A	C
10 H Saxby House	N/A	B/C	F	B	N/A	C
10 G Keelby House	N/A	B/C	F	B	N/A	C
05 E Croxton House	N/A	B/C	U	C	N/A	C
05 F Elsham House	N/A	B/C	U	C	N/A	C
10 C Edward Jenner	N/A	B/C	U	C	N/A	C
10 E Edward Jenner	N/A	B/C	U	C	N/A	C
10 D Edward Jenner	N/A	B/C	U	C	N/A	C
10 B Edward Jenner	N/A	B/C	U	C	N/A	C
10 A Edward Jenner	N/A	B/C	U	C	N/A	C

Goole & District Hospital (GDH)

Table 39 - GDH - Multi-Facet Survey Results

Property	Physical Condition	Functional Suitability	Space Utilisation	Quality	Statutory Compliance	Environmental
Ambulance Station	CX	B	F	B	B	B/C
Catering and Stores	D	B	U	BC	B/C	B/C
Grounds	B	N/A	N/A	N/A	N/A	B/C
Main Block	D	B	U	C	C	B/C
Ward Block	D	B	U	C	C	B/C
Workshop/Boiler House/Crèche	CX	CX	O	B	B/C	B/C

The total backlog maintenance costs identified in the six facet surveys will bring the estate up to Estate Code condition B where the building/facility is in good condition with only minor maintenance items to be addressed.

It will take a considerable amount of time and significant investment to address this due to the logistics of an operational site and while the highlighted areas are being addressed other areas of the estate will fall into Estate Code Condition C or D. Investment is therefore an ongoing cycle.

In addition, regardless of the safety critical nature of the estate which will be addressed through this investment, the layout and age of the estate prevents the delivery of an efficient service in line with modern methods of working.

3.6 Capital Investment

The Trust ran a modest capital programme during 2018/2019, except for the conclusion of the delivery of the new staff residences build on the Grimsby site called the Roost which was completed in November 2018. The rest of the capital plan was mainly based on the Trust's level of depreciation, however £1.3m was received as a donation to implement a cardiac project and £1.2m of urgent capital support funding was received for essential replacements.

Towards the end of the year the Trust confirmed it will receive £29.26m of capital funding over the next five years as part of the HCV HCP bids that were submitted, subject to formal bids to the Treasury.

Over the last five years the following schemes have been completed or scoped.

Diana, Princess of Wales Hospital (DPoW)

Table 40 - Capital Investment Profile at DPoW - 2015/2020

Ref	Project	Progress / Status	Year
1	Cardiology Day Case Unit	Complete	2015
2	Assisted Living Centre	Complete	2015
3	Retail Catering Reconfiguration	Complete	2016
4	Theatres 3,5 & 6	Complete	2016
5	Main Concourse	Complete	2017
6	Carter Review - Land Disposal	Complete	2018
7	Demolition & Reconfiguration (Northside)	Complete	2018
8	New Staff Accommodation	Complete	2018
9	Home from Home facility on ward A1 Reconfiguration	Complete	2018
10	New 2 x1.5T MRI facilities	Onsite & in development	April 2021
tbc	Water System Upgrades	Ongoing	Ongoing
tbc	Theatres 7 & 8	Not Started	TBC

In addition to the those marked on the plan, Wards C1 and C2 are being refurbished, and there has been a temporary relocation of ITU.

Figure 25 - Five Year Capital Investment at DPoW (2015-2020)

Scunthorpe General Hospital (SGH)

Table 41 - Capital Investment Profile at SGH - 2015/2020

Ref	Project	Progress / Status	Year
1	New Endoscopy Suite	Complete	2017
2	Theatre D refurbishment	Complete	2017/8
3	Wards 10 & 11 decanted from Coronation Block to Queens Building	Complete	2018
4	Minor upgrade and reconfiguration of ECC	Complete	2018
5	Additional ED treatment rooms for GP Streamlining	Complete	2019
6	Relocate Belton House (Linked to SGH accommodation)	Feasibility Stage	2019
7	Implement SGH Accommodation Strategy (Demolish Belton and Croxton House)	Feasibility Stage	2019
3	Re-purpose Coronation block (currently looking at refurbishing two floors for admin	Feasibility Stage	2019
8	Renewal of the boilers at associated infrastructure	Feasibility Stage	2019
9	Development of CT	Complete	2019
10	Development of an additional MRI	Funding approved. Commences 01/21	2019
11	Ward 29 conversion into clinical ward	Complete	2020
12	Ward refurbishments as prioritised by clinical need	Awaiting Clinical Strategy	TBC
13	Relocate remaining clinical services in Coronation block to fully empty block	Awaiting Clinical Strategy	TBC

Figure 26 - Five Year Capital Investment at SGH (2015-2020)

Goole & District Hospital (GDH)

Table 42 - Capital Investment Profile at GDH - 2015/2020

Project	Progress / Status	Year
Disposal of six residential properties currently owned by the Trust	Complete	2018
Replacement of the coal fired boilers	Full Business Case awaiting approval – BEIS and PSDF funded	2020

Community Properties

Table 43 - Capital Investment of Community Properties - 2015/2020

Project	Progress / Status	Year
Dispose of several properties and acquire (leasehold) of Global House	Complete	2017
Acquire leasehold of New Beacon House for corporate functions administration in support of Agile Working	In progress	2020
Dispose of several properties and acquire (leasehold) of Scawby House	In progress	2021
Monitor and improve compliance of community properties	In progress	2021
Acquire leasehold of New Beacon House for corporate functions administration in support of Agile Working	In progress	2020

3.7 Backlog Maintenance

As detailed above, various costs have been attributed to each acute site in accordance with bringing the estate up to Estate CODE Condition B. **It must be noted that the costs identified in the survey does not include VAT.** The investment required over the next five years to do this (in both net cost and whole scheme costs) is shown below.

Table 44 - Total Backlog Maintenance Costs over the next Five Years

Site	Total Facet Survey Costs (works cost only)
Scunthorpe General Hospital	£60,182,971
Diana Princess of Wales	£27,689,248
Goole District Hospital	£9.830,912
TOTAL	**£97,703,131**

The backlog costs above were identified as at 31st March 2020. The first year of the Five-Year Backlog Maintenance Plan commences on 1st April 2020. The net cost per facet is cost is broken down as follows:

Table 45 - Net Cost per Facet

Site	Scunthorpe General Hospital	Diana, Princess of Wales Hospital	Goole District Hospital	TOTAL
Physical Condition	£47,633,491	£21,129,452	£7,813,472	£76,576,415
Statutory Compliance	£1,343,880	£845,386	£889,440	£3,078,706
Quality	£6,687,600	£415,200	£738,000	£7,840,800
Functional Suitability	£2,718,000	£259,210	£102,000	£3,079,210
Environmental	£1,800,000	£5,040,000	£288,000	£7,128,000
Space Utilisation	£0	£0	£0	£0
TOTAL	**£60,182,971**	£27,689,248	£9,830,912	£97,703,131

Risk Adjusted Backlog Maintenance (RABM)

RABM is reported annually to the DHSC via the Estates Return Information Collection (ERIC). It is the cost associated with ensuring the estate is safe and fit for purpose and requires an ongoing annual capital investment, in conjunction with a team which is able to deliver the Capital Programme.

RABM is calculated as follows:

$$\frac{\text{Low \& Moderate Risk Costs (non-critical backlog)}}{\text{Remaining Life of the Building}} + \text{High \& Significant Risk Costs (safety critical backlog)}$$

The surveys identified a RABM cost/Critical Infrastructure risk of £51,124,069 (net cost only). This cost is split between the three acute sites as follows:

Table 46 - RABM costs (net)

Site	Total Critical Infrastructure Risk / RABM Costs (net)
Scunthorpe General Hospital	£27,613,703
Diana Princess of Wales	£19,360,230
Goole District Hospital	£4.150,136
TOTAL	**£51,124,069**

Critical Infrastructure Risk/RABM costs are therefore over half of the forecasted capital expenditure/investment required over the next five years. Should there be no significant capital investment over the next few years this safety critical risk will increase year on year.

RABM should therefore be a key consideration when looking at an overall investment/dis-investment strategy.

3.8 Estate Summary

In many areas, the physical condition of estate and quality of accommodation for providing services is not fit for purpose and estates are a major financial risk. Significant fire safety issues were identified in relation to evacuation of patients due to the layout of the Coronation Building at SGH.

In October 2018 following routine random sampling, major water infrastructure issues were identified, leading to the closure of two wards and two laminar flow theatres.

The majority of the current buildings are not appropriate for delivery of modern healthcare services. For example, they do not meet standards for en-suite facilities in ward bays or for sufficient single cubicle capacity. A high-level summary would include:

- Estates backlog – c.£97.7m after years of under investment of which c.£51.1m is Critical Infrastructure plus VAT, fees, equipment, IT and other non-works enabling costs these costs will be significantly higher
- The physical condition of the estate and quality of accommodation is below modern and safe standards
- Non-compliance with fire standards and water infrastructure issues have led to the closure of clinical areas
- Aged estate
- Clinical equipment deficits – i.e. requirement for additional scanners
- Staff accommodation at SGH is in very poor condition

Further work will help to identify whether there is potential estate that could be better utilised, or capacity optimised, at GDH. Through the current pandemic this has been accelerated as a result of the requirement for zoning and social distancing and keeping patients safe through compliance with Infection Prevention Control standards. There is an urgent need to therefore ensure all hospitals have increased single cubicle capacity on our wards and appropriate space in waiting areas.

This will include the need to separate emergency and elective pathways wherever possible and use digital processes by default as a way of minimising patient contact wherever appropriate and practicable. All of this will be considered through a revised phased implementation.

For the longer term, the ongoing transformation schemes to support patient flow through the hospital within the developments of the Acute Assessment Unit (AAU), and new builds to increase MRI and CT scanning capacity, will ultimately help configure the estate to support the clinical capacity in fit for purpose facilities. This is a key enabler for infrastructure programmes to take shape, increasing the Trust's clinical footprint thereby improving its Carter Metric. The Trust is currently developing plans to deliver new ED/AAU facilities at both DPoW and SGH to a value of £54.86m.

The Trust has been working with the Department of Business, Energy and Industry Strategy (BEIS) to replace the coal fired boilers at Goole with a new low carbon Energy Centre. The scheme is at full business case stage with work due to commence on site in January 2021 due to complete September 2021. BEIS are funding 50% of the project with the remainder funded from the Public Sector Decarbonisation Scheme (PSDS) grant fund.

The Trust has commenced an Energy Performance Contract (EPC) supported by Essential Trading Ltd with an application to fund via the PSDS. The scheme is out to tender for the Investment Grade Audit (IGA). The IGA is to be funded by the Low Carbon Skills Fund and is due to start in January 2021, with the EPC construction between March to September 2021.

The IGA will primarily focus on the potential for the decarbonisation of our heat demands across our sites. This includes the potential to de-steam our heating systems, renewable heat pump solutions, building fabric upgrades and energy optimisation technologies.

To address the high risks, the Trust is working in collaboration with the Integrated Care System (ICS) and progressing with a strategic outline case in readiness for to secure large scale capital through the national Health Infrastructure Plan (HIP) through the Humber Acute Services to form potential opportunities of rebuilding our hospitals.

3.9 Clinical Services

Five Clinical Divisions provide a range of services supported by the following corporate functions:

Figure 27 - Corporate Functions

Table 47 - Clinical Services delivered by NLaG

Medicine	• Emergency Department • Acute Medicine • Cardiology • Stroke • Respiratory	• Diabetes & Endocrinology • Gastroenterology • Clinical Haematology • Dermatology	• Rheumatology • Palliative Care • Neurology • Elderly Medicine
Surgery & Critical Care	• Critical Care • Theatres • Acute Surgery • Anaesthetics	• General Surgery • Trauma & Orthopaedics • Colorectal • Upper Gastroenterology	• Urology • Ophthalmology • ENT • Maxillo-Facial Surgery
Family Services	• Obstetrics • Gynaecology	• Paediatrics • Community Paediatrics	• Breast Services • Neonatal Care
Clinical Support Services	• Radiology • Endoscopy • Pharmacy • Pathology	• Medical Physics • Audiology • Medical Illustration	• Mortuary • Outpatients • Cancer
Community & Therapies	• Physiotherapy • Occupational Therapy • Nutrition & Dietetics • Speech & Language Therapy • Community Dental	• Podiatry & Orthotics • Neuro-Rehabilitation Centre • Rehabilitation • Nursing – community & specialist	• Community Response Team • Psychology • Equipment Stores • Wheelchair Services

Clinical services are provided across all three hospital sites as shown in the diagram below; alongside various services provided in the community such as district nursing and therapies in North Lincolnshire, End of Life and palliative services, community paediatrics and rehabilitation elsewhere.

Table 48 - Services Delivered across the three Acute Sites

	DPoW	SGH	GDH
Emergency Department	✓	✓	
Stroke	✓	Hyper acute	
Cardiology	✓	✓	✓
Gastroenterology	✓	✓	
Respiratory	✓	✓	
Haematology	✓	✓	
Oncology	✓	✓	
Dermatology	✓	✓	✓
Diabetes / Endocrinology	✓	✓	
General Medicine	✓	✓	
Neurology	✓	✓	
Rheumatology	✓	✓	
Elderly Medicine	✓	✓	
Radiology / Imaging	✓	✓	✓
Pathology	✓	✓	✓
Rehabilitation	✓	✓	✓
Palliative Medicine	✓	✓	✓

	DPoW	SGH	GDH
Critical Care	✓	✓	
Trauma	✓	✓	
General Surgery Acute(all)	✓	✓	
Anaesthetics	✓	✓	✓
Orthopaedics	✓	✓	✓
General Surgery Elective	✓	✓	
Colorectal	✓	✓	✓
Upper GI	✓	✓	
Urology	✓	✓	✓
ENT	✓	✓	
Ophthalmology	✓	✓	✓
Maxillofacial/Oral	✓	✓	✓
Breast	✓	✓	
Gynaecology	✓	✓	✓
Obstetrics	✓	✓	Home from home
Paediatrics	✓	✓	
Neonatal	✓	✓	

3.10 Quality and Patient Safety

From a quality and patient safety perspective, NLaG has had several outstanding achievements that it should be proud of, but there are also several areas to develop that are at the heart of its strategy.

The Trust set out five key quality priority themes to focus on in 2018/2019 financial year. These themes, and the Trust's performance against each of these themes, are summarised below:

Safety

Specific focus on pressure ulcers, recognition of the deteriorating patient and mortality indicators:

- Overall, during the latter half of 2018/2019, improvement has been seen against the quality indicators used to measure this quality priority theme.
- **Pressure ulcer incidence** has shown significant reductions during the 2018/2019 period within the Trust's acute hospitals
- **Early Warning Scores recorded on time** has shown progress during the year, following the change in systems used to record this, from paper based to electronic recording.
- **Mortality performance** has been measured during 2018/2019 using the national '*Summary Hospital Level Mortality Indicator*' (SHMI), which includes deaths within the hospital and those within 30 days following hospital discharge; and the '*Hospital Standardised Mortality Ratio*' (HSMR). The Trust's performance against these indicators during 2018/2019 has shown improvement, with the '*official*' SHMI indicator reducing and the HSMR reducing to demonstrate '*as expected*' performance against the national average.
- **Falls** within the Trust have been decreasing as demonstrated by the trending over time.
- **Infection prevention and control indicators**, specifically the number of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile infections resulting from a lapse in clinical care, has demonstrated that systems in place are effective. NLaG has not had a Trust apportioned case of MRSA in the last 18 months. Gram Negative Blood Stream Infections (GNBI) is a newly measured indicator during 2018/2019 and demonstrated a higher than target number of infections.
- **Venous Thromboembolism (VTE)** is an indicator demonstrating the percentage of patients admitted who have documented evidence that their risks of acquiring VTE have been assessed, leading to preventative treatment. The Trust's performance during 2018/19 has demonstrated improvement towards the 95% target, but performance during December and February has slipped.

Safe Emergency Care

With specific focus on access to non-elective care and flow through NLaG's hospitals:

- The Trust's performance against the **A&E 4-hour target** has not yet achieved the 90% goal; performance should be considered in the context of a growing demand on the Trust's urgent and emergency care services.
- Patients who have been in hospital for long lengths of stay are referred to as **super stranded**, if in a hospital bed for more than 21 days. NHSI set a target for the Trust to achieve 61 days length of stay working as part of its local system. Trending data demonstrates reductions during 2018/19. Whilst not yet achieving the target, there have been reductions which support the wider hospitals' ability to cope with increased demands.
- Following a switch in the systems used to record and track patient's **early warning score (NEWS)** being recorded on time, performance has seen significant improvement across the Trust. In urgent and emergency care, performance with this indicator has remained static.

Safe planned Care

With specific focus on cancer care, 52 week waits, overdue follow up appointments and clinical harm reviews:

- The Trust has been focused on delivering significant improvements against the **62-day GP referral to treatment (RTT) for cancer** during 2018/19. Progress has been made and performance during the year has been improving as measured by this target. Recent work has reduced the number of patients waiting 62 days or more by 50% with a similar reduction for those waiting between 42-62 days.
- The **Maximum 6-week wait for diagnostic procedures** is not yet meeting the target set (>99%). This reflects the wider diagnostic challenges the Trust is facing, for which some investment has been successful in CT scanners and in endoscopy.
- **Patients on an incomplete RTT pathway waiting more than 52 weeks** has seen significant improvement during 2018/2019 towards the Trust's quality aim of having zero patients waiting in excess of 52 weeks by the 31 March 2019 and zero patients waiting more than 40 weeks by 31st March 2020.
- **Patients on an incomplete referral to treatment (RTT) to be less than the Trust's March 2018 reported figure** is a national target aiming to focus on reducing waiting lists across the NHS. The Trust has demonstrated a reducing waiting list.
- At the end of 2017/2018 it was a key priority for the Trust to establish and embed an effective process to integrate clinical harm reviews into the Trust's focus on waiting list improvement. This was initiated and overseen by an external **clinical harm review** group. The principal focus of this group's work was to establish a clinical harm review process for a snapshot of patients who, at the 8th August 2017, had waited in excess of 40 weeks for treatment; or who waited more than 6 months after their due follow-up date; or who had waited more than 104 days on a cancer tracking pathway. The Trust has now assessed and seen all these patients.

Safe Maternity Care

- The **ratio of midwives to births** data is currently unavailable as this is being validated against standard definitions to ensure accuracy of reporting.
- The Trust chose a priority indicator linked to the commencement of **cardiotocography (CTG)** to ensure that women who needed such investigations had no delays in accessing. Performance has remained above 89% during 2018/2019. Linked to this, **fresh eye reviews** are designed to reduce the risk of misinterpretation of a CTG trace. This was found to be effective in reducing the incidence of errors. The Trust has been focused on ensuring that CTGs are reviewed by more than one person during the period of CTG monitoring, to reduce the risk of errors and harm to women in the Trust's care. NLaG has maintained consistently high performance, exceeding 93% during 2018/2019.
- The proportion of still births in the Trust is low and in line with the England average. Whilst public health and social factors affect the risk of still births, the Trust has been focused on identifying the risk of **still birth** due to small for gestational age (SGA) and fatal growth restriction (FGR) in the use of **individualised growth charts**. The Trust uses the Perinatal Institute tool for this purpose and is performing above the UK average.

Safe Staffing and Improved Staff Engagement.

- **Safer staffing fill rates** is a measure of the extent to which rota hours on ward areas are being filled by registered nurses, midwives and unregistered care staff to enable ongoing monitoring of safe staffing for the Trust; and to provide reassurance to local people that wards are safely staffed. The trending data demonstrates an increased fill rate by registered nurses and midwives. Un-registered carer staff has also exceeded the target set following a targeted recruitment programme during the latter part of 2018 which has led to a decrease in carer vacancies across the Trust.
- **Registered nursing staff vacancy rates** - During 2018/2019 NLaG set a vacancy target of <6% for registered nurses and <2% for unregistered nurses carer staff. During the year these had been increasing, largely as a result of the Trust rebasing its establishment needs for ward areas (i.e., reviewing the demands on each ward and resetting the number of trained nurses needed in that location) so, in effect, deciding that more staff were needed, rather than this being solely in relation to nursing staff retention rates. During November 2018 the vacancy rates reduced significantly towards the target.
- **Medical staff vacancy rate** - At the beginning of 2018, the Trust set an improvement target to reduce the medical staff vacancy rate to less than 15%. In February 2019 NLaG reduced its Medical vacancy rate to fewer than 14% and has maintained this trajectory to close the 2018/2019 financial year and thus achieve the target set.
- **Staff engagement, satisfaction and feedback** – This has been supported during 2018/2019 as the Trust continued to focus on several work streams designed to improve engagement and support to staff within the organisation. These have resulted in several very positive outcomes; however, the Trust recognises that more time is needed to evaluate the outcomes from these programmes.
- **Patient voice and listening to the feedback of patients and service users** - Work was undertaken during 2018 to listen more acutely to patient feedback and, as a result, some improvements were made.

3.11 Patient Environment

Care Quality Commission (CQC)

Quality is defined by whether services are safe, effective, caring, responsive and well led, how NLaG performs in these determines the overall quality of the healthcare provided to patients. The CQC, the independent regulator of health and social care, rated the Trust as '***Requires Improvement'*** in their last inspection report, published in February 2020. A summary of performance is shown in the table below.

Figure 28 - CQC Performance Summary

@ Feb 2020	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Inadequate ↓	Requires improvement →←	Good →←	Requires improvement →←	Requires improvement →←	Requires improvement →←
Community	Requires improvement →←	Requires improvement ↓	Good →←	Requires improvement →←	Requires improvement →←	Requires improvement →←
Trust Overall	Inadequate ↓	Requires improvement →←	Good →←	Requires improvement →←	Requires improvement ↑	Requires improvement →←

The Trust's mandate is to ensure full delivery of the agreed programme and be responsible and accountable for engagement of staff at all levels of the organisation. There are four significant differences in the approach moving forward which are detailed below.

- pace to progress outstanding actions
- provision of evidence of what we have done
- ensuring all our staff know how we are progressing across the organisation.

1) Dedicated resource

In order to achieve the pace and scale that is required for change and evidencing that change, two posts have been created to direct and pull together the work. The Compliance and Assurance Programme Director will keep the performance and governance structures and Trust Board fully cited on the progress being made. This role is to be supported by the Inspection Compliance & Assurance Manager, who will work with the Divisions to ensure the robust collation and management of appropriate evidence in a timely manner.

2) Programme Governance

A new governance and reporting mechanism for CQC recommendations has been implemented by the Trust.

3) Divisional Ownership

Divisions will develop and take ownership of the CQC improvement plan for their area which will enable a focused approach which will ensure that regulatory actions are quickly achieved, embedded and then sustained.

4) Culture in the organisation

There will be a continued focus on culture and engagement. A new approach to frontline engagement has been agreed which includes:

- Task and Finish Groups
- Quality Improvement Network

Whilst the majority of the improvement priorities identified, are being addressed at clinical divisional level and are transactional in nature, there are other key themes which require transformational change both at organisational and system level. These include:

- Outpatient care
- RTT waiting times
- Cancer waiting times
- Access to diagnostics
- End of Life care

As the Trust progresses to the required level of transformational change, it is important to acknowledge the progress achieved through the transactional step changes to support the improvement of safe, effective, caring and responsive care across the organisation such as:

- Focusing on governance process to ensure learning from incidents and complaints flow through the organisation
- Improving mandatory training and performance, appraisal, development review compliance
- Developing a new complaints process to ensure timely responses which answer patient and carer concerns
- Ensuring specific actions identified within divisions are addressed, embedded and monitored.

The challenges in addressing identified areas for improvement include the uncertainty of COVID-19 both in terms of patient uptake of services, changing regulations and the potential of a further spike, an inability of capacity to meet demand, the ability to recruit and retain highly skilled staff, and the ability to sustain a financial balance.

Innovative models of service delivery and workforce utilisation across the Trust and in partnership with other organisations will be integral to address these challenges and is underpinned by developing a culture of continuous improvement.

Patient Led Assessment of the Care Environment (PLACE)

According to NHS England (NHSE), '*Good environments matter*'. The expectation is that every NHS patient should be cared for with compassion and dignity in a clean and safe environment and if patients believe that standards fall short then they should be able to hold the service and its management to account. This is assessed annually through PLACE.

The table below shows a summary of performance against peer acute Trusts for the 2019 reporting period, and as the changes following the methodology review have been extensive, it is important to note that 2019 scores establish a new baseline and are not comparable to those achieved in previous assessments. In addition, due to the COVID pandemic PLACE Assessments for 2020 did not take place.

To compare with the national performance, the **median value** is used – this gives the middle score of all the acute Trusts ranked in order. The position compared to the top 25% of Trusts (i.e. the upper quartile or quarter) and the bottom 25% of Trusts is also reviewed.

Table 49 - Comparison of NLaG's 2019 PLACE Scores against 130 Acute Trusts

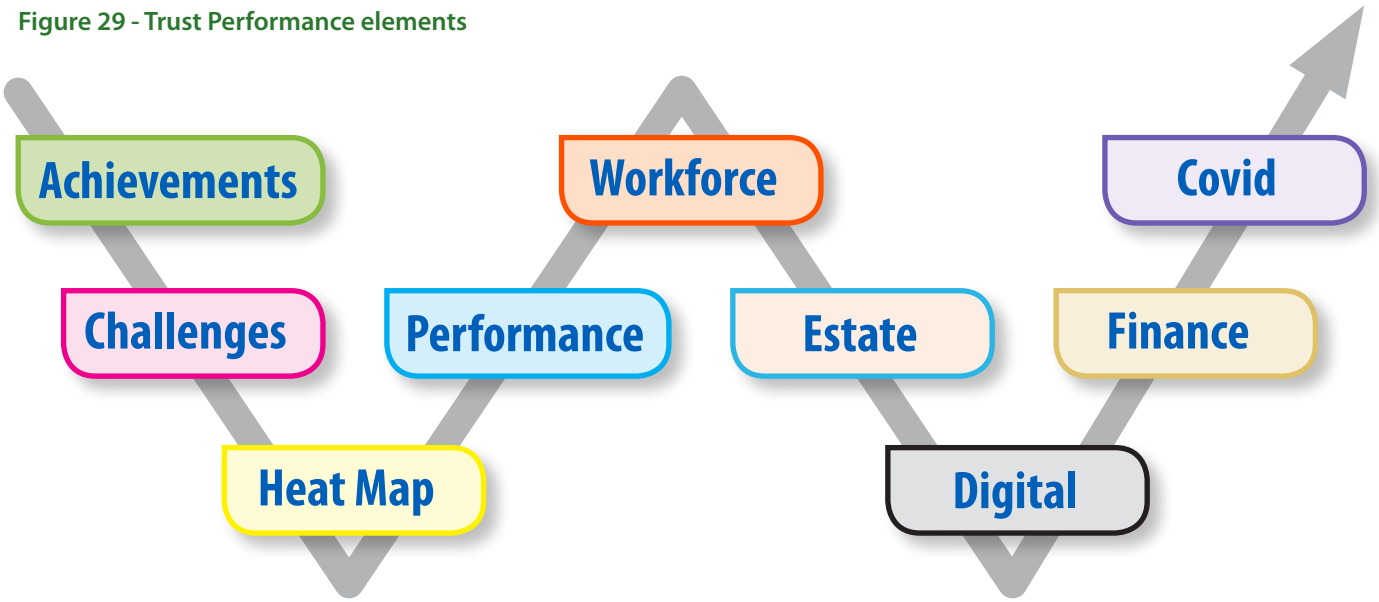
	Indicator	NLaG Trust Scores	Acute Trust Median	Performance Against Median	Quartile
A	Cleanliness	**99.3%**	99.0%	**Higher**	Middle 50%
B	Food & Hydration	**90.0%**	92.4%	**Lower**	Middle 50%
C	Privacy, Dignity & Wellbeing	**85.9%**	85.0%	**Higher**	Middle 50%
D	Condition, Appearance & Maintenance	**97.5%**	97.1%	**Higher**	Middle 50%
E	Dementia	**82.7%**	78.7%	**Higher**	Middle 50%
F	Disability	**85.7%**	82.3%	**Higher**	Middle 50%

- NLaG's performance in five out of six domains was higher than the median in 2019
- For all six domains NLaG's position was within the middle 50% of Trusts
- NLaG was within the bottom 25% of Trusts for organisational food scores
- PLACE Assessment of DPoW shows that the site was:
  - within the middle 50% of hospital sites for five out of six domains
  - within the bottom 25% of hospital sites for food & hydration
  - above the median for cleanliness, condition, appearance & maintenance, dementia and disability
  - below the median for food and hydration, ward food scores, and privacy, dignity & wellbeing.
- PLACE Assessment of SGH shows that the site was:
  - within the middle 50% of hospital sites for all six domains
  - above the median for privacy, dignity & wellbeing, dementia and disability
  - below the median for cleanliness, food & hydration, ward food scores, and condition, appearance & maintenance.
- GDH's PLACE Assessment indicates that the site was:
  - within **the top 25% of hospital sites** for five out of six domains – cleanliness, privacy, dignity & wellbeing, condition, appearance & maintenance, dementia and disability
  - within the middle 50% of hospital sites for food & hydration and ward food score
  - above the median for all six domains.

3.12 Performance

This section provides an overview of recent achievements, the challenges NLaG is at present facing and where the Trust currently is with performance, workforce, estates and infrastructure, digital and financial stability; and, more recently, the impacts of COVID-19. It is important to recognise that some achievements in terms of service improvements were heading in a positive direction (i.e., waiting times) which have now altered as a result of the pandemic.

Figure 29 - Trust Performance elements



Achievements

Whilst the Trust acknowledge the challenges it is currently contending with, there have been improvements and achievements driven by the clinical divisions in various domains of workforce, governance, quality and service delivery to aid the improvements in patient experience and outcomes. A few examples of these are:

- Strengthened Divisional Governance Frameworks and improved risk management processes
- Improvements in mortality position has reduced over the last four consecutive monthly releases to be within 0.07 of the '***as expected***' threshold (4.95% reduction from July 18-June 19)
- Changes to workforce, i.e., Consultant of the week rotas, emergency physician in charge rota, increase in emergency department consultant cover and clinical co-ordinators
- 81 newly qualified nurses joined the Trust in October 2019
- Implementation of AAU interim model in November 2019
- Introduction of multi-disciplinary falls huddles to reduce risks for vulnerable patients
- Pressure ulcer prevention and reduction in reported cases
- Implemented electronic prescribing
- Ward refurbishments in both DPoW and SGH and a second CT scanner in SGH
- Implementation of 15 steps ward accreditation programme
- Increased access to therapists over seven days
- Partnership working with primary care, ambulance services and local authorities in developing responsive services through the Single Point of Access
- Development of acute to community pathways, including those which prevent hospital admission.

Challenges

NLaG is facing challenges across workforce, quality of care, operational issues and Estates and Facilities; ultimately leading to financial unsustainability. Significant work has been done to address these challenges in recent years. Proactive international recruitment, operational and quality improvements, and financial measures have been put in place, resulting in multiple improvements but there is still a long way to go to achieve improvements to the services provided to deliver the optimal patient experience. This includes:

- Standards for urgent care, cancer care and routine waiting times
- NLaG is unable to meet all four priority standards for providing consistent access to high quality emergency care
- The Trust has reached a critical point which means that it can no longer operate some services as they are
- The need to work with primary care, to enable the needs of local people to be managed at place, bringing expertise to the community, especially considering the needs of frail elderly residents
- The need to recognise when people are at the end of their lives and ensure those who have reached the end of their life receive a high standard of quality care and compassion
- The scale and long-standing nature of the workforce, service sustainability, and estates challenges across the region suggest that it will take more than the efforts within each individual organisation to address threats to the Trust
- It requires Trusts to work together in a range of ways to secure the future for key services. It is believed that joint working across the Humber could help bridge the workforce gaps, address some of the quality and financial issues, and protect fragile services from failing, avoiding emergency reconfigurations
- The challenges are even more significant within current circumstances of COVID-19 with strains on staffing, capacity and PPE to continue delivering safe services in response to COVID-19.

Performance

As detailed in the challenges above the required NHS constitutional performance standards have shown a sporadic picture predominantly for the A&E 4 hour wait, cancer waiting times for 62 days to treatment from GP referral and the 18 week wait RTT targets. Prior to March 2020, improvements to waiting times and some of the performance domains were heading in the right direction such as the over 40 weeks and 52 weeks waiting times.

NLaG saw pre COVID, a significant improvement in RTT waiting time performance. The Trust is now beginning to see an increase in patients waiting over 40 and 52 week waits as treatment was paused in line with national guidance due to COVID.

The A&E four hour wait was starting to show improvements mid-year but unfortunately declined due to the impacts of winter and the rising demand in attendances. Pre-COVID the performance significantly improved in March 2020.

Cancer waiting times have been a significant challenge for the Trust throughout 2019/2020. This is an urgent priority to transform cancer services to ensure quicker diagnosis and treatment.

The current position for performance delivery is even more constrained with the impacts of COVID and therefore accelerates the need to address the way clinical services are delivered through service transformation.

Heat Map

An accumulation of workforce status, performance positions and finance are periodically collated into a Trust heat map which provides a summary of information to highlight fragile services, and provides an evidenced based platform to support the prioritisation of services requiring review or reconfiguration.

The information provides a Red, Amber, Green (RAG) rating position for each speciality against the following key indicators:

- Medical workforce vacancies (based on vacancies against the establishment at that time)
- Sickness rates (percentage of sickness within the speciality for medical staff)
- Referral growth (from previous referral levels in each speciality)
- Reference costs (sourced from Reference Cost Index including Market Forces Factor)
- RTT performance (18 week wait incomplete against 92% target)
- Backlog volumes at a point in time (volume ratios will differ between high/low volume specialities)
- Average length of stay (in comparison to the Peer average from NHS Healthcare Evaluation Data (HED)

Heat map RAG ratings are based on the following criteria:

Figure 30 - Heat Map RAG rating criterion

Medical Consultant & Other Medical Workforce vacancy rate against establishment	Medical staff Sickness rate	Referral rate no greater than previous levels	Reference Costs	18 ww Incomplete RTT Performance against 92% standard	Backlog volumes - outpatient overdue	Average LOS - elective and non-elective
Vacancies: = to or >30% of Establishment	> 4%	Growth above 10%	>100	<92	> or = to 800	Higher than national
Vacancies: = to or >10% <30% of establishment	> 1% <4%	Growth up to or = to 10%	< or = to 100	> or = to 92	> or = to 500 <800	Equal to or lower than national
No vacancies: <10% or over established (+)	< or = to 1%	Reduced Referrals (-)			<500	

The heat map output and identification of a '***fragile***' service is based on the criterion defined above for each speciality scoring over 50% of red ratings. The current position for the Trust has identified the following services within the '***fragile***' category or identified as '***vulnerable***' due to quality concerns:

- Haematology
- Respiratory
- ENT
- Urology
- Neurology
- Ophthalmology
- Cardiology
- Dermatology
- Gastroenterology
- Oncology

These services will form part of the Humber Acute Services Interim Clinical Plan to address the concerns at pace incorporating the immediate and forecasted changes due to COVID and recovery planning.

Covid

As indicated in the sections above the impact of COVID-19 across all domains of healthcare is now a fundamental part of ensuring service delivery is rapidly transformed to ensure services are safe.

Continuing to care for patients in line with infection control guidance which safeguards both staff and patients during this pandemic has reduced the number of contacts the Trust can undertake, due to shielding, self-isolation and sickness absence in particular amongst medics and nursing staff.

Essential cancer treatment has continued although challenges within the current processes have delayed diagnosis. The Trust continues to work with the Cancer Alliance to develop hubs to provide increased access to diagnostic and surgical capacity locally and regionally.

NLaG is currently in the second phase response to COVID-19 which indicates that it is aiming to maximise utilisation based upon our available capacity, although this is not without challenge.

However, the waiting times and backlog has shown continued growth and will continue to impact whilst NLaG works through the recovery phasing.

Departments and wards have had to be reconfigured to take account of social distancing rules and the introduction of ward zoning has reduced the number of beds available within the Trust to a current bed stock level of 615. The recovery planning indicates beds increasing subject to investment through the use of escalation beds (mobile wards) to cope with the demands of winter.

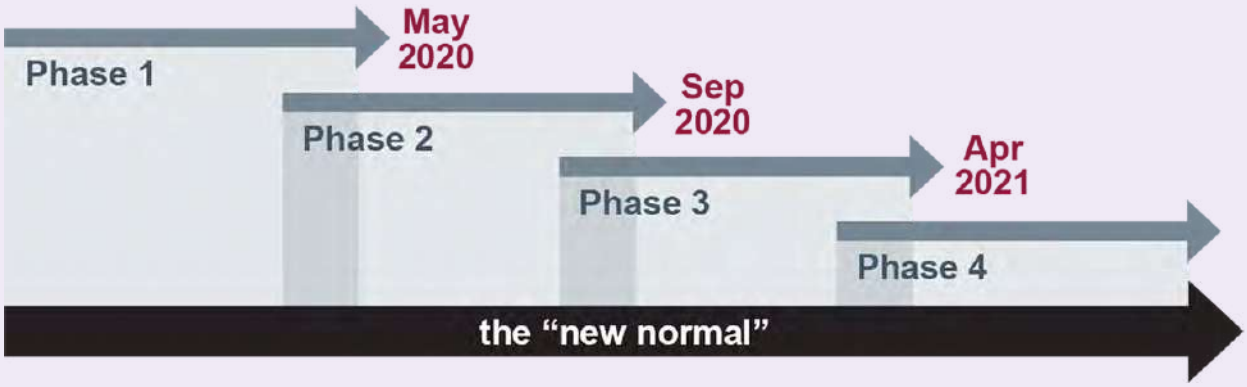
NLaG has been working closely with the Integrated Care System on the following issues:

- Insufficient diagnostic capacity in MRI/CT/Endoscopy to meet demand and clear backlog
- Insufficient theatre capacity to deliver 100% pre-COVID activity levels, in particular for routine patients
- Following the introduction of red and green sites the Trust was able to identify only one green site within the Trust
- Insufficient IT equipment to facilitate rapid roll out of non-face to face appointments in outpatients
- Pressures on PPE availability
- Inter-dependencies between one service/department and another
- The Electronic Referral System, directly bookable service used for outpatients. First appointments could not be used due to the high number of clinic cancellations required.

For recovery planning, the fundamental impact upon waiting lists and future capacity to provide services is significant. NLaG's Clinical Strategy will take into account the need to address the recovery of activity, ensure the wards and departments are adapted appropriately and to continue working as an integrated health system to reconfigure services where required.

The Trust is working through the national steps of recovering activity which is taking a phased approach as depicted below:

Figure 31 - National Steps of Recovering Activity Phases



In terms of COVID-19 recovery planning the detailed phases are described below. Phases 1 and 2 are set in the context of responding to the pandemic crisis and phases 3 and 4 and the steps to building the 'new normal' for the future:

NLaG is actively working through an activity recovery plan as part of phase three aiming to accelerate the return of near to normal levels of non-COVID health services by March 2021.

Workforce

There is a national shortage of specialist staff – doctors, nurses, radiographers etc. and NLaG is competing to attract staff. Many of them want a lifestyle which is better offered by living in, or close, to larger cities. As these areas have larger teaching hospitals, they also offer staff the opportunity to work in more specialised services.

Staff who do work in NLaG's hospitals are under pressure because of these shortages and the Trust needs to make their hospitals better places to work so that they do not leave. NLaG's current model of trying to run similar services across multiple sites, 24 hours a day and seven days a week, stretches the existing staff base thinly, which is not fair on staff or patients.

Although the last two years have seen a reduction in the vacancy position across staff groups, partly aided by innovation in the introduction of alternative roles such as Advanced Clinical Practitioners, Trainee Nursing Associates and use of the apprenticeship levy, NLaG still has challenges to address.

The medical and dental vacancy position has been supported by the development and extensive use of the Medical Training Initiative with appointments of International Training Fellows being made across clinical areas. The Trust has seen an increase in junior doctor fill rates over the last two years and newly qualified nurse recruitment is at an all-time high.

The age profile of the organisation presents significant challenges over the next five years with high proportions of the clinical workforce reaching retirement age. This, combined with higher pressures placed on staff within the clinical system, may mean staff choose to retire early.

Workforce redesign is still required to achieve the Trust's strategic and quality priorities and transformation changes.

This includes transformation of the current and future workforce by working with partner agencies, introducing new roles and new types of workers, and alternative models of care, as an integral part of the HASR.

It is recognised, given the current circumstances of COVID-19, there is, and will be, workforce implications.

This is mainly due to shielding, self-isolation and sickness absence in particular amongst medics and nursing staff. There is also a further requirement for an enhanced level of capacity, particularly medics capacity, due to the unique characteristic of COVID-19 related processes such as zoning within the hospital to ensure the safety of patients and the requirements of PPE.

Figure 32 - Workforce Challenges

Digital

For many years it has been a challenge for the Trust's IT infrastructure to keep up with modern technology and capacity due to ongoing system issues and lack of investment. NLaG's new digital strategy covering 2021-2024 looks to build on recent successes and uptake of digital tools across key areas of delivery.

Digital enablement has been a focus of the NHS in response to tackling the recent challenges of the virus pandemic in 2020. A rapid shift in the way some care activities are being delivered has occurred over a short time period. This has relied on digital toolsets to provide alternative options to clinicians in how they can continue to deliver care to patients. The digital agenda continues to progress at pace with focus during 2020/2021 on maximising the benefits from investment delivered to support the COVID-19 management response.

To support NLaG on its journey to successfully deliver this Digital Strategy, six relevant and realistic principles were developed. These principles aim to contribute to the desired outcome which is a 'meaningful end-user digital experience'.

1	**People first**	Staff will be supported to build digital skills to create a system that when patients view information there is a '***legend of interpretation***' to know what is meant. There will be provision on the normal range of results so patients can understand the context on an individual basis. Solutions will be explored from the human perspective first, then prototype, learn, and iterate. Make life easy!
2	**Quality & safe care**	Systems will be rationalised and Trust staff will work together to implement processes and digital technology that improves the safety and quality of care for patients while working to improve quality of life for staff.
3	**Resource sustainability**	Gaining efficiency and realising benefits by not duplicating processes. Being clear on what the Trust needs to stop doing and what will be enabled with digital. A digital first approach will help to attract and retain resources. New ways of working will be required, including working more collaboratively and finding creative ways of managing finances. This will be done together with the right people to manage risk (not avoid risk).
4	**Modernised IT infrastructure for scalability & flexibility**	Leveraging cloud services appropriately and moving architecture toward Application Processing Interfaces (APIs) to gain access to the data that is in legacy systems. Rationalising systems to improve efficiency and decommissioning systems that are not able to meet current operating standards for security and interoperability.
5	**Open platform for interoperability**	Adopting the use of Application Processing Interfaces (APIs) to interface with a network of providers so that, with permission, the Trust can exchange member data. In alignment with NHS standards, it will be mandatory for all systems procured to meet this open standard. The objective will be for data points to move seamlessly where and when needed across the ICS.
6	**Reliability & security**	Meeting and maintaining the cyber security essentials assessment. Security of information is a constant concern in healthcare. To gain trust, the organisation must continue to fortify its infrastructure to protect against a constantly evolving security threat. As the organisation is becoming more dependent on technology, it will become even more important that the technology used is reliable, resilient, and robust.

Finance

NHS Improvement (NHSI) formally placed the Trust in Financial Special Measures in March 2017 and although it delivered its control total in 2019/20 the Trust still finished the financial year with a deficit in excess of £50m. Prior to COVID-19 the Trust developed the following five-year plan:

Table 50 - NLaG's Pre-COVID Financial Five-Year Plan

	£m				
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Baseline Deficit (excl. FRF, PSF & MRET)	**(66.2)**	**(51.2)**	**(47.6)**	**(44.1)**	**(40.3)**
MRET	3.7	3.7	3.7	3.7	3.7
Tariff, Inflation, Pay Awards & MFF Adjustments	(5.0)	(4.9)	(5.1)	(4.8)	(4.5)
CIP @ 1.1%	4.5	4.5	4.4	4.3	4.2
Additional CIP over 1.1%	15.5	4.0	4.1	4.2	4.0
Financial Trajectory (pre FRF)	**(47.5)**	**(43.9)**	**(40.4)**	**(36.6)**	**(32.9)**
Indicative FRF	*22.1*	*39.8*	*39.8*	*36.6*	*32.9*
Control Total Deficit	**(25.4)**	**(4.0)**	**(0.5)**	**0.0**	**0.0**
Total Indicative CIP	**20.0**	**8.6**	**8.6**	**8.6**	**8.3**
CIP % Operating Expenditure	**4.9%**	**2.1%**	**2.1%**	**2.2%**	**2.2%**

The Trust was planning to build on the financial foundation it provided in 2019/20. Instead of planning to get surplus, the plan above shows a steady improvement in financial performance over a five-year period. At the end of the period the Trust was planning a £32.9m deficit which would be supported by Financial Recovery Fund (FRF) monies from NHSE/I.

In order to deliver this improvement, the planning assumption is that NLaG will deliver a Cost Improvement Programme (CIP) each year of just over 2% and circa £8.5m per annum. This compares with the delivery of a CIP of £20.6m in 2019/20.

This gradual improvement in the Trust's financial position was also planned to be an enabler for the delivery of steady improvement in quality.

With the introduction of COVID, the finance regime for Trusts has changed and there is no certainty of what finance regime the Trust will be working under after August 2020.

Regardless of this, the Trust is committed to understand and manage its cost better to allow the previously planned steady improvements in quality and finance to progress.

3.13 Sustainability

The NHS estate and its supporting facilities services – including primary care, trust estates and private finance initiatives – comprises 15% of total carbon emissions. Significant opportunities for emission reductions can be seen in energy use in buildings, waste and water, and new sources of heating and power generation.

Reducing Emissions from Hospital Estates and Facilities

Delivering a net zero health service will require work to ensure new hospitals and buildings are net zero compatible, as well as improvements to the existing estate. To support this, a new Net Zero Carbon Hospital Standard will be available from Spring 2021 and applied across the 40 new hospitals to be built as part of the government's HIP. This will involve both the use of innovative, low-carbon materials, as well as new design that allows for flexibility and shifts in how care will be delivered in the future.

While these new hospitals will need to meet the Net Zero Carbon Hospital Standard, they form less than a fifth of the secondary care estate and so significant interventions will also be required in the retained estate nationally.

Engineering solutions to upgrade buildings represents a total of 473 $ktCO_2e$ in potential emissions savings. The £50m NHS Energy Efficiency Fund (NEEF) plans to upgrade lighting across the NHS estate, acting as a pilot for future work and saving £14.3m and 34 $ktCO_2e$ per year across the NHS. Delivering 100% LED lighting could be achieved with an additional non-recurrent investment of £492m, which would be paid back over a 3.7 year period, providing an estimated net saving of over £3 billion during the next three decades.

Between 2017 and 2020, NLaG has seen a 28% rise in delivered unit energy costs. The rise in energy and water prices is likely to continue for many years and therefore energy efficiency and reduction measures are increasingly vital.

Financial gains can also be made from achieving efficiency savings through environmental and social projects and from embedding carbon reduction in financial mechanisms. Such schemes should be seen as Invest to save projects. The more energy NLaG saves now, the lower the costs will be as utility costs continue to rise.

Reducing demand and investing in renewable onsite generation technologies will keep costs down. Money saved by such actions can be either reinvested into further decarbonisation projects or diverted to patient care.

Investing in a net zero NHS aligns with investment in the long-term sustainability of the health service and with the health of the people in our region. The net zero ambitions outlined in the Trust's Green Plan will need to be appropriately resourced with the right capital investment and will require recurrent investment and an aligned financial policy and decision-making process.

These net zero ambitions will be aligned with existing commitments as far as possible; for example, to ensure that major building works and refurbishments, take into account the need to reduce emissions, and that wherever possible maintenance or the replacement of equipment is done in a way that improves energy efficiency and reduces emissions. We will work to ensure that these factors are taken into account in investment decisions.

NLaG will actively work with relevant bodies to utilise funds directed towards the UK wide target towards net zero. This potentially includes accessing substantial funding through the Government's Decarbonisation Grant and other Salix Finance opportunities.

NLaG's Green Plan 2021/22

NLaG recognises the importance of a sustainable health economy, and will act as the anchor point within the Integrated Care System to ensure the Trust reduces the impact on the environment, working to protect and improve the health of communities, patients, staff residents and public.

The NLaG Green Plan 2021/22 focuses on all the current initiatives, legislation and NHSE/I documentation and campaigns. This Green Plan provides the role of sustainability in the context of both the national and local agendas and upon delivery will ensure NLaG makes a substantial contribution in meeting future targets and thus reducing carbon emissions.

The plan contains a programme of principles to reduce carbon and details specific energy conservation measures that will reduce energy consumption, lessen production of waste and promote more sustainable modes of travel.

The Trust's reporting and governance structure through the E&F directorate will provide assurance via the Finance & Performance committee and then to Trust Board, with the decision making forums of Trust Management Board and Capital Investment Board approving energy conservation schemes and associated funding.

The Sustainability Management Group will produce an action plan to enable the E&F directorate to monitor progress against the Green Plan.

Sustainable Models of Care

The NHS Long Term Plan (LTP) set out a commitment to deliver a new service model for the 21st century. If the NHS is to reach net zero emissions, that new service model must include a focus on sustainability and reduced emissions.

NLaG is committed to carbon reduction and sustainable development and achieved the National Carbon Reduction target of 10% by 2016. This involved a reduction of carbon emissions from energy of 19% as well as a reduction in waste emissions by changing from an incineration contract to an autoclave contract and various Transport initiatives. The Trust did not quite achieve the 25% target presented in the Carbon Management Plan as some of the measures identified in the Plan remain to be completed.

Whilst there is significant progress being made, the following issues will need to be taken into account going forward:

- A continuing increase in community premises owned by the Trust
- A new accommodation block has been complete at DPoW
- Site rationalisation at DPoW is complete
- A new energy centre at SGH
- The awaited outcome of the HASR will need to be considered
- Replacement of coal fired boilers at Goole.

4. Where do we want to be?

"The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most." The NHS Constitution.

Our estate will support clinical models to maximise patient safety and efficient staffing. We want an efficient, well-utilised estate that offers an excellent and safe environment for patients, staff, carers and visitors. Our estate must be sustainable in environmental and financial terms and we need to ensure that any investment is central to these aims.

At the same time, we need to align with wider proposals at the national and regional level, which impact the projects or timeline in our estate improvements.

4.1 Strategic Context

The Trust

NLaG was established as a combined hospital Trust on 1st April 2001 and achieved Foundation status on 1st May 2007. It was formed by the merger of North East Lincolnshire (NEL) NHS Trust and Scunthorpe and Goole Hospitals NHS Trust, and delivers services from all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the Trust became a combined hospital and community services trust (for Northern Lincolnshire).

The Trust covers a wide geographical area and delivers services from a total of 860 beds and a gross floor area of 142,535m2. It provides a range of hospital-based and community services to a population of more than 450,000 people across North Lincolnshire (NL), NEL and East Riding of Yorkshire (ERoY).

The Trust has 860 inpatient, maternity and critical care beds across 45 wards, 120,000 inpatient episodes, and saw over 360,000 outpatient appointments. NLaG employs around 6,800 members of staff.

NLaG operates out of the following three main hospital campus sites and a number of community sites.

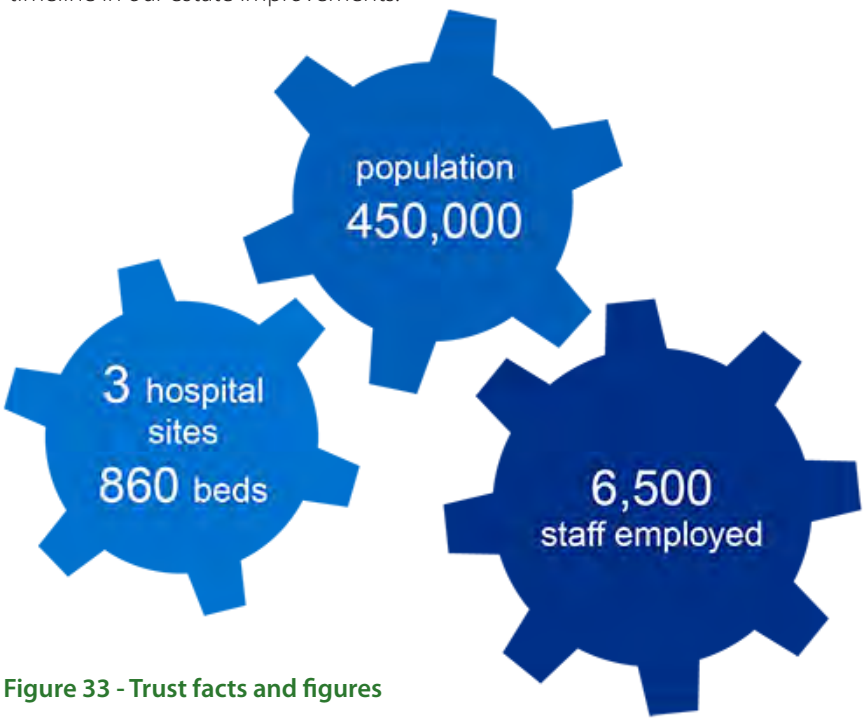


Figure 33 - Trust facts and figures

- Diana, Princess of Wales (DPoW) in Grimsby
- Scunthorpe General Hospital
- Goole District Hospital.

DPoW and SGH both provide acute hospital care and a range of community services across NL and NEL with GDH predominantly providing outpatient, diagnostic, planned surgery and rehabilitation. NLaG delivers District General Hospital services on the Grimsby and Scunthorpe sites which include Emergency Departments (EDs) and Intensive Treatment Units (ITUs), whereas the smaller GDH operates a lesser portfolio of services and has an Urgent Treatment Centre (UTC) rather than a full ED. All three sites provide inpatient, day case and outpatient services.

As part of its community provision, NLaG delivers adult, dental and end of life community health services across North Lincolnshire.

In the financial year 2019/2020, within an operating expenditure of £421m, NLaG:

- Received 148,500 ED attendances
- Delivered 4,077 babies
- Performed 77,900 surgical operations
- Received 112,200 inpatient admissions
- Received 397,100 outpatient attendances.

Strategic Partnerships

As part of the Trust's Five-Year Strategy, the Trust Board reinforced previous findings that the local health services, as currently configured across NL, are not sustainable in the medium to long term, under the current NHS payments system.

However, no compelling case for change had been made for a radical downgrading, rationalisation or centralisation programme of the Trust's services.

The Trust instead identified a programme of clinician-led integration of pathways and services, with the principal aim of controlling net demand growth, through this means limiting future cost growth and delivering sustainability.

This would build on the work already underway across local providers of primary, secondary, community, social and mental health care.

Given the push for NHS organisations to collaborate more with each other, as well as with the private and voluntary sector, the geographic area in which the Trust provides services has seen a number of new partnerships develop. These include:

- Northern Lincolnshire Out of Hospital Transformation Board;
- NL Place Board
- NEL Health Care Executive
- Hull University Teaching Hospitals NHS Trust (HUTH).
- NHS Property Services (NHSPS)

North Lincolnshire Out of Hospital Transformation Board

The purpose of the 'North Lincolnshire Out of Hospital Transformation Board' is to provide system leadership to shape and deliver an integrated model for out of hospital services for both adults and children.

The Transformation Board has been established to oversee the development of a model of out of hospital services (including physical and mental health needs) that takes account of future needs, is developed around the person and their needs, and uses innovative technologies to provide a sustainable model. Its principal outcome will be to improve health and care services and the health and wellbeing of children, young people, adults and communities in North Lincolnshire.

The Board's key aims are to:

- Develop models of delivering integrated out of hospital services
- Broker integration of care
- Commission innovation & outcomes
- Promote understanding of current community services contracts.

Senior leaders from the Council, Clinical Commissioning Groups (CCGs), NLaG, Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH), East Midlands Ambulance Service (EMAS), Safecare and the voluntary sector are members of the Board.

North East Lincolnshire Place Board

North East Lincolnshire Place Board has taken on the role of the HWB to become the strategic leadership board for place – the forum through which all organisations and partnerships will work together and invest for better community outcomes.

A place-based wellbeing framework with five key outcomes, including health and wellbeing, has been out for consultation.

This sets out the intent to revise and align existing place-based strategies such as safer, stronger communities and economic growth, and will serve as the joint health and wellbeing strategy.

Asset-based approaches, social value, encouraging personal resilience and devolving decision making to communities and individuals are central to the ethos of the place board.

This builds on the work of the HWB – for example, investment in voluntary and community groups to develop community-led solutions to key wellbeing priorities such as smoking in pregnancy, and peer support to help drug and alcohol users rebuild their lives.

The place board's future priorities will be a small number of complex issues which are best tackled by all partners working together. They are likely to include:

- targeted support for families who come into contact with many services
- improving skills, employability and employment aspirations for local people – particularly necessary with the large growth in jobs expected from the development of the 'energy estuary'.

North East Lincolnshire Voluntary, Community & Social Enterprise Alliance (NEL VCSE)

NEL VCSE was founded by local voluntary sector organisations to support the growth and sustainability of the VCSE sector in NEL. The Alliance aims to create greater opportunities for collaboration between VCSE organisations and public and private sector partners for the benefit of the local communities served.

The Alliance's vision and purpose is to provide a resilient & vibrant VCSE sector and to support the growth and sustainability of the VCSE sector in NE Lincs. Its core values are:

Hull University Teaching Hospital NHS Trust

HUTH is a large acute NHS Trust situated in Kingston upon Hull and the ERoY. It provides a full range of urgent and planned general hospital services, covering major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services.

These secondary care services are provided to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area. Its core values include:

- Care
- Honesty
- Accountability.

HUTH is working as a key partner within the Humber, Coast and Vale Health and Care Partnership (HCV HCP), along with CCGs and other health and care providers. ICS status was received in April 2020, underpinned by Integrated Care Partnerships (ICPs) covering North Yorkshire and York; Hull and the ERoY; NEL and NL.

The Trust's role in delivering this plan is to work openly and collaboratively with partners to support the development of new models of care and the closer integration of health and social care services.

The Trust is also supporting two reviews of acute or secondary care, one across the Humber region and one across the York and Scarborough areas.

The Trust is working closely with local partners on the HASR to identify opportunities for collaboration and joint working across the Humber.

Commissioners

NL Clinical Commissioning Group (CCG), NEL CCG and ERoY CCG commission the majority of the Trust's services, based on the needs of their local populations.

Analysis of public health data highlights that North East Lincolnshire:

- Is one of the top 20% most deprived areas in the country
- Life expectancy is lower in the most deprived areas of North East Lincolnshire when compared to the least deprived areas, for men this is 13.1 years lower and for women 9.1 years lower
- In school year 6, 21% of children are classified as obese.

This compares to data for NL which sets out that:

- Life expectancy is lower in the most deprived areas of NL when compared to the least deprived areas, for men this is 9.7 years lower and for women 9.1 years lower
- In school year 6, 20.6% of children are classified as obese.

NHS North East Lincolnshire CCG

NEL CCG is responsible for commissioning health and adult social care services for over 165,000 people in North East Lincolnshire and is committed to putting families and communities at the very heart of everything they do.

They are also part of the HCP and part of the Humber Transforming Care Partnership for Learning Disability.

By working in partnership with North East Lincolnshire Council, NHS NEL CCG is able to deliver joined-up health and adult social care services for local people.

NHS North Lincolnshire CCG

NL CCG is responsible for planning and paying for healthcare services in the region. In early 2019, NL CCG developed a strategy to guide how they plan and deliver healthcare services for people living in NL over the next five years. They want to:

- enable good health
- keep people out of hospital where needs can be met in the community
- support children and families to live independently
- ensure mental health is given the same priority as physical health.

Through implementing these changes, NL CCG will create a healthier, more sustainable future for NL.

https://northlincolnshireccg.nhs.uk/wp-content/uploads/2019/07/NLCCG-Strategy-2019-2024.pptx

The Strategy details what NL CCG's ambitions are for the next five years and how they intend to achieve them for their population.

NHS NL CCG have also worked alongside NL Council to produce a joint Health and Care Integration Plan. This five-year plan shows how they intend to focus on transforming the lives of the people of NL through developing an integrated health and social care system that empowers the local population.

In addition, NLaG takes some patients from East Riding and Lincolnshire CCGs where appropriate.

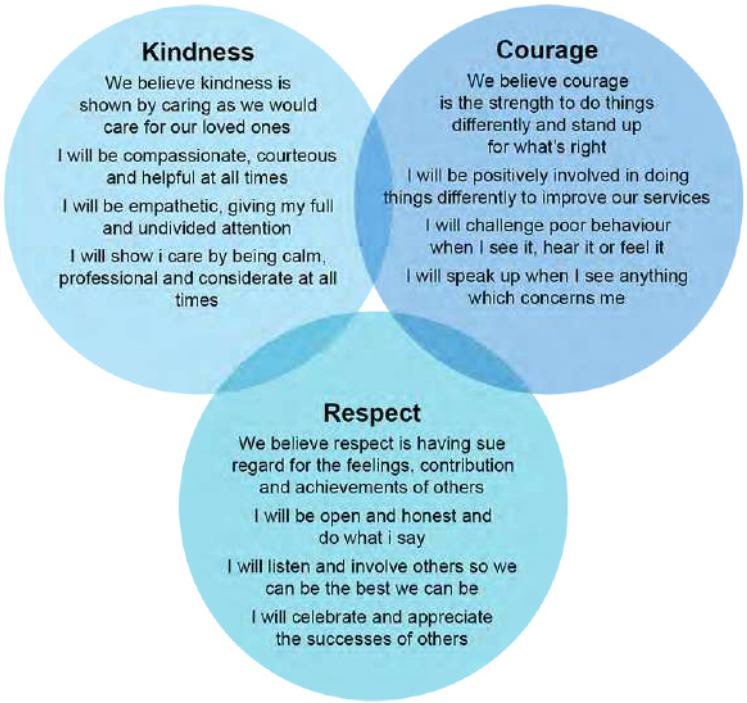
Trust Values and Behaviours

During 2018 the Trust engaged over 800 staff and stakeholders, in creating the Trust vision, values, behaviours and strategic priorities for the organisation from 2019 – 2024.

Through its Pride and Respect programme to improve the culture of the organisation, NLaG spent a long time talking to staff about their values and how they matched, or not, with those of the Trust.

As a result of this work a decision was taken to change the values to reflect what staff said. The new Trust values and behaviours of **Kindness, Courage** and **Respect** were agreed at the start of 2019.

Figure 34 - Trust Values & Behaviours



Trust Principles and Objectives

- The following table details the principles and objectives under the Trust's Strategic Framework.

Table 51 - Trust Principles and Objectives

Principles	
Right care, right place, right time	• Patients are very clear they want, wherever possible, services which are close to them and their homes. Whilst this is not always possible – because of the lack of specialist staff, for example – it is something which the Trust is committed to achieving as much as it can. To make this happen the Trust will be looking at how technology can help to provide services in a different way. • Specifically, the Trust will be working on the basis that: • Staff travel to treat the patient where clinically appropriate • Treatments for some conditions at specialist hospitals • Use virtual technology • More and more use of technology for patient appointments to save coming to hospital.
Whole system thinking, whole system practice	• This principle is all about making sure all the different organisations offering healthcare in the Northern Lincolnshire and Goole areas, as well as across the Humber and wider where appropriate, work together so patients only tell their story once and information about them can be viewed by anyone who needs to see them. It also means making sure patients, wherever they live and whatever they need, get the same service and level of care. • The Trust aims to: • Work together with other organisations so patients get what they need every time • Deliver the same service and care to Patients wherever they are seen.
Patient Centred Care	• All the evidence shows patients like to be involved and communicated with so they know what is happening to them and why. It helps them to understand their condition, what treatment they are receiving and often means they recover more quickly. Making sure this happens every time the Trust needs to involve patients and their families and carers when it is making decisions to change services or provide them in a different way. Sometimes Trust staff think they are working on things which they think are important to patients when actually the patients want them to spend time doing something else. • To stop this happening, and to make sure we really do focus on our patients' needs, the Trust will: • Listen to feedback from our patients to improve what we do • Do our best to provide what is important to patients • Learn lessons and make changes from complaints and incidents • Involve patients, carers and families in future service changes.
Transformation of services where appropriate	• Given the challenges the Trust faces, it is clear it cannot continue to do what it has been doing. NLaG does not have the staff or infrastructure (in terms of buildings and equipment) to do that. Accessing the sums of money needed to put this right, which totals more than £50 million, is very unlikely. Even if the money was available, NLaG would not have the staff available to run services because of the national shortage of doctors and nurses. This means working with other hospitals and partners to create services which, together, do have the specialist staff to offer safe and effective services. • The Trust also needs to learn from peers on better ways to run services to improve the outcomes for patients. If all of this is undertaken three vibrant and sustainable hospitals offering high quality services to our communities can be created. • This can only be achieved if NLaG: • Reshapes the workforce • Works in a different way so the specialist skills of each member of staff is used effectively • Learns from others with regard what improves services and make those changes in its hospitals • Maximises the use of new technologies – for patient care, service delivery and staff development • Benchmarks and adopts best practice • Is outward looking and learns from the best.

Objectives	
To give great care	• We want to offer high quality, safe services which are stable and are not reliant on just one or two members of staff. We want to make sure we have a culture of continuous improvement and we learn from incidents and other hospitals. We want to make sure we focus on patients and their needs. • So, to provide great care we will work and make decisions where we: • Never compromise on safety • Give care which works and is clinically proven • Work on what matters to patients • Always seek to learn and make improvements.
To be a good employer	• Our staff are, without question, our most important asset. We need to do everything we can to offer great jobs and career progression in an environment where everyone feels supported, appreciated and invested in. We want our staff to feel they can raise concerns and ideas and know they will be listened to. Only by doing these things will we begin to attract and retain the numbers of staff we need to run our services. • We will therefore look to: • Develop a skilled and motivated workforce • Promote staff wellbeing • Create a safe and nurturing environment • Listen to the concerns and ideas of staff.
To live within our means	• For many years the Trust has spent more money than it gets in. It is for this reason it was put into Financial Special Measures. We need to be better at financial planning and managing our scarce financial resources. Reporting a deficit very year is not something the Trust can do forever. In the next five years we need to make sure every pound we receive is spent in the right way and we make sure we live within our means. • So, we will be aiming to: • Deliver value for money • Work to eliminate the deficit • Spend every pound wisely • Innovate and educate to save • Secure more investment.
To work more collaboratively	• The Trust is not in a position to offer high quality services to everyone who needs them. Some patients' needs are too complex for us to treat as we don't have the specialist skills and knowledge to do that. Other patients need the support and help of mental health specialist teams which we do not have. For the local health providers to do the best for every single person in our communities we are going to have to work together. This means, for example, thinking about new ways to attract staff who might work for a number of organisations. • To make sure we collaborate more the Trust will: • Work with others to provide sustainable services • Develop talent for the health community • Use resources in the best way we can.
To provide strong leadership	• This strategy can only be successful if all the Trust's staff are committed to making it happen. That commitment comes from making sure they have the tools, knowledge, skills, and equipment they need to provide the care they strive to. It also means they have managers who show a similar commitment to make sure their teams are working effectively, and everyone knows what they need to do and how they are going to do it. Our leaders need to be role models for all that is best in the NHS and in the Trust. By doing this they will create ambitious, motivated and successful teams. • As such we see strong leaders to be those who: • Ensure professional standards • Be ambitious and aspirational • Role model values and behaviours • Develop skills and knowledge • Strengthen team working.

Trust Strategic Framework – 2019-2024

NLaG's Trust Strategy (Strategic Framework) 2019-2024 complete with other supporting strategies will provide the framework within which operational planning will take place over the next five years. It not only addresses existing challenges but is also in alignment with National and Regional objectives.

It describes how the organisation will achieve the vision and values within defined principles to achieve their six key priorities. This will be achieved through a system-wide approach, working in collaboration with key stakeholders, to align key assumptions over the next five years.

Figure 35 - Strategic Framework 2019-2024

At a high level the strategy is focused on delivering the following outcomes which will address current challenges facing the Trust:

- Improved patient experience
- Improved clinical outcomes
- Reduced waiting times
- Equity of access for patients
- Safe services.

Trust Strategic Priorities

The strategy states that by 2024 the Trust will deliver its six priorities as follows:

Table 52 - Delivery of the Trust's Strategic Priorities

Ref	Priority	
1	**Integrated Urgent & Emergency care**	• The creation of an urgent and emergency care service which means patients are seen by the right staff members in the best place for them and as quickly and efficiently as possible. Often this means patients are not seen or treated in the A&E department (as they have been for many years) but in other, more appropriate services. In order to achieve this the Trust will, over the next five years: • Develop and implement community-based assessment for frail patients • Achieve the integration of UTCs • Create multidisciplinary assessment models combining surgical and medical assessment • Ambulatory care and short stay services to reduce length of stay and avoid admissions • Achieve the reconfiguration of existing infrastructure through allocated capital funding to combine the above services into appropriately located multidisciplinary assessment units • Deploy allocated capital funding to locate the above services together.
2	**Transformed outpatient services**	• The NHS 10 Year Plan sets out the national vision for outpatient's services. It is ambitious and talks about reducing visits to hospitals for these appointments by about a third, using technology to achieve this. The plan also talks about finding better ways for different healthcare services to share information about patients. In order to make sure the Trust can meet these ambitions it will, in the next five years, work to: • Implement advice and guidance across all specialities to improve referral flow and reduce demand • Achieve virtual clinics to avoid the need to attend hospital • Develop and implement shared care plans with other healthcare professionals • Develop digital systems to deliver a third of outpatient attendances out of hospital.
3	**Worked in partnership with Primary Care Networks**	• Working more closely with primary care, i.e., GPs and their surgeries, is another key element of the NHS 10 Year Plan. This makes sense to share resources – people and money – and to share getting the best out of them through shared training, recruitment and retention approaches. In the next five years the local health system will change through the development of PCNs. Each network consists of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. The Trust will work with these networks to: • Explore opportunities to join resources with primary care • Strengthen clinical recruitment and training across the healthcare system • Work to share skills and knowledge across the primary care system.
4	**Reconfigured specialties on to one site where appropriate**	• Through the HASR the Trust will ensure all services are reviewed and assessed to provide optimal care for the population in the right place and at the right time with a particular focus on: • Development and implementation of a Cardiology Strategy • Review of maternity and paediatrics to meet the required standards and ensure we have the right pathways and service support in place • Development and implementation of a Medicine Strategy • Development and implementation of a Surgery Strategy.
5	**Restructured cancer services**	• Cancer services are one of the areas where the Trust needs to improve: to make sure patients get access to diagnostics quickly and, where cancer is identified, treatment can start as soon as possible. The Trust does not have access to skilled and experienced cancer specialists and needs to change what it does to make sure it provides the best possible care to every patient. It will look to do this by working with other Trusts and hospitals which do have the experienced staff as well as the facilities to provide the very latest treatments. To ensure this happens in the next five years the Trust will: • Review and assess tumour site services to provide best care • Explore and develop new models of care to ensure faster diagnosis is delivered in 28 days and treatments provided to time • Expansion of MRI and CT scanning through capital funding to implement new scanners.
6	**Create a sustainable hospital at Goole**	• The Trust wants to create three vibrant hospitals to serve its local communities, this means focusing on Goole as well as Grimsby and Scunthorpe. In 2019/2020 the Trust set a priority to move more planned care to GDH. This was the start of a longer-term piece of work to create a sustainable hospital in the town. In the following years the Trust will: • Increase the elective/day case planned surgery provision to its full potential • Through wider integration, develop opportunities to create a base for a centre of excellence i.e. rehabilitation services.

- ***'These priorities underpin our work not only internally but also with external partners as we seek to identify opportunities to deliver services more collaboratively across the Humber region'.***

The quality priorities are a significant part of the Trust's Clinical Strategy in terms of providing safe, effective and responsive services.

Quality Priorities

Quality is at the heart of the organisation's priorities in all domains of patient care and experience. The approach within the Trust's five-year strategic plan outlines what NLaG is aiming to achieve through a quality perspective and alignment to national, regional and local priorities.

During 2019/2020, the Trust reviewed and aligned its five year quality strategy with the Trust's strategic direction.

The strategy, based upon the National Quality Board's (NQB) 'Shared Commitment to Quality', outlines that whilst also setting long term quality objectives that are linked to the Trust's strategic objectives, the Trust will continue to review and set annual quality priorities.

Following consultation and subsequent setting of the 2020/2021 quality priorities, the Trust received the Care Quality Commission's (CQC) inspection report of Trust services in February 2020.

The CQC report identified a number of quality themes requiring further improvement focus. The Trust will prioritise the delivery of these areas for further improvement, and there is a close correlation between the 2020/2021 quality priorities and many of the CQC recommendations.

The Trust's local priorities were set following a review of performance during the year and reflection of where further improvement or assurance is needed. The Trust has agreed 6 quality priority areas for 2020/21which are shown in table 39 below:

Table 53 - 2020/21 Quality Priorities

Ref	Priority		
1	**Patient Experience**	Waiting lists	QP1: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups
2	**Clinical Effectiveness**	Mortality and End of Life	QP2: Reduce mortality rates and strengthen end of life care
3	**Patient Safety**	Management of Diabetes	QP3: Improve the management of diabetes
4	**Patient Experience & Clinical Effectiveness**	Cancer Pathways	QP4: Improve the effectiveness of cancer pathways focussing on time to diagnosis
5	**Patient Experience & Clinical Effectiveness**	Quality and Timeliness of safe Flow & Discharge	QP5: Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon
6	**Patient Experience**	Patient Feedback	QP6: Improve the quality and timeliness of complaints responses using a more individualised approach

Supporting Strategies

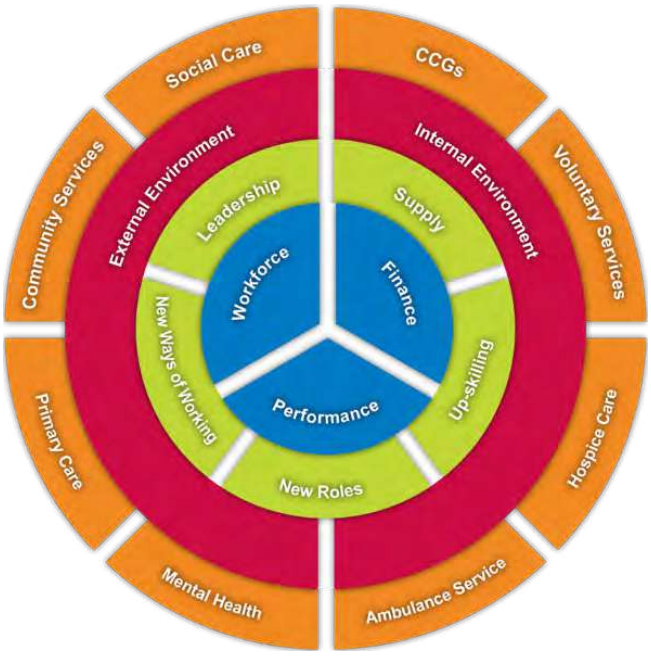
Workforce Transformation

The Trust's vision for internal and external workforce transformation supports a more systematic and effective approach to workforce redesign in support of the long-term plan, quality priorities and transformation changes. This includes transformation for current and future workforce by working with partner agencies, introducing new roles and new types of workers and alternative models of care.

Strategic transformation will be achieved by reducing demand on current acute services through changing the way we work together as described in the transformational schemes. This is both internally and externally, across the whole local health and social care economy; thereby creating a portable and flexible local workforce.

This will be responsive to change, through new models of care, increased use of digital and other technology delivered through a collaborative approach.

Figure 36 - A collaborative approach to Workforce Transformation



Digital Strategy

Trusts which have embraced technology are realising efficiencies in administrative processes, safer care delivery and improved quality of care and outcomes for patients. It has also driven shared responsibility for health by patients and care providers and contributed to attracting and retaining a workforce that wants to work with the cutting-edge technology.

While a Digital Strategy is about the business, it is equally about people and culture. To be successful, it will require everyone to lead and model the behaviours of a '***digital hospital***'. By adopting a digital first approach, patients, families, and care providers can expect:

- **Better, more connected tools for frontline providers:** Providers will be able to access patient records stored across multiple health service providers to provide better, safer, faster care. Digital initiatives championed and owned by clinicians will be identified and driven through to create a more user-friendly experience to help care providers better manage patient pathways and improve quality of work life for employees.
- **Greater data access for patients:** More patients will be able to review their secure health record online and make informed choices about their care. This means that the patient's electronic records are interoperable and connect with other systems.
- **Digital inclusion:** Understand the digital maturity of the community and create ways to educate and help citizens access and use digital tools to support the management of their health and wellness journey.
- **Digital workforce:** Upskilling current staff in digital skills and building a digitally literate workforce which will be able to champion innovation and drive through digital initiatives, as well as attracting digital talent. Digital leadership through a Chief Information Officer (CIO)/ Chief Clinical Information Officer (CCIO)/Chief Nursing Information Officer (CNIO) will help with targeting where digital skills need to be focused for employees and will support embedding of digital literacy within the organisation.
- **Data integration and predictive analytics:** Providers will face fewer barriers to integrating and using secure health information to manage health resources and improve patient care. The goal will be to achieve improvements such as earlier intervention and better management of chronic disease. To provide correlations across data sources to predict and improve health outcomes.
- **Strengthening of community linkages to broaden the circle of care:** Modernising digital tools will enable the Trust to reach primary care, community care services and care homes joining up the patient's life cycle from cradle to end of life care.
- **More virtual care options to enable *'care where I am'*:** Expanding availability of video consultations and enabling other virtual care tools such as secure messaging and electronic reminders. Additionally, providers will be able to leverage a variety of virtual care technologies that best meet patient's needs. This includes remote monitoring devices that enable remote care delivery and broader reach within the community.
- **Introducing innovation:** Once the foundations are modernised and there is high adoption of digital processes and transformation, the Trust will be in a position to introduce Artificial Intelligence (AI) and robotic automation and recommend apps that provide more personalised choice and access to health and care information.

The Trust also needs to consider the digital element of a safe and sustainable infrastructure to enhance Estates and Facilities inter-operability, e.g., improved Building Management System (BMS) telemetry, automation control systems.

The National Context

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

The NHS Long Term Plan (LTP) published in January 2019 and the interim NHS People Plan published in June 2019 set out the policy context and guidance for the delivery of services over the next 10 Years.

NHS Long Term Plan

Health and care leaders have developed a LTP to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment. The plan has been drawn up by a number of stakeholders including frontline health and care staff, patient groups and other experts.

Looking towards the future, the NHS LTP must tackle the pressure its staff are facing while making extra funding go as far as possible. As it does so, it must accelerate the redesign of patient care to future-proof the NHS for the decade ahead. The Plan sets out how the NHS will do that. As an organisation it will be able to because:

- There is a secure and improved funding path for the NHS, averaging 3.4% a year over the next five years, compared with 2.2% over the past five years
- There is consensus about the changes now needed. This has been confirmed by patients' groups, professional bodies and frontline NHS leaders who since July 2018 have all helped shape this plan – through over 200 separate events, over 2,500 separate responses, through insights offered by 85,000 members of the public and from organisations representing over 3.5 million people
- Work that began after the NHS Five-Year Forward View (FYFV) is now beginning to bear fruit, providing practical experience of how to

bring about the changes set out in the Plan. Almost everything in the Plan is already being implemented successfully somewhere in the NHS.

The NHS LTP sets out to improve care for patients over the next ten years through a number of ways. Its vision is organised into three overarching aims:

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems
- Supporting people to age well.

Namely the NHS Long Term Plan is looking to:

- Develop a new service model for the 21st Century:
  - Boost 'out of hospital' care and dissolve the historic divide between primary & community health services
  - Reduce pressure on emergency hospital services
  - Give people more control over their own health and more personalised care when they need it
  - Go mainstream with digitally enabled primary and outpatient care across the NHS
  - Increasingly focus on population health – moving to ICS.
- Increased action on prevention and health inequalities (to included smoking, obesity, alcohol etc.)
- Progress care quality and outcomes:
  - A strong start in life for children & young people improving:
  - Maternity & neonatal services
  - Children & young people's mental health services
  - Learning disability & autism
  - Children & young people with cancer
  - Redesigning health services for children & young people.
- Better care for major health conditions (e.g., cancer, cardiovascular disease stroke care, diabetes, respiratory disease, adult mental health services):
  - Short waits for planned care
  - Research & innovation to drive future outcomes improvement.
- Supporting NHS staff through:
  - A comprehensive new workforce implementation plan
  - Expanding the workforce
  - International recruitment
  - Enabling productive working.
- Deliverables for sustainable development:
  - Reduce air pollution and environmental impacts
  - Ensure net zero standards in all new builds and refurbishments.

Delivering a 'Net Zero' National Health Service

In October 2020 the NHS published the ***'Delivering a Net Zero National Health Service'*** in response to the health emergency that climate change will bring. More intense storms and floods, more frequent heatwaves and the spread of infectious disease from climate change threaten to undermine years of health gains.

Two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

- For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- For the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

A number of early steps will be taken to decarbonise:

Table 54 - Steps towards decarbonisation and a 'Net Zero' NHS

Ref	Step	
1	**Our Care**	By developing a framework to evaluate carbon reduction associated with new models of care being considered and implemented as part of the NHS LTP.
2	**Our Medicines & Supply Chain**	By working with our suppliers to ensure that all of them meet or exceed our commitment on net zero emissions before the end of the decade.
3	**Our Transport & Travel**	By working towards road-testing for what would be the world's first zero-emission ambulance by 2022, with a shift to zero emission vehicles by 2032 feasible for the rest of the fleet.
4	**Our Innovation**	By ensuring the digital transformation agenda aligns with our ambition to be a net zero health service and implementing a net zero horizon scanning function to identify future pipeline innovations.
5	**Our Hospitals**	By supporting the construction of 40 new '***net zero hospitals***' as part of the government's Health Infrastructure Plan with a new Net Zero Carbon Hospital Standard
6	**Our Heating & Lighting**	By completing a £50 million LED lighting replacement programme, which, expanded across the entire NHS, would improve patient comfort and save over £3 billion during the coming three decades.
7	**Our Adaptation Efforts**	By building resilience and adaptation into the heart of our net zero agenda, and vice versa, with the third Health and Social Care Sector Climate Change Adaptation Report in the coming months.
8	**Our values & our governance**	By supporting an update to the NHS Constitution to include the response to climate change, launching a new national programme For a greener NHS, and ensuring that every NHS organisation has a board-level net zero lead, making it clear that this is a key responsibility for all our staff.

Primary Care Networks (PCNs)

The establishment of PCNs were formally announced in the NHS LTP. The vision of what PCNs would be and what they might be expected to do, was outlined in the new GP Contract that was published on 31st January 2019 whilst details of funding were published on 29th March 2019.

PCNs are groupings of local General Practices (GPs) that are a mechanism for sharing staff and collaborating while maintaining the independence of individual practices. NHSE and has stipulated that networks should 'typically' cover a population of between 30,000 and 50,000 people (the average practice size is just over 8,000). There are likely to be around 1,300 PCNs across England.

The networks are part of a set of multi-year changes, supported by the new five year GP contract published in January 2019. Neighbouring practices enter network contracts in addition to their core GP contract. Groups of practices collaborating as a network will have a designated single bank account through which all network funding – a significant proportion of future practice income – will flow. NHSE has calculated that by 2023/2024 a typical network covering 50,000 people will receive up to £1.47 million via the network contract.

The new GP contract is designed to deliver commitments made in the NHS LTP, for example on medicines management, health in care homes, early cancer diagnosis and cardiovascular disease case finding. PCNs are the key vehicle for doing this. Once they are formed, networks will have responsibility for delivering seven national service specifications set out in the contract in return for the new funding.

By formalising PCNs, the 2019 GP contract goes further than any previous efforts in giving clarity and direction on both form and function of general practice at scale in England. In particular, it is intended that new kinds of staff, including pharmacists, physiotherapists and paramedics, will become 'an integral part of the core general practice model throughout England,' rather than optional add-ons who could be 'redeployed at the discretion of other organisations'. According to NHSE, the networks will 'enable greater provision of proactive, personalised, coordinated and more integrated health and social care'. Three key rationales put forward for PCNs in both the NHS LTP and the 2019 GP contract (the latter in conjunction with the British Medical Association (BMA)) are set out below:

- A pragmatic response to chronic workforce challenges
- Consolidating general practice in the wider health system
- Improving population health.

Lord Carter's Report: Operational Productivity and Performance in English NHS Acute Hospitals

Lord Carter of Coles' report (February 2016) sets out how non-specialist acute trusts can reduce unwarranted variation in productivity and efficiency across every area in the hospital, to save the NHS £5 billion each year by 2020/2021. The final report builds on the findings of the interim report and sets out further findings of variation across 32 non-specialist acute trusts.

The final report details how hospitals must standardise procedures, be more transparent and work more closely with neighbouring NHS trusts.

Lord Carter's review found unwarranted variation in running costs, sickness absence, infection rates and prices paid for supplies and services. Implementing the recommendations will help end variations in quality of care and finances.

As part of the review, a '*Model Hospital*' reporting system has been developed which advises NHS trusts on the most efficient allocation of resources and allows hospitals to compare and measure their performance against other peer organisations. Other areas covered by the report include:

- **Appendix 1: Staffing** - The review calls for an improvement in the way the NHS deploys its staff, ending the use of outdated and inefficient paper rosters
- **Appendix 2: Procurement** - As part of the review, from April 2016, Trusts will publish their receipts on a monthly basis for the top 100 items bought by the NHS such as bandages, needles and rubber gloves
- **Appendix 3: Use of Floor Space** - Trust's unused floor space should not exceed 2.5% and floor space used for non-clinical purposes should not exceed 35%
- **Appendix 4: Administration Costs** - These should not exceed 7% by 2018 and 6% by 2020
- **Appendix 5: Delayed Transfer of Care** - Lord Carter has called for action to be taken on the 'major problem' of delayed transfers of care, which affect hospitals and Trust's earning and spending capacity
- **Appendix 6: Working with Neighbourhood Hospitals** - Lord Carter advises Trusts to work closely with their neighbouring hospitals, sharing services and resources to improve efficiency and reduce costs.

Options considered within this Estate Strategy will enable NLaG to deliver against some of the key recommendations in Lord Carter's report.

The Naylor Review

Sir Robert Naylor's review, '***NHS Property and Estates – Why the Estates Matter for Patients'***, was commissioned by the DHSC in 2017 and evaluates the condition of premises that are used to deliver NHS funded care in England. The review explains that change in estates is required in order to deliver new models of care in respect of expanding and strengthening primary and out-of-care hospital care. The review concluded that major investment is required to develop new models of care that will be capable of dealing with the growing numbers of older patients with chronic diseases and with the increasing problem of delayed transfers of care.

The review recognises the need for estates to change in order to meet the challenges associated with modern health needs. The Naylor review makes seventeen recommendations which are categorised into three areas:

- Appendix 1: Improve capability and capacity to support national strategic planning & local delivery
- Appendix 2: Encouraging and incentivising local action
- Appendix 3: Funding and National Planning.

This Estate Strategy is to be developed within this context, recognising the need to develop and improve the estate. The review encourages accountable care, whereby an individual organisation becomes responsible for the health needs of a given population, rather than the fragmented system this is support by the integrated approach to healthcare provide by this project. The report discusses the impact of community care and the benefits available through using estates to achieve this.

Policies and Guidance

Other key national drivers, policies and guidance underpinning the Trust's Annual Plan in service delivery and supporting safe practice are set out as follows:

Table 55 - Policies and Guidance

Health and Social Care (H&SC) Act 2012	• The Government's H&SC Act outlines NHS commissioning arrangements.
Care Quality Commission (CQC)	• The CQC implements the following five domains of quality care, against which to assess provision of care: • Safety • Effectiveness • Caring • Responsive to people's needs • A well-led organisation In addition, the CQC has also implemented an intelligent monitoring approach to give inspectors a clear picture of the areas of care that need to be followed up within an NHS trust.
NHS Operating Framework	• *Everyone Counts: Planning for Patients 2014/2015 to 2018/2019* sets out the business and planning arrangements for the NHS. The NHS should be aiming to improve five high-level outcome domains (see below): • Domain 1 – Preventing people from dying prematurely • Domain 2 – Enhancing quality of life for people with long-term conditions • Domain 3 – Helping people to recover from episodes of ill health or following injury • Domain 4 – Ensuring that people have a positive experience of care • Domain 5 – Treating and caring for people in a safe environment; and protecting them from avoidable harm
Quality, Innovation, Productivity and Prevention (QIPP)	• QIPP is the umbrella term used to describe the approach the NHS is taking at local, regional and national levels to reform its operations and redesign services in light of the economic climate. By assessing reforms against the four components – Quality, Innovation, Productivity and Prevention – the NHS intends to provide better-quality services in the most productive and cost-effective way possible (while making the best use of the potential of innovation and targeted investment in prevention). The four QIPP components are both distinct and inter-related. Initiatives focus on particular elements or bring some/all of the components together.

The NHS Five Year Forward View (2014) **and** **Next Steps on the NHS Five Year Forward View (2017)**	• The purpose of the NHS FYFV is to articulate: • Why change is needed • What that change might look like • How it can be achieved	• The NHS FYFV describes new models of care, defining actions required at local and national level to support their delivery. These are likely to include: • More integrated hospital care • Extended primary care • Concentration of elective care • Urgent/emergency care networks • Greater use of technologies
	• A mid-term review of the national NHS FYFV outlines progress against the vision of closing healthcare and financial gaps and moving to new care models. • In relation to the development of Sustainability & Transformation Plans (STPs), the 2017 FYFV review recognises a flexible approach to developing them alongside opportunities for shared decision-making at STP level. It signals a move to focus on Sustainability & Transformation Partnerships: • Allowing different STPs to move at different speeds • Enabling the fastest to progress without delay • Not forcing others to adopt a single uniform approach	
Future Hospital: Caring for Medical Patients, Royal College of Physicians (RCP) (Sept 2013)	• The Future Hospital Commission was established by the RCP: it is an independent group tasked with identifying how hospital services can adapt to meet the needs of patients, now and in the future. Its report, Future Hospital: Caring for Medical Patients sets out the commission's vision and recommendations.	

COVID-19

The Impact of COVID on the working practices of the NLaG Estate and the services delivered has been a positive step forward enabling a number of staff to be able to work remotely while also potentially enabling a left shift of certain services into the community, freeing up valuable clinical space within the Acute sites. It is anticipated that NLaG will continue to deliver these services out in the Community in line with future the strategic direction of the Trust and the work is being co-ordinated by the "Agile working Steering Group".

The Regional Context

Humber, Coast & Vale Health & Care Partnership

NLaG is part of the Humber, Coast & Vale Health & Care Sustainability Transformation Partnership (HCV STP), which later became an ICS in April 2020, after its application for ICS status was ratified by NHS England and NHS Improvement (NHSE/I) An ICS is an even closer collaboration of NHS organisations, local councils and other health and care partners, taking collective responsibility for managing resources, delivering effective health and care services and improving the health and wellbeing of the population it serves.

Figure 37 - HCV HCP Region

The former STP, and now ICS, is a collaboration of nearly 30 different organisations across a geographical area of more than 1,500 square miles taking in cities, market towns and remote rural and coastal communities. The ICS covers six NHS CCGs and six local authority boundaries representing communities in Hull, East Riding, York, Scarborough and Ryedale, North Lincolnshire and NEL.

The scale of the ICS creates opportunities to share resource in areas where services are stretched, providing a better service to patients and a better experience for the staff who work within those services. Across the area support services such as finance can also be shared to reduce costs and improve efficiency. The principle aim of the partnership is to improve the health and wellbeing of the population it serves, as well as the quality and effectiveness of services. The partnership priorities are to:

- Help people look after themselves and to stay well
- Provide services that are joined up across all aspects of health and care
- Improve care provided in key areas
- Make the most of all our resources.

Building better places

HCV CP is leading and coordinating the building better places project which lays out the ambition to build a healthier vision for the Humber region. The following partners from across the public and private sector involved throughout the programme are:

- Greater Lincolnshire Local Enterprise Trust
- Hull City Council
- Hull University Teaching Hospitals NHS Trust
- Humber Local Enterprise Partnership
- North Lincolnshire Council
- NHS East Riding of Yorkshire CCG
- NHS Hull CCG
- NHS North Lincolnshire CCG
- NHS North East Lincolnshire CCG
- Shared Agenda
- University of Hull
- University of Lincoln

Investment Plans

HCAV HP's investment proposition is about much more than improving healthcare services and the places where they are delivered.

They are adopting a unique approach to its capital investment programme to ensure that it serves as a catalyst for economic and social revitalisation on a much grander scale, transforming the lives and welfare of people and communities across the Humber region.

Plans include the:

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

The Partnership's plans encompass eight unique visions, spanning the region's economy, healthcare services, buildings, workforce, digital infrastructure, sustainability, research and development, and long-term prosperity.

By driving a collaborative, region-wide approach to investment planning and implementation between Local Authorities (LA), NHS organisations, Local Enterprise Partnerships (LEP), universities, and private and public sector organisations, the partnership can achieve its bold ambitions and deliver a lasting legacy of transformative health improvements across the Humber, building great places to live, learn and work for generations to come.

Table 56 - HCAV HCP's Vision

HCAV HCP's Vision for Humber's Future	What we'll do • Power collective prosperity through healthcare investment by building great places to live, learn & work.
	What we'll achieve • **A thriving economy** – inclusive long-term economic growth which benefits everyone in our region, through **strategic expansion in key sectors**, from health and care, to ports and logistics, green energy and sustainability, and data, research and innovation • **Thriving organisations** – growth and expansion of local private and public sector organisations, through **closer collaboration, shared use of resources** and extending regional prosperity • **A Thriving population** – sustained improvements in health and wellbeing for local people through the provision of better jobs, housing, education, cultural opportunities and community assets • **Levelled up communities** – reduce inequality across our region, through targeted community development and a collective focus on creating opportunities and raising aspirations.
Building better prosperity	What we'll do Unlock the potential of our region and its people through **investment in healthcare infrastructure.**
	What we'll achieve Healthcare facilities that re fit for the future by: • **Transforming or replacing our existing hospitals to provide new state-of-the-art health and care campuses,** using leading edge design. This will significantly improve patient care whilst also promoting research, innovation and greater employment prospects. • Sustained and inclusive economic growth by: • Maximising the benefits of our investment programme for local people through **forging new cross-sector partnerships** • Supporting inclusive opportunities and prosperity by driving a **collaborative approach** to developing our investment proposal • Growing our workforce by **working with education partners** to equip people with the skills and knowledge to build long-term healthcare careers • Boosting our economy through **partnering with local suppliers** and leveraging the buying power of NHS organisations • Optimising investment potential by taking a creative approach to funding opportunities, achieving financial stabilisation across Humber organisations and **being more efficient with our assets** • Shaping regional corporate, operational and workforce plans around maximising the long-term economic and social benefits of **capital investment** • Evaluating the impact of the investment on the region using financial modelling.
Building better services	What we'll do Create a network of vibrant healthcare campuses to meet the changing needs of our communities.
	What we'll achieve Expanded provision of care by: • Enabling people to get advice and treatment more easily by **improving access to routine care in community settings** and offering more digitally enabled care • Helping more people access high quality treatment by **improving the way our hospitals work together** • More efficient management of services by: • Helping hospital staff make the best use of resources by implementing a **networked approach to care planning and delivery** • Streamlining and accelerating treatment by **investing in fully connected services**, underpinned by common ways of working, pooled resources and shared records • Reducing risks to the delivery of safe and effective care through **implementing sustainable service models** that maximise positive results.

Building better infrastructure	What we'll do Future proof our healthcare buildings to ensure long term service quality.
	What we'll achieve Significantly improved standard of care by: • Maximising the prevention and control of infection by **developing state-of-the-art healthcare hubs** • Helping staff to provide exceptional specialist treatment by **developing networked services** across our five sites • Widening access to care by taking a collaborative approach to estate management • Sustainable and adaptable infrastructure by: • Making best use of resources by seamlessly blending new and retained buildings • Ensuring our healthcare hubs can be **upgraded** to incorporate the latest technologies and ways of working through utilising **intelligent, flexible design** • Capitalising on local expertise in **modern methods of construction** to build high quality, sustainable buildings fit for the future.
Building our future workforce	What we'll do Create opportunities for our population to thrive by offering rewarding careers and nurturing future talent.
	What we'll achieve A flexible and diverse workforce that meets our needs by: • Investing in, nurturing and training our current and future workforce, equipping them to provide the highest quality healthcare and looking after their mental and physical wellbeing • Introducing more flexible roles and **enabling staff to move between organisations** and sectors with ease • **Creating vibrant and dynamic places to live and work**, attracting the brightest and best to work in our organisations • Encouraging and supporting our staff to be innovative and lead the design of **new ways of working** A region of opportunity where everyone can thrive by: • Working with schools and colleges to promote careers in health and care, remove barriers to entry and raise aspirations of our young people • Offering flexible career pathways that enable people at all stages of life to reach their full potential • Tackling discrimination, encouraging diversity and creating a sense of belonging • Collaborating with universities and private sector organisations to generate employment opportunities in other related industries.

Building better connected services	What we'll do Use digital technology to power our services and create better connected people and communities.
	What we'll achieve Improved health and care for local people by: • Empowering people to take charge of their own wellbeing by giving communities access to support through dedicated apps and websites • Ensuring everyone can benefit from digital opportunities by working with partners to take a proactive approach to digital inclusion • Enabling more patients to access round the clock care by empowering staff to digitally connect with people from anywhere, at any time • Driving innovation through continually upgrading our infrastructure and services and designing new buildings that are fully digital enabled. More effective, data driven decision making by: • Empowering staff and patients to make better healthcare choices by pooling data across organisations into one accessible, centralised digital source • Increasing access, visibility and accuracy of patient information by storing data in one centralised place, utilising the Yorkshire and Humber Care Record • Enabling practitioners to make better choices about care through sharing data across organisations to give them a rounded view of patients' needs • Keeping our data fully secure by investing in the latest cyber-security technology.
Building better research opportunities	What we'll do Create outstanding and diverse learning environments to position the Humber as a centre for life changing research.
	What we'll achieve Expanded research, training and innovation capabilities by: • Increasing collaboration and aspiration in healthcare research through strengthening partnerships between our academic, public and private partners • Working with the University of Lincoln and the University of Hull to develop an ambitious collaborative research and development programme • Giving our workforce the resources they need to pioneer new ideas by **investing in our state-of-the-art healthcare hubs** • Cementing the Humber as a national driver of cutting edge advancements in health and care by building a culture of innovation across the region • Delivering on our ambitious plans for growth in clinical and applied healthcare research. Increased expertise across our workforce by: • Establishing the University of Hull's **Health Campus as a centre of excellence** in clinical and applied healthcare research • Increasing opportunities for local healthcare professionals through expanding and developing regional clinical academic careers • Broadening understanding of the role of research in enhancing and transforming healthcare services.

Building sustainable futures	What we'll do Put environment sustainability at the heart of our investments to maximise long term benefits for our region and the planet.
	What we'll achieve More eco-friendly services by: • Reducing carbon emissions and single use plastics across our healthcare campuses • Making better use of digital technology across our services and communities to reduce the environmental impact of healthcare delivery. More sustainable infrastructure by: • Incorporating cutting edge innovation into our development plans, combining the latest academic and industry expertise • Leveraging the assets, knowledge and expertise in green energy within the Humber to play our part in reducing the region's carbon footprint.

NLaG's Clinical Strategy cannot be created or delivered in isolation and this collaborative working across the health and care system will continue to strengthen the integration of services with a strong connection to integrate out of hospital care through PCN.

This has formed one of the Trust's priorities over the next four years.

NLaG will need to ensure wider care engagement and involvement with social care, community and voluntary sector.

The Estates Strategy will also need to align to the HCAV HCP Strategy which sets out its ambitions in three key areas:

- Making better use of existing buildings, including reduced running costs and increased sustainability
- Rationalisation of the estate and commercial disposal of surplus land and buildings
- Development and replacement of buildings and equipment to ensure business continuity and facilitate service transformation.

Humber Acute Services Review

This is a collaborative review of acute hospital services across the five main hospital sites in the Humber area – (DPoW in Grimsby; SGH; GDH; Hull Royal Infirmary; and Castle Hill Hospital). The Humber Acute Services Programme was established to create a Humber wide response to the challenges faced in delivering healthcare across a large geographic area which has high levels of health inequalities, deprivation and experiences significant issues in recruiting staff in some areas.

The review will look at how the ICS can provide the best possible hospital services for the people living in the area, whilst making best use of the money, staff and buildings that are available. Due to the COVID-19 outbreak and national lockdown, certain aspects of the HASR were paused or delayed so that resources can be focused on the frontline.

Background

Across the Humber area, local health and care organisations are working in partnership to improve services for the local population. Since 2018 they have been working together to carry out a review of how acute hospital services are provided in the Humber area. The review considers how to provide the best possible hospital services for the people of the Humber area within the resources (money, workforce and buildings) that are available. The review will consider both 'current' and projected 'future' needs for hospital services, taking into account local plans to improve and extend the types of care and treatment that are available outside of hospital settings. The purpose of this review is to develop plans for delivering

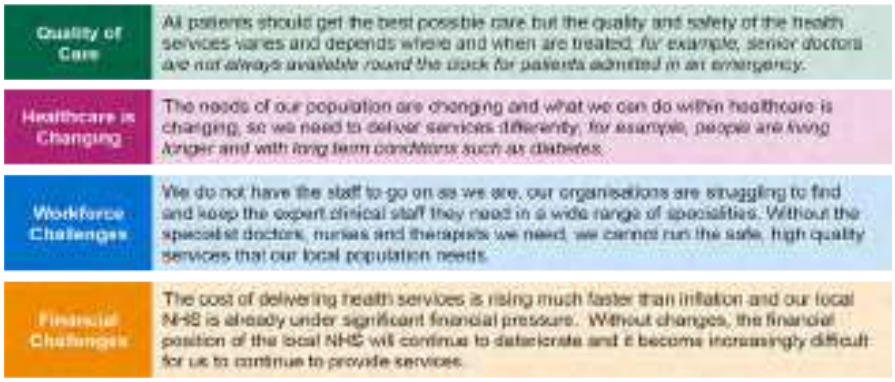
acute hospital services that are safe, sustainable and meet the needs of local populations across the Humber area. This may include delivering some aspects of care outside of hospital settings and in peoples' own homes to better meet the needs of the population.

A transparent and inclusive approach will be adopted at all stages of the process. The review will implement a rigorous process for generating and refining potential future scenarios that will offer a variety of opportunities for clinicians, staff, patients, the public and any other interested parties to share their views and ideas on how services could be delivered differently. Any significant service changes that are proposed will then be subject to formal consultation and the decision-making processes of the constituent organisations in the HCP.

What is the purpose of the review?

There are four key reasons why NHS services in the Humber area need to change:

Figure 38 - Four key reasons why the NHS in the Humber area needs to change the way it works



What will the review entail?

Across the Humber area, there are two acute hospital Trusts –NLaG and HUTH– which provide a variety of hospital-based services from five different hospital sites:

- DPoW, Grimsby;
- SGH;
- GDH;
- Hull Royal Infirmary;
- Castle Hill Hospital, Cottingham.

The review of acute hospital provision across the Humber area will consider how best to organise the acute hospital services that are currently being provided across the five acute hospital sites. The review will consider how to provide the best possible care for local people who need acute hospital services within the resources (money, staffing and buildings) that are available to the system.

The review will build on the well-established collaborations between NLaG and HUTH in the provision of acute hospital services but, where appropriate, will consider opportunities to develop additional collaborations with other acute providers. This will include looking outside of the Humber geography for some patients, particularly those living near the boundaries. Working as a Humber partnership will not preclude discussions with other providers where this will best address the needs of local people. Links have been established with HCPs in West Yorkshire, South Yorkshire and Lincolnshire who are conducting similar reviews to ensure coordination across areas. A similar review of acute hospital provision in the York/Scarborough area will also be undertaken in parallel. Further arrangements are being made for a specific group of services (e.g., Pathology) to be reviewed on a regional or multi-regional basis.

The purpose of the review will be to look at service arrangements across the Humber area and how these might be strengthened; it is not within the scope of the review to consider an organisational merger of the two hospital Trusts.

The review will investigate possible scenarios for the provision of acute services for the population of the Humber area that are person-focused, safe and sustainable. It will look at how we can work differently, making the most of new technology and new ideas to provide the best possible care for local people.

This may include delivering some aspects of care outside of hospital settings services meaning people can access care locally rather than having to go to an acute hospital as they do now. The review will be undertaken in accordance with the following principles:

- A commitment to provide acute hospital services that are patient-focused, safe and sustainable, meeting the needs of our population both now and in the future
- The service review will be clinically led
- The review will be evidence-based and take into account best practice
- The review will focus on hospital ***services*** rather than hospital buildings and organisations
- The review will be cognisant of local developments in out-of-hospital care and work towards solutions that support joined-up care across the system
- A transparent, collaborative and inclusive approach will be adopted at all stages of the process, ensuring engagement with key stakeholders from the outset
- Plans for the future provision of acute hospital services will be developed in accordance with the levels of human, physical and financial resource expected to be available
- Plans for the future provision will include urgent and emergency care and maternity care at Hull Royal Infirmary, DPoW in Grimsby and SGH
- The review will be undertaken in accordance with a project plan that sets out objectives, processes, timescales and resources.

At the time of developing this Estates Strategy the work undertaken to date by the review, considered within this document, includes:

Table 57 - Progress to Date of HASR

October 2019 Developing Outline Ideas (Public engagement)	A review team, led by an independent clinical lead, engaged with local clinicians to look at a range of possible ways of delivering services for each of the following key service areas: • Maternity and paediatrics • Urgent and emergency care • Planned care These possible approaches were displayed along a continuum from least to most change. Patients and their representatives were consulted at a series of events (throughout October 2019) about their views on these approaches. The review wanted to know what patients thought about the different ideas and whether they would have a positive or negative effect on them and their families.
November 2019 Refining Service Models (Citizens' Panel Meeting)	• Feedback from patient and public workshops, clinical design group meetings as well as a range of other engagement activities with clinical and non-clinical staff members and other stakeholders was used to refine the outline ideas into possible service models. The Citizens' Panel meeting in November 2019 reviewed the possible service models for the key clinical areas individually.
December 2019 – February 2020 Combining Service Models (Clinical Design Group)	• The Clinical Design Group was asked to review whether each possible clinical model would be sufficient to address the issues set out in the Case for Change (i.e., would the change be enough to solve the problems that the system currently faces, and be enough to provide safe and effective care for local people). • Looking at sufficiency enabled the Clinical Design Group to rule out a number of (theoretically possible) models. The next stage was for clinicians to review all the possible service models and combine them together into '***whole hospital***' models. Clinical colleagues felt strongly that it made most sense to start with urgent and emergency care and build planned care models around this. There are strong links (interdependencies) between urgent and emergency care services, maternity and paediatrics and therefore these have been combined first to create viable '***whole hospital***' models. • Across Hull and East Riding, these service areas are largely consolidated onto a single site and therefore the focus of this element of the review work is on the sites on the south bank of the Humber. Planned care will be brought back in at a later stage. The Clinical Design Group looked at the clinical interdependencies that might apply to determine which models could be safely put together on a single hospital site. The Clinical Design Group reviewed multiple iterations of the possible combinations and discussed the different interdependencies and the viability of the different models.
February to March 2020 Evaluating Clinical Models (Clinical Design Group/Citizens' Panel)	• The next stage of the process was to evaluate the different clinical models against the evaluation criteria set out at the start of the review as listed below: **Figure 39 - HASR - Evaluation Criteria** 

At its February meeting, the Clinical Design Group evaluated the four models set out above against two of the criteria (where they were best placed to exercise their professional judgement) – **workforce/staffing** and **clinical outcomes**.

It was then proposed that the Citizens' Panel would use their judgement and the information gathered through the patient feedback events to assess the four models against two further criteria – **access & transport** (getting there and parking); and **patient experience & satisfaction**.

The outcome of the above will be used to support decision-makers to confirm a short list of possible models, on which further engagement with clinical teams, patients, members of the public and other stakeholders can be undertaken.

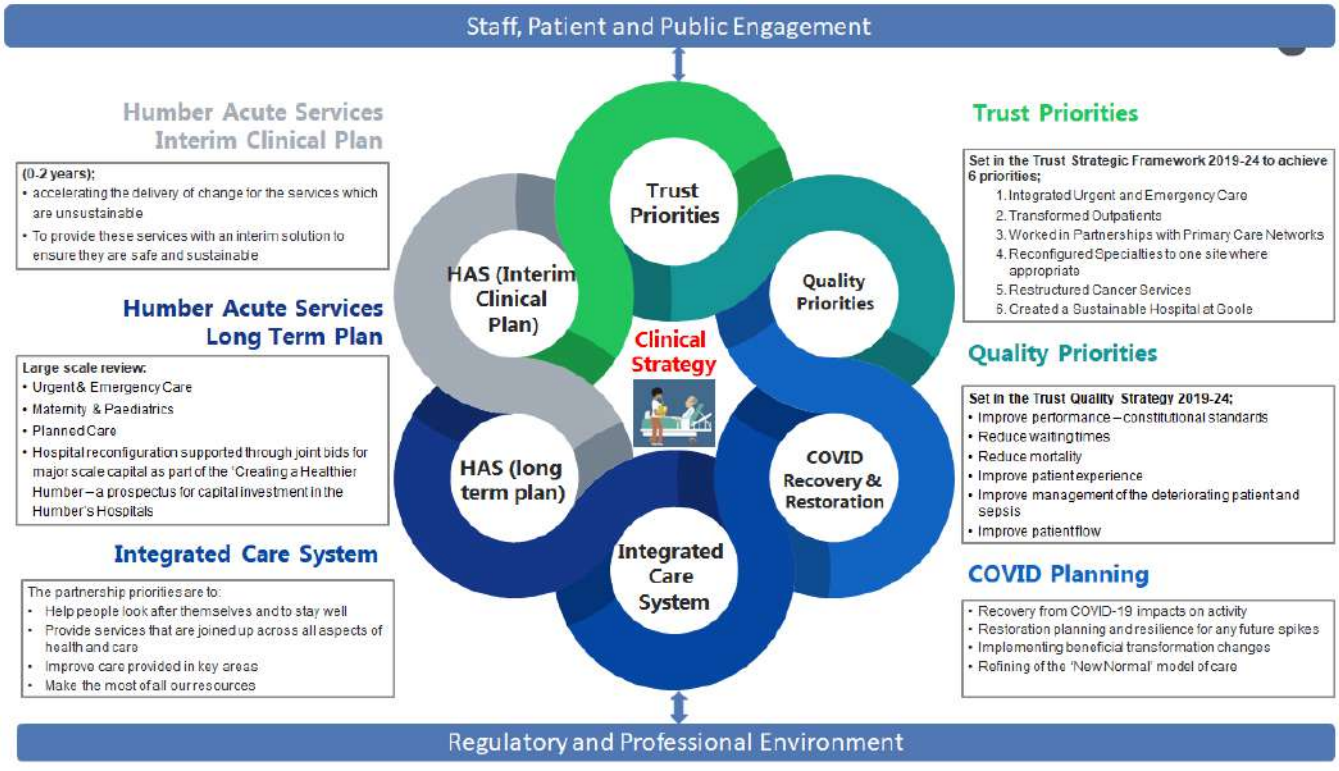
As stated previously, due to the global pandemic the HASR has not yet been completed.

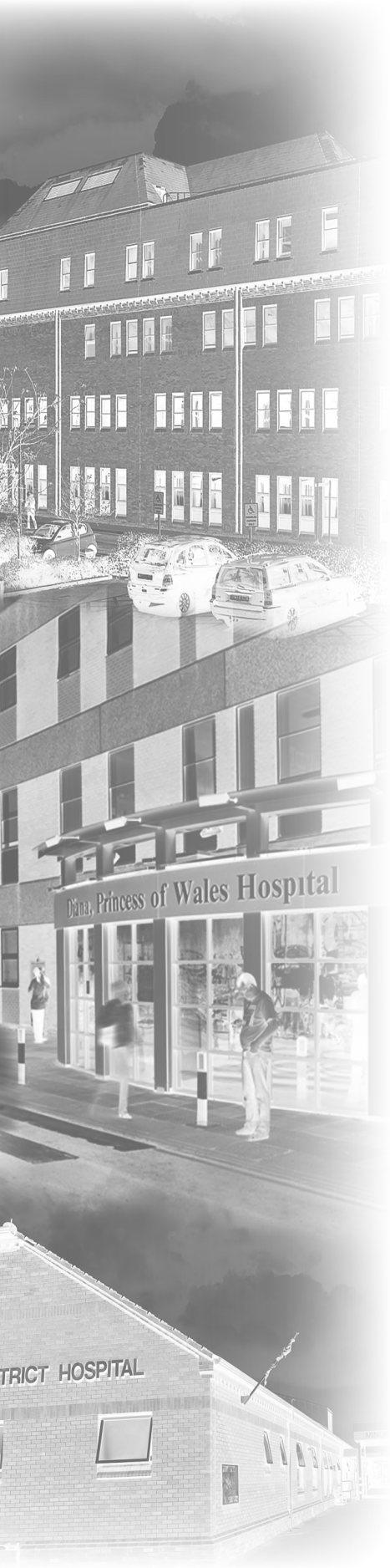
The outcome of the HASR and transformation of primary care will dictate the anticipated activity and location of services across the region. This will have a direct impact on the reconfiguration of the estate and how the estate can support the Trust and regional objectives.

4.2 Alignment

There are multiple evolving journeys in progress to achieve these outcomes, all of which need to closely align to ensure the most optimal result. The clinical strategy aims to reflect an end state of ultimately achieving safe, effective and sustainable services. The diagram below reflects the key areas of alignment:

Figure 40 - Alignment with Regional Whole Health Economy





4.3 Challenges

This is all set in the context of an organisation facing the dual challenge of double special measures, both quality and financial, resulting in the rebuilding of many services.

Since 2014 the Trust has faced several challenges which resulted in being placed in both finance and quality special measures. The latest CQC inspection report (published in February 2020) showed some improvements but the Trust was rated as '***requires improvement***' overall. It is clear the Trust faces challenges on several fronts including:

- Financial position
- Improving the quality and safety of services
- A deteriorating infrastructure – both hospital buildings and diagnostic equipment – with little access to capital funding to make improvements
- Meeting the NHS constitutional performance standards
- Recruiting and retaining skilled, ambitious and motivated staff
- Long waiting lists
- Providing a consistent and good patient experience
- Improving the reputation of the Trust with the general public, partners and national regulators.

It is important that NLaG plans to deliver within the overarching health and care landscape, within the context of the existing challenges, while addressing the new challenges that COVID-19 brings to the organisation.

4.4 A More Productive/Efficient Estate

In addition to understanding the organisational objectives and strategies impacting the estate, evaluation of its current position in terms of finance and performance has highlighted the need to improve the performance and productivity of the estate on a number of levels. These include;

- Improving utilisation of clinical space to reduce inefficiency and maximise the use of the highest quality assets for optimal income generation
- Reducing the amount of estate used for non-clinical activities and incentivise efficient use
- Improving the efficiency of long-term assets through disposal, demolition or reconfiguration
- Supporting the provision of a technology led and enabled environment to enhance productivity and utilisation of resources (including space)
- Adopting a set of metrics which show both the cost and performance of built assets to support Service Line Management principles
- Reducing operating costs through effective use of resources, robust management and environmental performance improvements
- An implementation plan which is capable of being delivered in phases, each of which can '***stand-alone***'
- Being productivity enabling whilst achieving return on investment
- Ensuring the physical condition of the estate is based on health and safety and business risk assessments
- Provide easily accessible services and facilities
- Reflects the Trust's desired image and reputation.

A number of priorities in terms of schemes have already been identified for inclusion in this current Estate Strategy and are being progressed. These are highlighted further within section 5 '***How do we get there?' of this Estate Strategy. These were developed b***y taking into consideration the Objectives of the Trust and the Estates Department in connection with local, regional and government strategies, our current position and estate performance and the available funding.

5. How do we get there?

This section sets out the major projects that are proposed or underway to achieve our estate vision. Some projects only affect the NLaG estate; others have a wider effect on health services in the region and therefore will require a collaborative response between stakeholders.

5.1 NLaG Estates Masterplan 2020-2050

NLaG's 2020-2050 Masterplan, developed in early 2020 as a precursor to the production of this 2020–2025 Estates Strategy, identified existing and potential future development options with regard to the physical condition, quality, utilisation and location of the whole Trust estate.

This was developed without fully taking into account the latest National, Regional and Trust strategic priorities described within this Estates Strategy. The schemes noted in the 2020-2050 Masterplan were proposed to address the following site risks and issues:

- Pockets of aged buildings unfit for clinical use across all sites, along with significant, safety critical infrastructure backlog maintenance
- Specific need to address old estate at SGH – potential need for wide scale redevelopment and provision of a new clinical centre of excellence
- Potential alleviation of bed pressures following reconfiguration and refurbishment of existing departments
- High demand for imaging facilities at DPoW and SGH – works underway to increase capacity
- Residential accommodation at SGH is poor and fails to attract interest from staff. Potential for redevelopment
- Option to provide assisted living facility and land sale for private residential accommodation at the SGH site to reduce non-clinical footprint in response to the Carter report. (A similar scheme has already been completed at DPoW).

In response, the masterplan identified the following estate priorities:

Table 58 - Estate Priorities as Identified in 2020-2050 Masterplan

Estates Priority	Outcome	Alignment to Strategic Framework & Quality Priorities
Emergency and assessment Departments under significant strain and in need of expansion – (works underway to reconfigure through national capital funding - £29.26m).	Integration of AAU and SDE Care by 2023	Integrated Urgent & Emergency Care Restructured Cancer Service Improve performance Reduce Waiting Times Reduce Mortality Improve Patient Experience Improve Management of the Deteriorating Patient & Sepsis
Specific need to address old estate at SGH – potential need for wide scale redevelopment and provision of a new Clinical Centre of Excellence – (long-term large-scale planning)	Achieve required standards for healthcare buildings. Increase in quality of services and patient experience.	Integrated Urgent & Emergency Care Restructured Cancer Service Improve Performance Reduce Waiting Times Reduce Waiting Times Improve Patient Experience Improve Management of the Deteriorating Patient & Sepsis
High demand for imaging facilities at DPoW and SGH. Works underway to increase capacity through national capital funding (£11m).	Quality priority Faster diagnosis and treatment for patients reduced waiting times. AAU by 2023	Integrated Urgent & Emergency Care Transformed Outpatients Restructured Cancer Service Improve Performance Reduce Waiting Times Reduce Waiting Times Improve Patient Experience Improve Management of the Deteriorating Patient & Sepsis

As a result of the above, the following short-term development options identified were:

Diana, Princess of Wales Hospital (DPoW)

Table 59 - Short terms development options DPoW

Ref	Scheme	Est Cost
1	New Main Entrance and A&E	£15m
2	New Main Entrance to form a Welcome Centre only (No longer Progressing)	n/a
3	New MRI Facility	£7m
4	AAU - refurbish an existing department to form AAU (part of 24.86 AAU Business Case)	£12.43
5	Demolish Doctors' family accommodation, build two storey block to form Clinical Opportunity & New Parking provision (New multi-deck as part of ED scheme)	£5.5m
6	Administrative Accommodation Refurbish West Arch (£1.5m) Refurbish Phoenix (£1.5m) Refurbish Drs' accommodation (£0.25m)	£3.25m
7	Clinical Opportunity - Refurbish currently vacant ITU	£3.25m
8	Therapies - Partly Refurbish Block D	£3m

Figure 41 - Short Term Opportunities at DPoW

The new main entrance and A&E/Welcome Centre projects are currently on hold whilst feasibility studies are under way for the new MRI facility and AAU. All of the other schemes identified above are pending the outcome of the HASR.

Scunthorpe General Hospital (SGH)

The following options were identified in the 2020-2050 Masterplan:

Table 60 - Identified options SGH

Ref	Scheme	Est Cost
1	**Coronation Block** - Refurbish for Administration. Major site reconfiguration with purpose built multi-function facility.	TBC
2	Expansion of **Car Parking** Facilities via a multi deck as part of the ED scheme	
3	**ED Expansion** - Courtyard infill to provide ED expansion to release pressures.	£3m
4	**New** AAU/SDEC - Demolish existing CDU and PIU to create new 50 bed AAU/ED & re-provide PIU. Refurbish Ward 2 to provide clinical opportunity.	£12.43m
5	**New MRI Facility** (*excluding scanner) - New build MRI scanner for Blue Sky Imaging Suite expansion.	£3.2m*
6	**Cardiology** - Refurbish Ward 24 to enable CCU to relocate from Level E within the Integrated Cardiology Unit.	£5.9m
7	**Vacant spaces** - Admin moves to Coronation Block will provide additional refurbishment spaces for clinical opportunities. This would be at significant cost.	TBC
8	**Clinical Opportunity** - Refurbish existing Ward 27 - Day Surgery	TBC
9	**Clinical Opportunity - ward refurbishments at SGH with an increased number of side rooms**	TBC
10	**HDU Expansion & ICU Offices** - Relocate existing ICU offices to provide HDU bed facilities. Refurbish underused HSDU area to form new ICU offices. To be considered as part of 2021/22 core capital programme.	TBC
11	**Energy centre replacement** required - The central steam raising boilers that supply the primary heat source (steam) to the whole of the SGH site are 28 years old and were originally procured under an ESCO contract. Feasibility estimate costs at £2.7m (as at 2019, not including VAT and project manager costs)	TBC
12	• Redevelop existing Church Lane to provide staff accommodation (Housing); • Redevelop staff car park to provide assisted living facility above; • Release remaining area of The Pit' for residential housing.	TBC

Figure 42 - Short Term Development Opportunities at SGH

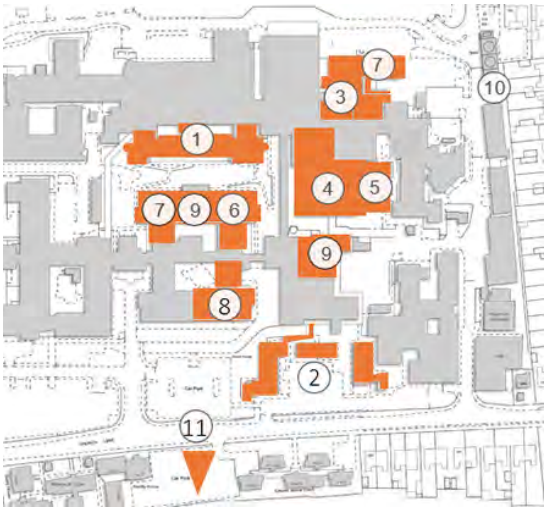
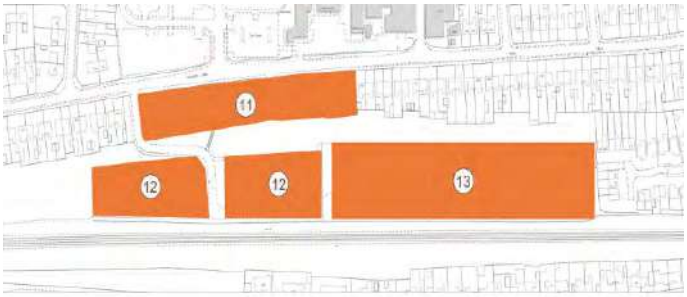


Figure 43 - Short Term Development Opportunities at 'The Pit' (SGH)



The Energy Centre replacement is in development and a feasibility study is underway for the new AAU and PIU. The refurbishment of the Coronation Block was deemed unaffordable and is no longer an approved plan and all other schemes are on hold in order to link to the wider plan, whole scale redevelopment.

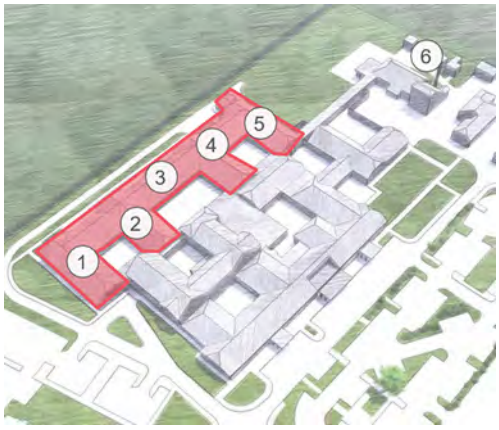
Goole & District Hospital (GDH)

The following options were identified in the 2020-2050 Masterplan:

Table 61 - Identified options GDH

Ref	Scheme	Est Cost
1	**Refurbish Vacant Ward 1** - Provide compliant clinical ward.	£1.8m
2	**Refurbish Existing Ward 2** (Ward 2 aged & requires modernisation. Refurbish ward to provide compliant clinical ward.	£1.5m
3	Admin	TBC
4	**Refurbish & Expand Neuro-Rehabilitation** - Existing Neuro-rehabilitation Ward requires refurbishment & has a demand for expansion, Neuro to be expanded to adjacent Ward	£3.2m
5	**Refurbish Day Theatres** - Existing Day surgery theatres require refurbishment to gain compliance;	£1.5m
6	**Energy Centre Replacement** - The central boilers that provide the primary heat source (LTHW) for the Goole site consist of one of the only two NHS coal fired boilers, remaining in England.	£2.3m

Figure 44 - Short Term Development Opportunities at GDH



The Energy Centre replacement scheme is in development and the short-term development opportunities at GDH will now be looked at as longer term with the proposed replacement of GDH as one of the Trust's strategic priorities.

5.2 Current/Planned Schemes

The table below highlights the status and value of current, planned schemes the Trust has, or is seeking, funding for:

Table 62 - Planned Schemes (incl. Status, Value and Funding)

Project	Est. Value	Funding	Site Operational
Major Capital Still to be Approved			
New SGH Development - Pre-Consultation Business Case (PCBD) SOC	c.£400m	TBC	Post 2030
Wave 5 National ICS/STP Bidding to incl. DPoW/GDH	c.£150m	DHSC/NHSE/I	TBC
Trust Approved			
ED/AAU (ED x 2 & AAU x 2)	£54.86m	ETP & ED Funding	ED - 2021/22 AAU – 2022/23
SGH MRI	£4.88m	STP Wave 4/Trust Capital	2021/22
DPoW MRI	£8m	DHSC Loan	2021
DPoW CT	£1.9m	DHSC Loan / Core	Dec 2020/Jan 2021
Critical Care	£1.4m	NHSE/I	Dec 2020/Jan 2021
Critical Infrastructure Risk (CIR)	£3.6m	NHSE/I	Mar 2021
COVID Equipment	£1m	COVID	Delivered
Awaiting Approval			
Goole Energy Scheme	£2.3m	Central Gov.	TBC
Infection Prevention Control (IPC) - Phase 3/COVID/Winter)	£24m	NHSE/I	Winter 2020/21
Digital Accelerator	£5m	NHSE/I	TBC
Approved Core Capital & Completed Schemes			
Back Log Maintenance (BLM)	£1.8m	Core	March 21
IM&T	£1.4m	Core	March 21
Equipment	£1.3m	Core	March 21
Mental Health & Mortuary - CQC	£0.9m	Core	TBC
Endoscopy JAG Accreditation	£0.037m	Core	2021/22
SGH Ward 29	£2m	Core	Completed/Open

These options are to be further developed and considered taking into account NLaG's emerging Clinical and other supporting strategies e.g., Workforce and Digital Strategies; the outcome of the Humber Acute Services Review, the Integrated Care System and the transformation of Primary Care through the PCN.

5.3 Short to Medium Term Options

Strategic Priority One – Integrated Urgent & Emergency Care

There is a requirement to develop facilities within the HCV region to support and enable the roll out of a standardised front door Urgent & Emergency Care Clinical Assessment Service Model including Same Day Emergency Care (SDEC). The aim is to create an Urgent Care Hub that brings together the Emergency Department, a priority admission area, alongside an Acute Assessment Unit (including assessment, Same Day Emergency (SDE)), frailty and short stay areas that span all specialities.

To this end NLaG have developed plans to create new A&E Departments and AAUs at both DPoW and SGH. The new facilities will allow transformation of the service and see Urgent and Emergency care come together in a multidisciplinary assessment area co-locating surgical and medical assessment with same day emergency care.

The projects will be developed via the Procure 22 framework and the Trust has appointed WT Partnership, P+HS Architects, Mott Macdonald and Kier as a multi-disciplinary team to assist in the design and procurement of the AAUs for both sites.

When developing and finalising its designs and Outline Business Case (OBC) in readiness for NHSE/I approval for this scheme, the Trust was notified of an opportunity to access additional funding of circa £30m for the renewal of A&E departments at both sites which the Trust was successful in securing.

The total estimated project budget, (including PSCP costs, Trust costs such as equipment, fees and non-work

costs, Trust and SCP risk/optimum bias, and VAT) is £54.86m. Whilst the new A&E Departments and AAUs will be funded via separate funding streams it is the Trust's intention to procure the facilities under one scheme, delivered by Kier Health through the ProCure22 framework.

The preferred solution at both sites has been selected following an extensive option appraisal process, involving all key stakeholders. This has been approved by the Trust Programme Board and may be summarised as follows:

Urgent Care Scheme -

Diana, Princess of Wales Hospital (DPoW)

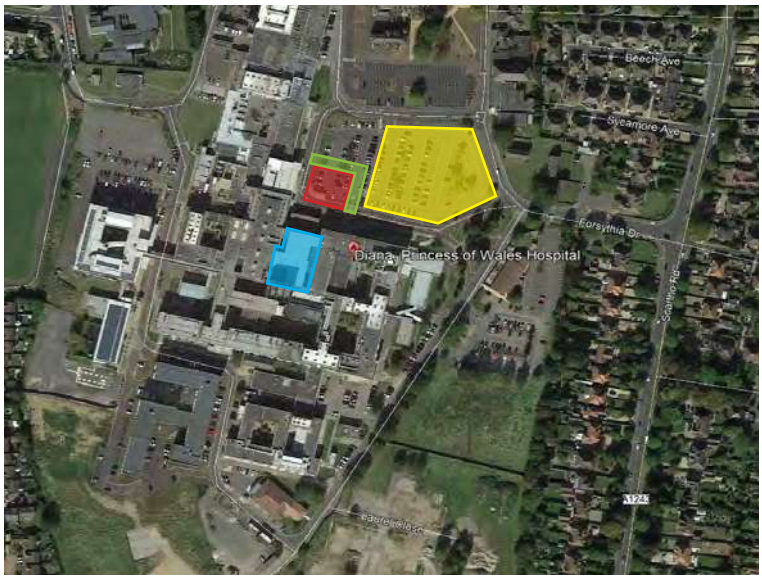
The scope of the DPoW works includes:

- A new build A&E department on the main car park opposite the existing A&E facility with links into the hospital
- Existing A&E department refurbished to provide the SDEC and assessment area;
- Existing Ward A1 to form the short stay ward
- Car parking re-provided via the installation of a lightweight modular deck installed on an existing car park.

Current, A&E services are to remain operational throughout the construction. The footplate will include the removal of CCU and potentially a core shell for ITU, this is due to the existing modular building being on the roof. This scope has been split up between various phases (0-3) as follows:

Phase 0 – Enabling Works	
Date	**Scope**
23/11/2020	Install new multi-storey car park
23/11/2020	Demolish and remove existing modular ward on roof (works delayed until 2021)
14/12/2020	Provide temporary vehicular route alteration including drop-off arrangements and Note requirement to alter ambulance route
14/12/2020	Create construction site and carry out any service diversions, protect route for ambulances to existing ED and preserve access to main entrance throughout the works.

Figure 45 - Phase 0 Enabling Works - DPoW Urgent Care Scheme



Phases 1-3 – Proposed Works	
Date	**Scope**
04/01/21	**Phase 1** - New build ED (2,200m^2 plus Plant), potential for first floor ITU and complete external works including drop off and alterations to road layout.
TBC	**Phase 2** - After completion of ED - Remodel existing A&E to provide SDEC and Assessment Unit.
TBC	**Phase 3 -** Concurrent with Phase 2 - Remodel existing Therapy area to provide additional bed capacity and break-through into existing Ward A1 to create 25-Bed Short Stay ward.

Figure 46 - Phases 1-3 Proposed Works - DPoW Urgent Care Scheme

Urgent Care Scheme - Scunthorpe General Hospital (SGH)

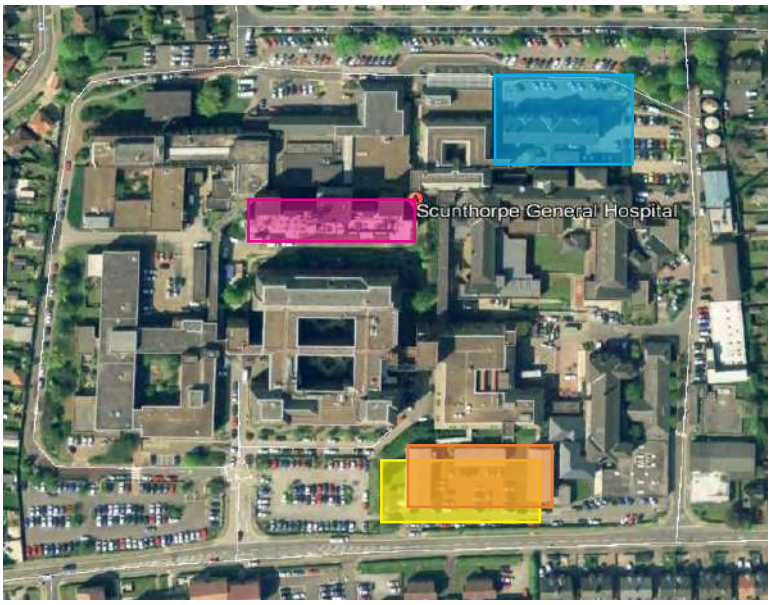
The scope of the SGH works includes:

- Demolition of the link block, war memorial block and courtyard block
- Provision of a new build A&E department within the car park area
- Refurbishment of the existing A&E departments to form the SDEC and assessment area
- Refurbishment of the existing CDU department to form the new short stay ward
- Re-provision of car parking via the installation of a lightweight modular deck installed on an existing car park.

Current, A&E services are to remain operational throughout the construction process. This will also include the re-provision of the administrative and Doctors''On-Call' accommodation. This scope has been split the following phases (0-3):

Phase 0 – Enabling Works	
Date	**Scope**
23/11/20	Refurbish Coronation Block to provide decant admin space
21/12/20	Install new multi-storey car park for patients/staff/visitors
21/12/20	Relocate accommodation from existing admin block and linked buildings. Once relocated, demolish admin block and linked buildings and carry out any service diversions prior to commencement of new ED.
TBC	New staff car park through existing patient/visitor car park

Figure 47 - Phase 0 Enabling Works - SGH Urgent Care Scheme



Phases 1-3 – Proposed Works	
Date	**Scope**
01/02/20	**Phase 1** - New build ED (2200sqm + Plant) and potential for first floor ITU.
TBC	**Phase 2** - After completion of ED - Remodel existing A&E to provide SDEC and Assessment.
TBC	**Phase 3** - After completion of Phase 2 - Retain existing CDU as 26-Bed Short Stay.

Figure 48 - Phases 1-3 Proposed Works - SGH Urgent Care Scheme

Urgent Care Scheme Programme

Figure 49 - Urgent Care (AAU/ED) Programme

Task	Start	Finish	20		21												22												23				
			N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M
Enabling Works	23/11/2020	25/06/2021																															
DPoW Site Works	14/12/2020	25/06/2021																															
SGH Site Works	04/01/2021	25/06/2021																															
ED Delivery	23/11/2020	06/05/2022																															
AAU's FBC	23/11/2020	01/10/2021																															
Construction Completion	04/10/2021	22/10/2022																															
AAU Construction	31/01/2022	26/05/2023																															

5.4 Long Term Development Options

Strategic Priority Two – Transformed Outpatients/Building Better Services (HCAV HP's Investment Plan)

The Trust Strategic Framework refers to the transformation of outpatient services which is to change the way outpatients is delivered over a four year programme. The priority's aim is to:

- Expand the use of non '*face-to-face*' appointments by implementing technological solutions to maximise capacity in outpatients, this includes the implementation of software and kit to undertake video consultations
- Support operational teams to reduce the backlog of follow-up appointments to ensure there is no patient harm due to delayed access to appointments. This is supported by clinical risk stratification
- Undertake clinical service re-design with system partners in the key priority specialities.
- Work towards the objectives for outpatients set out in the NHS Long Term Plan published in January 2019 to avoid a third of 'face-face' outpatient appointments visits by 2023/24.

The programme will be delivered by enabling the use of technology, innovation and efficiency to support operational teams to maximise capacity in outpatients and deliver the transformational change of clinical pathways across primary and secondary care.

This programme has been accelerated through the COVID-19 period, due to the need to move to virtual assessment and review where safe to do so. The establishment of a referral assessment service (RAS) across the system in April 2020 and agreement of clinical pathways to support this has resulted in the beneficial achievement of the NHS Plan objectives to move to virtual review from years to a matter of weeks. There does remain a significant challenge to ensure that these changes are now embedded through recovery.

Outpatient Departments 1 and 2 at SGH were identified through the six facet surveys as requiring significant investment for either major repair or replacement in order to bring these properties up to Estate CODE Condition B. Therefore, there is an opportunity to transform outpatients whilst removing significant backlog maintenance costs (c£3.6m net construction costs).

Delivery of the Outpatient Transformation programme will support the achievement of the Trust priorities for transforming Outpatients and working in partnerships with Primary Care (see next section).

A realistic implementation programme is required that will deliver outpatient services in the community and other settings. It is anticipated that the outcome of the HASR and the more developed future strategic direction of the HCAV HP will identify those services which can be amalgamated regionally and delivered across the whole regional health economy. It is only by working together that efficiencies can be made in terms of digital technology, estate use and patient pathways.

HCAV HP's intention is to create a network of vibrant healthcare campuses to meet the changing needs of our communities. Provision of care will be expanded by:

- Improving access to routine care in community settings and offering more digitally enabled care
- Helping more people access high quality treatment by improving the way our hospitals work together.

A networked approach to care planning and delivery will enable hospital staff to make the best use of resources. The ability to streamline and accelerate treatment will be underpinned by investing in fully connected services such as common ways of working, pooled resources and shared records. The implementation of sustainable service models that maximise positive results will be delivered by the Trust in conjunction with the HCAV HP.

Strategic Priority Three – Work in Partnership with PCNs

Working more closely with primary care, GPs and their surgeries, is a key element of the NHS 10-Year Plan. In the next four years the local health system will change through the development of PCNs and the Trust will be working closely with primary care to bring the right skills to the networks, developing a greater partnership between acute and primary care services. Clinical networks across all sectors will support new ways of working

PCNs will be an important part of a broader '*out-of-hospital*' offer for our communities. The intention will be to provide the care people need at, or close to, home so that our hospitals only provide those things that absolutely need to take place in a hospital.

The integrated out-of-hospital offer will incorporate both planned and unplanned care and aims to stem the current growth in referrals to hospital services by meeting people's needs better in local communities. The system will achieve this by supporting people to manage their health conditions better to avoid flare-ups and other crisis situations and simplify the way we provide care to avoid people being bounced around from one part of the system to another.

The conditions we will focus on will vary from place to place depending on local circumstances; however, across HCV there will be a focus on supporting people with **diabetes**, **respiratory conditions** and **cardiovascular disease** because these are areas where significant improvements can be made by working together at scale.

The system will also improve the coordination of end of life care so that more people can be supported to die in their chosen place and not be rushed into hospital unnecessarily.

The right estate in the right place will play a key role in helping to facilitate the transformation of primary care. To fully understand the clinical need and consequent opportunities to improve services, activity and capacity modelling of primary and community services, alongside those that could be provided out-of-hospital, should be undertaken. This will allow objective decisions to be made on the opportunities to provide services in the community closer to where people live and enable an estates strategy and implementation plan to be developed which will support the transition. NLaG will again work with the HCAV HP and Primary Care Sector to understand how this transformation will develop and will update subsequent Estate Strategies accordingly.

Strategic Priority Five – Restructured Cancer Services

Cancer services are one of the areas where the Trust needs to improve: to make sure patients get access to diagnostics quickly and, where cancer is identified, treatment can start as soon as possible. The Trust does not have access to skilled and experienced cancer specialists and needs to change what it does to make sure it provides the best possible care to every patient. It will look to do this by working with other Trusts and hospitals which do have the experienced staff as well as the facilities to provide the very latest treatments. To ensure this happens in the next five years the Trust will:

- Review and assess tumour site services to provide best care
- Explore and develop new models of care to ensure faster diagnosis is delivered in 28 days and treatments provided to time
- Expansion of MRI and CT scanning through capital funding to implement new scanners.

To support the improvement of cancer services capital investment in imaging services is required.

The demand for MRI and CT scanning has dramatically increased over recent years causing significant capacity issues in the ability to meet the demand and scan patients within acceptable timescales. The Trust has invested, and continues to invest, in the much-needed additional scanning capacity and has been successful in receiving capital funding to progress the following schemes:

- **CT at DPoW -** A new innovative modular build to provide an additional CT scanner on the DPoW site is in progress. The completion date for the development is December 2020 and this will provide additional capacity to support the timely access required for cancer diagnostics and emergency care.
- **MRI at DPoW -** This scheme will see a new purpose £8.8m built MRI suite providing two state of the art MRI scanners (one replacement and one additional) to support the rising demand and improve timely access for patients. Construction started in February 2020 and is due to complete in June 2021 with the aim of providing the required capacity to meet existing and future demand.
- **MRI at SGH -** The Trust has been successfully in securing £4.4m in funding to expand the existing diagnostics suite and provide an additional MRI scanner. The scheme is planned to commence in January 2021.

The expected **benefits** of the diagnostics schemes include:

- Increasing number of MRI scanners available, doubling from two to four scanners to meet increasing demand;
- Reduction in waiting times for MRI to deliver National Targets, six week diagnostic targets and support referral to treatment pathways;
- Improving patient outcomes by ensuring 28 day faster diagnosis for cancer, thereby reducing the risk of patient harm;
- Improving the quality of the MRI service, delivering a full range of scans at both SGH and DPoW, reducing the need for patients to travel/be transferred between sites;
- Reducing the reliance on mobile scanners to deliver the MRI service, reducing the revenue cost of the service;
- Reducing waiting times, providing a rapid response for patient flow in particular for unplanned care. Underpins the ability to deliver SDEC and Acute Frailty Services, so that such patients can be assessed, treated and supported in a timely way;

- New machines result in less service disruption due to '*down times*' from machine breakages. Replacement parts should be more readily available meaning the machines can be repaired quicker;
- Older machines having '*down times*' add to bed pressures because patients are in beds waiting for scans while the machine is waiting to be repaired, taking into account the additional risks on being able to purchase older machine parts due to advance technology;
- Enables the Trust to respond accordingly to the Integrated Care Systems post-COVID-19 Recovery Plan.

However, it must be noted that the impact of COVID-19 has resulted in a significant additional scanning backlog and forecasted reduced capacity position due to the infection control requirements of down time between each scan for which urgent recovery solutions. A recovery plan has been developed to address this

As described earlier, the Trust is part of the HCV partnership strategic diagnostic programme to achieve the development of regional diagnostics centres to support the improvements in time to diagnose and treat.

This will support the achievement of the Trust's priorities for Integrated Urgent & Emergency Care, Outpatient transformation and Restructured Cancer Services.

5.5 Whole Site Transformational Long Term Options

Strategic Priority Four – Reconfigure Specialities to One Site where appropriate

This Trust strategic priority also addresses **HCAV HP's Investment Plan Visions**, **Building Better Prosperity and Building Better Infrastructure**.

Underpinning the need for service change is the dependency on infrastructure and estate and the ability for existing buildings to adhere to the required clinical standards. Given this is one of the main challenges the Humber is facing, there is a commitment to creating a healthier Humber through significant capital investment. Put simply, we want to provide 21st Century infrastructure which will attract top talent to our hospitals and provide the best care for our patients.

HCAV HP's investment plan to unlock the potential of our region and its people through investment in healthcare infrastructure will be achieved by transforming or replacing existing hospitals to provide new, state-of-the-art health and care campuses, using leading edge design. This will significantly improve patient care whilst also promoting research, innovation and greater employment prospects. This will enable the future proofing of healthcare buildings in the region to ensure long term service quality.

Capital investment in our hospitals will act as a catalyst for the continued regeneration of the region, because the opportunity a cash injection brings in terms of employment, education and mental and physical well-being for local people. It also provides an opportunity to build on the regions skills and expertise in green energy to develop a lower carbon future for our healthcare facilities and support the development of green jobs in the region.

In support of HASR, NLaG will look to secure future funding to develop new hospitals or refurbish and reconfigure DPoW (Grimsby), SGH and GDH. Options for these new hospital developments were proposed in the NLaG 2020-2050 Masterplan produced in early 2020. The reconfiguration of specialities to one site is identified as a HASR strategy.

A summary of the plans for PoW and SGH are as follows:

Diana, Princess of Wales Hospital (DPoW)

The long-term plan for the DPoW Hospital site is to demolish the existing hospital buildings and build a new 3-storey hospital with car parking facilities re-providing for the clinical facilities demolished. The initial proposal has been included below.

Figure 50 - Proposed New Hospital on DPoW Site

Figure 51 - Artist's Impression of Proposed new Hospital in Scunthorpe

Scunthorpe General Hospital (SGH)

A new hospital re-development at SGH was included within the NLaG 2020-2050 Masterplan which was produced in early 2020. This involved a phased approach over a medium to long-term timescale. The medium term included the demolition of existing buildings on the site, building a new six storey hospital, and provision of a multi-storey car parking facility. The longer-term scheme, phasing demolition on the site, would result in a three-storey new build.

However, the master planning works undertaken for the SGH site highlighted that developing a new hospital on the same site would not be efficient and would be very expensive involving significant decanting, causing disruption to the provision of clinical services over many years, while resulting in a sub-optimal clinical solution.

It would also incur a significantly longer programme due to the high level of decanting required and logistical constraints with regard to the temporary relocation of services.

The Trust are therefore developing proposals to build a brand new hospital on a new site in the Scunthorpe area which would enable a faster, cheaper and much more efficient construction process.

These findings have led to four new potential sites being identified by the Trust which are currently under evaluation.

The master planning and subsequent work undertaken by NLaG feeds into the wider HASR and during Summer 2020, preparatory work was undertaken to develop high level plans for a programme of major capital developments across the ICS area.

The NHSE/I Regional Team has identified the redevelopment of Scunthorpe Hospital and re-provision of the tower block at Hull Royal Infirmary as top priorities for inclusion within the national Health Infrastructure Plan (HIP) programme. Prior to the start of the COVID-19 pandemic it had been expected that an expansion of the HIP programme would be confirmed by the government before the end of the calendar year.

Given the very high level of support being provided by the Regional Team, it had been anticipated that the Scunthorpe/Hull major development would be selected for inclusion in the expanded HIP programme.

This proposed solution will significantly improve the standard of care by maximising the prevention and control of infection, helping staff to provide exceptional specialist treatment by developing networked services across all five sites included with the HASR, and widening access to care through a collaborative approach to estate management.

In addition, the creation of vibrant and dynamic places to live and work will attract the brightest and best talent to work within the organisation. The new hospital will provide this workforce with the resources they will need to pioneer new ideas and cement the Humber as a national driver of cutting edge advancements in health and care, building a culture of innovation across the region.

Strategic Priority Six – Create a Sustainable Hospital at Goole

In 2019/2020 the Trust set a priority to move more planned care to GDH. This site also offers real potential in terms of the ICS and future models of care. This was the start of a longer-term piece of work to create a sustainable facility in the town.

A long-term scheme proposed in NLaG's 2020-2050 Masterplan would be the redevelopment of GDH. GDH physical condition facet survey results highlight that the whole site (all five blocks surveyed) are either '***very poor facilities' or "less than acceptable facilities'*** and ***'requires capital investment or replacement'***. In addition, ***perhaps as a result of the aforementioned 91.8***% of the total area surveyed for space utilisation was under-utilised.

This would require:

- Demolition of existing facilities (see proposed demolition area below)
- Re-provision of facilities demolished by way of a new build two storey hospital (see proposed site below)
- Provision of new car parking facilities for the site
- Land Disposal.

Figure 52 - GDH New Hospital Site - Proposed Demolition Area

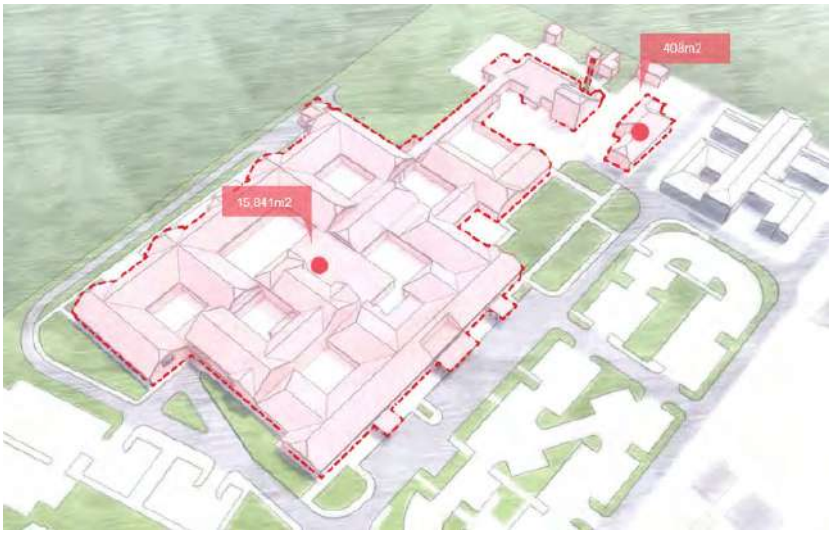


Figure 53 - GDH New Hospital Proposed Option

5.6 Implementation Plan

Approach to Next Stage of Planning

Given the recent changes in the strategic planning context as described above, consideration has been given to the next stages of planning of the major capital development programme. Possible approaches have been identified for further consideration by the Executive Oversight Group, as set out below:

Table 63 - Approach to Implementation

Approach	Description
Plan A	This approach would involve the proposed major development being selected for inclusion in the national HIP programme. As a consequence, national funding would be provided to cover the costs of developing a SOC for the proposed scheme. The SOC would need to be developed in accordance with the current national (Better Business Cases) guidance.
Plan B	This approach would involve the Regional Team confirming its support for further planning work to be undertaken, including the development of a guideline compliant SOC, in advance of a decision being taken about the future expansion of the HIP programme. The planning work would be undertaken on the basis that Treasury capital funding might be secured in the future, within reasonable timescales. Under this approach it is unlikely that national or regional NHS funding would be made available to cover the cost of developing the SOC.
Plan C	This approach would involve the development of a SOC for the whole of the proposed programme of development, but with a primary focus on alternative sources of capital funding (i.e., non-NHS and non-Treasury). It is unlikely that national or regional NHS funding would be made available to cover the cost of developing the SOC under this approach.
Plans D, E, etc.	This approach would be similar to Plan C but would involve the development of a separate SOC for each scheme (Scunthorpe, Hull etc.). The resulting SOCs would be developed alongside wider Town Plans and Masterplans for the different areas. Again, under this approach it is unlikely that national or regional NHS funding would be made available to cover the cost of developing the SOCs.

Planning Process and Resource Requirements

Under all of the possible approaches it will be necessary to develop a guideline compliant SOC (or SOCs).

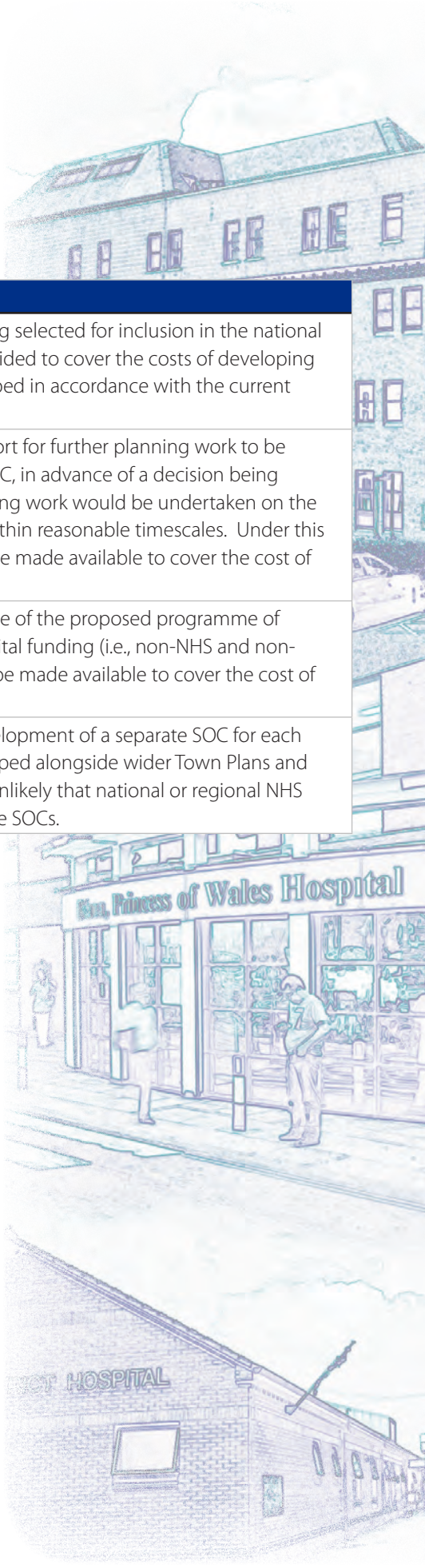
The planning process and resource requirements would therefore be very similar across all of the approaches. For Plans, C, D, E etc., more detailed work will need to be undertaken on alternative sources of capital funding.

Some specialist legal and financial support would need to be commissioned to assist with this.

A small team would need to be established to manage the development of the SOC. This would comprise five or six people from partner organisations and some external specialists e.g., Health Care Planner, Architect, Quantity Surveyor, Design Engineers etc.

Further work is currently being undertaken to determine staffing requirements and costs. Based on the initial work that has been undertaken it is anticipated that the gross cost of developing a guideline compliant SOC would be around £1.5m.

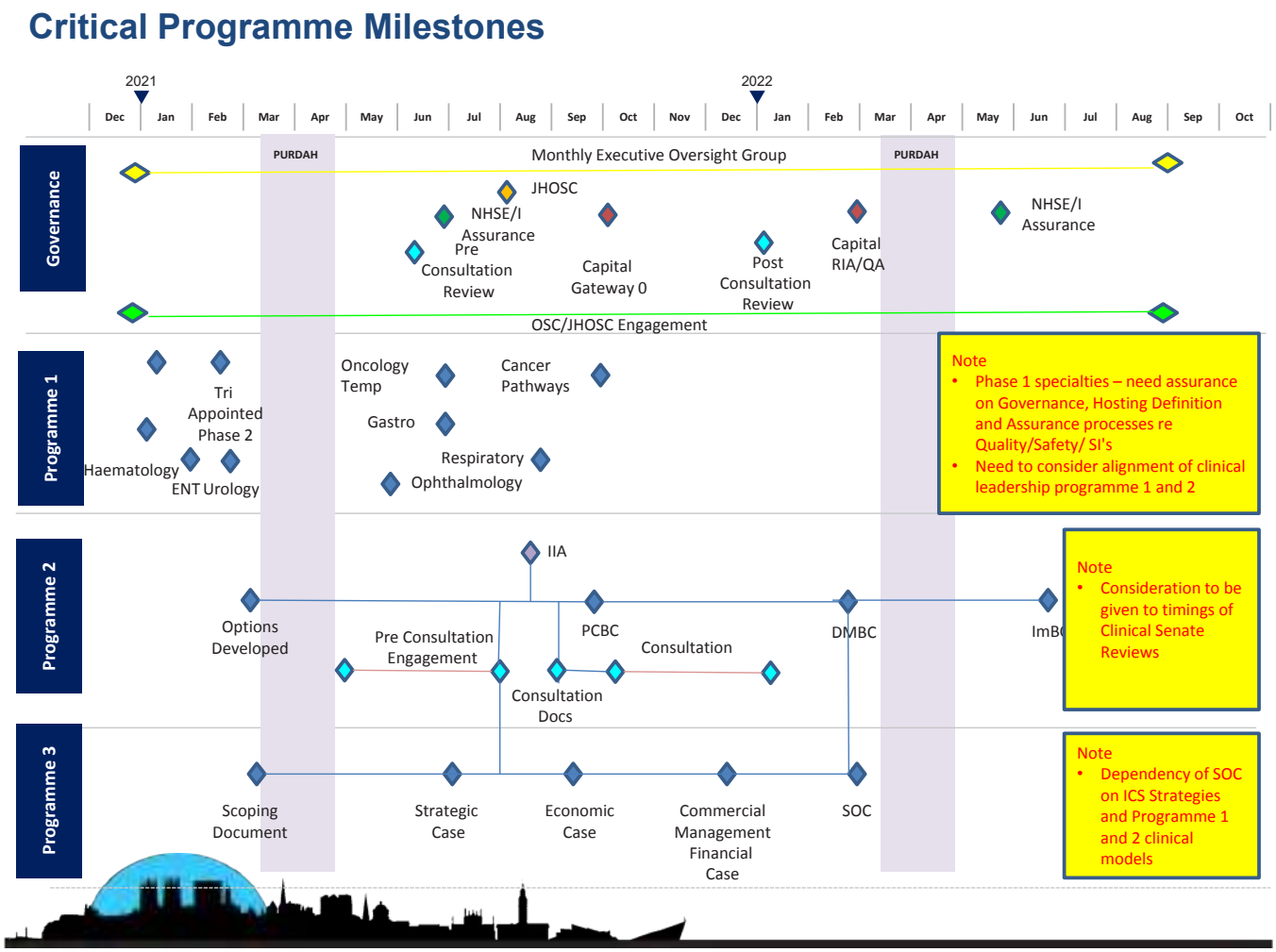
The net cost would be lower if staff from partner organisations can be freed up to work on the SOC without their posts being backfilled.



Implementation Plan and Timescales

In order to be able to deliver the whole scale transformation, which is required to continually provide, safe, effective and sustainable services, NLaG must have a clear implementation plan. This Estate Strategy (and the approval of other supporting strategies) represents the first phase of this plan and the diagram below identifies the subsequent steps and proposed timescales necessary to deliver an estate which will meet current demands whilst also being able to respond to future needs. It is planned to commence developing a scoping document in March 2021 leading to the production of a SOC by March 2022.

Figure 54 - Implementation Plan



5.7 Meeting Regulatory Obligations

NLaG recognises the importance of working with regulators to ensure they meet, if not exceed, the standards expected of an efficient and high performing NHS Foundation Trust. These standards ensure that high quality, safe and effective care is provided in an economically sustainable manner.

The Trust has an inherent obligation to protect patients, staff and visitors; ensure the services provided are to a high standard and that the Trust can demonstrate value for money to the taxpayer.

NLaG's aim should be to maximise funds to support the delivery of care through the elimination of waste, duplication and inefficient use of resources within the estate and how it is operated.

5.8 Sustainability

NHS Greener Plan

The Government has defined sustainability as 'the simple idea of ensuring a better-quality life for everyone, for now, and for generations to come'.

The NHS wishes to achieve significant benefits, including efficiency savings and improve quality as well as reducing environmental impact, by adopting a more environmentally friendly approach. Strategies have been outlined for energy, waste, water, transport and procurement.

A sustainable NHS will mean improved working environments, greater cost savings, a better service to the community, and reduced environmental impact. In conjunction with the service and operational strategies being developed this Estates Strategy will take into account sustainability issues when considering the future development of the estate.

NLaG is examining its current impact on the community and environment, for instance how it:

- Effective leadership, engagement and development of staff to promote sustainability
- Project management and intervention of Net Zero design for Capital Investments
- Infrastructure review of heating and energy centres
- Review of staff travel, parking and site links for logistics of staff and equipment
- Removing single use plastic
- Procurement of renewable electricity)
- Increasing the provision of Automatic Meter Reading (AMR) and energy monitoring systems
- Engagement in care model reviews
- Promoting staff health, wellbeing and enabling where possible
- Review of staff lease car arrangements, EV fleet and Infrastructure
- Zero waste to landfill, diversion to alternative treatments
- Reducing, reusing and recycling waste in line with waste hierarchy
- Engagement in developing IT strategy transforming care plans at home
- Use of estate review, agile working and one public estate
- Reduction of the Estate Back Log Maintenance Programme
- Engagement of wider stakeholders within community, commissioning, local authority to shape care services.

The need for a health service facility and its content will be driven by patient needs, national directives and the clinical requirements supporting the Trust's vision. There are, however, opportunities for NLaG to enhance its sustainability by determining how services can be provided efficiently, and by developing them locally or through shared estate with the wider health and social economy. The use of information technologies to link services and to provide information remotely can be an important component of ensuring that the most effective use is made of resources. Also, investigating the extent that other services can be provided from the same site can reveal significant benefits through economies of scale, increasing the viability of transport access and through effective integration of services. The Trust will strive to be as green as possible and target achieving Net Zero Carbon as part of our wider Corporate Social Responsibility.

Opportunities to co-locate Trust facilities with other organisations, both within the NHS, private health sector, and non-health public and private sector organisations could deliver:

- Cost efficiencies and sustainability benefits of using, leasing or funding a single building rather than several
- Provision of integrated services (Link to Strategic Priority 3 & 4)
- A greater opportunity for a '***one stop***' service delivery, this should reduce the time taken to procure healthcare and reduce travel (Strategic priority 4)
- NLaG will give careful consideration to the design of the estate and recognises that creative renovation will improve service quality, energy efficiency and will reduce the impact on the environment. The re-use, remodelling and refurbishment of the estate will contribute to sustainability objectives by:
- Reducing pressure to develop on previously undeveloped land, particularly the open countryside
- Improving the viability of public and other services in urban areas, particularly by procuring as much as possible in the local economy, and employing as many local people as possible
- Assisting in urban regeneration which could potentially improve the quality and vitality of the urban environment and urban living
- Application of BREEAM (Building Research Establishment Environmental Assessment Method).

A focus on the re-use, refurbishment and remodelling of existing buildings is good sustainability practice.

Each scheme implemented should deliver benefits under the focus of Government Energy Conservation targets and the Sustainability Agenda and reduce the Trust's carbon footprint reducing its energy costs and consumption to the minimum.

Waste minimisation, in all areas will be pursued. The key areas of focus are energy, design, construction, demolition and transport/access.

NLaG's Green Plan

As detailed in NLaG's Green Plan, the Trust will continue to make direct interventions to tackle climate change while delivering high quality care and improving public health. These interventions have been identified as:

Table 64 - NLaG Green Plan Interventions

Areas for Action	What this means	What we are doing at NLaG
Sustainable consumption & production	• Achieve more with less • Look at how goods and services are produced and the impacts of products and materials across their lifecycle • Reduce inefficient use of resources	• The Trust is reviewing all tender documentation including pre-qualification questionnaires (PQQs) and Invitation to Tenders (ITTs) to ensure that sustainable issues are considered within future procurement decisions • Consideration of life cycle costing • Increase recycling and review waste segregation • Seek opportunities to improve water efficiency • Reduce single use plastics
Climate change & energy	• The effects of climate change can already be seen and scientific evidence points to the release of greenhouse gases into the atmosphere by human activity as a primary cause of this • Decarbonisation of our estates and facilities • Prepare for the climate change that cannot now be avoided	• Future Energy performance contracts across our sites to guarantee meeting of carbon targets and production of savings • New Sustainable Energy Centre at Goole & District Hospital • Installation of carbon reducing technologies across the sites • Purchase of 100% REGO backed renewable energy • Increase implementation of AMR and energy monitoring
Protecting natural resources & the environment	• Natural resources are vital to the existence of all • Develop a better understanding of environmental limits, environmental enhancements and recovery	• Maintenance of green spaces around the sites • Seeking ways to improve the air quality at our sites
Creating sustainable communities	• Create sustainable communities that embody the principles of sustainable development at a local level • Working in partnership to get things done	• Working in partnership with Local Authorities, other NHS organisations and the voluntary sector e.g., Heat Networks and Travel Plans

5.9 Funding

Several capital funding options might be available. As part of the identification of the best way forward, detailed calculations will be required covering availability of reserves, the annual capital resource limit (CRL), the Trust's prudential borrowing limit (PBL) and the impact on the Trust's long-term financial model (LTFM).

Although the costs associated with developing a guideline compliant SOC would be covered by national NHS funding under Plan A, under all the other approaches an alternative source of funding would need to be secured. Under Plan B, the net costs would need to be funded by NHS partner organisations in the Humber area. Under Plans C, D, E etc., there may be scope to secure funding from non-NHS sources including Towns Deal funding, One Public Estate funding and external investor funding. All of these options would need to be negotiated and would probably require at least some of the net costs to be funded by NHS partner organisations.

STP Funding

A new approach to NHS capital funding was introduced in 2020/21, the main purpose of which is the allocation of a capital envelope for each STP/ICS. The aim of this is to provide greater clarity and confidence on the level of capital resource available; support system working and discussion on capital priorities; and enable faster access to national capital funding for critical safety issues.

Indicative STP 2020/21 allocations are shown below:

Table 65 - STP 2020/21 Capital Allocations (STP 13)

2016/17 STP Place-Based Allocation £'000s	2020/21 STP Place-Based Allocation £'000s	2020/21 Indicative STP Allocation (incl S&T Funds) £'000s
£1,242	£1,392	£1,444

Health Infrastructure Plan (HIP) Funding

The DHSC published the HIP 1 in September 2019. This will deliver a long-term, rolling programme of investment in health infrastructure, including capital to build new hospitals, modernise primary care estate, invest in new diagnostics and technology, and help eradicate critical safety issues in the NHS estate.

At the centre of the HIP is a new hospital building programme, to ensure the NHS' hospital estate supports the provision of world-class healthcare services. Under this approach, the Government has committed to build and fund 40 new hospitals over the next 10 years.

In October 2020 the government confirmed that 40 hospitals will be built by 2030 as part of a package worth £3.7bn, with eight further new schemes invited to bid for funding. It is anticipated that a bidding process for the remaining 8 places will take place in Spring 2021.

The HIP is the largest hospital building programme in a generation and sets out five key priorities that need to be reflected in proposed schemes:

1. Clinical Briefing and Patient Flow improvements,
2. Modern Methods of Construction, including Design for Manufacture and Assembly,
3. Standardised design,
4. Coordinated and transformational digital improvements, and
5. Greater emphasis on sustainability and net zero carbon.

NHSE/I are working with partners to develop new specific guidance relating to the latter three priorities and it is envisaged that this guidance will be published shortly.

In-order for NLaG and its partners to achieve their strategic ambitions, plans for new development need to focus on evidenced based planning to make modern facilities which are fit for purpose and safer for staff, patients and visitors. Plans for new facilities must be developed to ensure not only are they world class facilities but also that the operational and workforce implications receive the highest weighting.

Existing additional guidance must also be considered when developing plans for new facilities, in particular:

- General design guidance for healthcare buildings (HBN 00-01)
- HBN00-01 Supplement A: Clinical Briefing in Estates Planning
- Detailed Health Building Notes and Technical Memoranda.

The need to introduce standardisation should start at the outset of the project delivery cycle and it is essential when commencing a project that current guidance and the benefits of standard designs are embraced.

The healthcare landscape has altered dramatically since the last major hospital building programme via four fundamental shifts which need to be embraced during the development process for new facilities:

1) National and International factors

- The accelerating climate crisis; the need to implement net zero carbon
- The digital revolution; how can technology be used to influence long lasting change
- The COVID-19 pandemic; the flexibility and adaptability of

the estate to respond to health emergencies

- The need to rationalise approval processes and construction delivery, reducing costs and build programmes.

2) Health System Change

- The shift towards ICS has led to system-wide planning, development and delivery of hospital and healthcare capacity.

3) Cultural Change

- How does the NHS become an employer of choice, providing a conducive and supportive environment to work and thrive?
- How can hospitals become a place of safety and healing?

4) Balance of Private and Public Space

- The balance of public realm spaces, collaborative workspaces and space for activities aligned to healthcare needs careful design
- Patients need space to heal in peaceful surroundings but also opportunities to mingle and socialise
- Staff need opportunities to collaborate with effective and efficient multidisciplinary teams.

NLaG should therefore be prepared to discuss plans, key milestones, governance, opportunities to streamline, expectations on progress to be made with seed funding, and how the Department and NHSE&I can support delivery.

Given the long lead-times for project development, it has been necessary to choose schemes now based on a list of priority projects already in the pipeline (and engagements with NHSE/I), but it is also recognised that there a number of other schemes suitable for these investments. The DHSC is therefore committing that HIP 3 (2030-2035) projects will be chosen based on an open consultation to determine which new hospital projects should be prioritised.

Areas that are not currently part of HIP 1 and 2 should nevertheless continue developing plans and priorities for local NHS infrastructure, and where exceptionally strong schemes come to light before HIP 3, they will be considered in the context of available funding.

NLaG will need to be prepared to act on any funding that becomes available off the back of any HIP 2 schemes not coming to fruition, and also look to be successful on and future phased programmes in HIP 3.

Trust Capital

Trust capital is limited and could provide an initial investment to kick start transformation of the estate. Whilst capital money is not readily available, and a portion of this capital is required to maintain statutory compliance across the estate whilst the transformation plan is being implemented, NLaG would be expected to fund some of the proposed strategic development internally. To this end NLaG has committed the following capital for 2019/2020:

Table 66 - Trust Capital Commitment (2019/2020)

Finance	Value
Investment to reduce backlog maintenance	£1,805,957
Capital investment for new build	£911,158
Capital investment for improving existing buildings	£3,360,497
Capital investment for equipment	£944,473
Private Sector investment	£0
Public sector investment	£4,969,428
Charity and/or grant investment	£246,700
Energy efficient schemes costs	£1,776,952
TOTAL	**£14,015,165**

Decarbonisation Fund

The Department for Business, Energy and Industrial Strategy (BEIS) recently launched their Salix Public Sector Decarbonisation Scheme. This Grant Scheme will offer £1bn of grant funding to tackle climate change and support the recently published NHS target of delivering net zero emissions in its estate and operations by 2040.

NLaG will be applying for a significant amount of this funding to deliver a range of energy efficiency technologies and heat decarbonisation schemes within our Estate. This will help support a new Energy Performance Contract (EPC) predominantly aimed at SGH and DPoW.

In addition, GDH has been chosen as one of the four Pathfinder projects forming part of the Modern Energy Partners (MEP) Catapult programme. BEIS will help fund a new sustainable Energy Centre at the site replacing coal boilers with a CHP and high efficiency gas heating system. Along with other strategic energy efficiency technologies, these measures, which are planned to be completed by September 2021, will reduce the carbon footprint of GDH by over 60% delivering substantial cost savings to the Trust.

Disposal of Land/ Property

If a new site is identified for the redevelopment of SGH the current site will become subject to disposal once construction is complete and all existing services have been relocated.

NLaG could then commission an independent RICS Red Book valuation of site to try to ascertain what value might be generated by disposing of the site, potentially for residential development.

There are then a number of options the Trust could consider:

1) *Prepare the site for sale on the open market*

In order to prepare the site for sale to realise the maximum value the Trust should prepare and submit an outline planning application. A timescale of between six to nine months is generally required to achieve outline planning consent.

2) *Consider a statutory transfer of the site to Homes England for them to manage the disposal*

Homes England is the Government's land disposal agency, charged with maximising land disposal receipts and accelerating the construction of new houses on surplus public sector land. An NHS Trust can engage with Homes England and agree to transfer surplus land to them for preparation and disposal. The statutory transfer process generally involves the joint commission of a RICS Red Book Valuation on acceptance of which the land can be transferred from the NHS Trust to Homes England for an immediate payment to the Trust of the current market value.

Homes England will then seek to obtain planning, they will carry out any land remediation or demolition and then ultimately sell the site to a developer. If Home England's activity increases the value of the land as anticipated, then 70% of the increase in value, less their holding and project costs are subsequently paid to the NHS Trust by way over overage.

Homes England is a government department and, as such, the transaction would not attract Stamp Duty Land Tax and furthermore the Statutory Transfer Model is approved by HM Treasury. The legal transfer of ownership can be done in as little as two weeks using standard pre-prepared legal documents.

3) *Enter into a land promotion agreement*

Under a typical planning promotion agreement a developer agrees to promote the landowner's property for development – to apply for and use reasonable endeavours to obtain planning permission and, having secured planning permission, to market the property for sale in the open market. In return for providing these services, the developer will receive a fee or a proportion of the net sale proceeds after various costs, such as planning costs and land costs, have been deducted and reimbursed to the developer.

Promotion agreements can be less risky than option agreements and they do have the following advantages for a landowner:

a) After planning permission has been obtained, the promotion land must be marketed for sale and sold in the open market for the best price reasonably obtainable. This ensures that the purchase price for the land will have been market tested which does not happen in the case of an option agreement

b) The developer is less likely to agree to unreasonable planning gain costs with a local planning authority since this will impact on its share of the proceeds of the sale.

4) *Enter into an option agreement with a Housing developer*

There are two sub-options under this opportunity:

a) Grant an '*option*' for a developer to buy the land at a specified point in the future, for example, when planning permission is granted. The price payable for the land is based on the value of the land once planning consent has been obtained

b) Alternatively, enter into a conditional sale contract. The contract may contain any number of conditions but the most commonly used is that when planning permission acceptable to the developer is granted, the sale goes ahead.

By undertaking the disposal, the Trust will satisfy STP obligations that may present an opportunity to apply for future STP Capital allocations and it will make a significant contribution to the DHSCs parliamentary obligation to dispose of £3.3 billion worth of NHS Estate land to be used to develop 26,000 homes.

5.10 Supporting Strategies

This Estate Strategy should be read in conjunction with the following strategies which all need to work together in alignment to deliver the Trust's Strategic Vision.

Digital Strategy

The next steps for NLaG's digital strategy are:

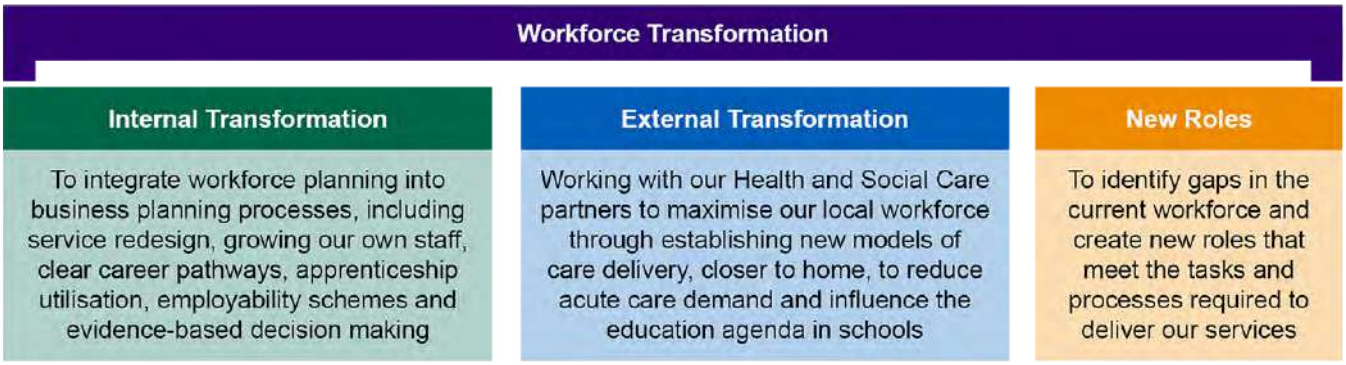
Table 67 - Digital Strategy - next steps

1	**Finance the Strategy**	• Develop a projected four-year digital capital & revenue plan
2	**Infrastructure**	• Modernise devices & processing (laptops, tablets, aim for fleet to be a maximum of three years old or less) • Modernise datacentre (migrate to cloud) • Conduct the HIMSS, INFRAM and EMRAM assessment to establish an industry recognised baseline for digital maturity • Work with ICS, CCG, NHS E/I & other partners to manage expectations & plan for future needs
3	**Digital literacy, engagement & digital quality oversight**	• Recruit CNIO & CCIO • Implement a Digital Operations Group responsible for business case approvals, monitoring project progress, & recommending digital projects to the Digital Strategy Board. Members include representatives from administrative/corporate & clinical providers across the 3 sites • Agree mandatory requirements to support getting the most out of assets, enterprise wide digital systems, where possible avoid fragmented '***one off/ single use***' purchases • Build digital resources to host digital café, and literacy support for use of digital tools • Continue to work with ICS, NHSE/I, & local councils to survey & obtain the levels of digital access within population
4	**EHR & elimination of paper documentation**	• Gain consensus on the priority & direction of the EHR/PAS approach • Ensure pharmacy (prescribing/dispensing); radiology, lab, operating theatres, booking, patient flow, the management & access to information is available in one location • Map patient pathways in EHR • Integrate system data-enterprise information platform/content management • Maximise functionality in current systems • Eliminate use of paper
5	**Data quality & reporting**	• Determine approach for one robust Data warehouse, maximise use of power BI • Eliminate non-value add informatics reports • Support a central oversight team that validates accuracy and assures reports are in compliance with agreed standards for production • Meet mandatory reports and work with NHSE/I to develop statistical process control reporting • Improve reporting dashboard for department managers • Establish central monitoring to enable data viewing and decision making by the operations team to improve patient flow (phased approach to full integrated data centre for patient & resource management-command centre)
6	**Patient Flow**	• Conduct market assessment to procure command centre & use AI to assist with system level management of patients

Workforce Development Strategy

The NHS LTP is clear that ICSs should be the main organising unit for local health services, leading on planning and implementation for place-based workforce planning and transformation locally. To enable this, a programme of internal and external transformation is in development to link together as illustrated below:

Figure 55 - Internal & External Workforce Transformation



The above aligns to the national, regional and local priorities linked to improvements in workforce and working collaboratively to achieve the best for the local health care systems. Workforce is pivotal in ensuring safe services are provided. This is one of the key challenges the Trust is facing with hard to recruit to vacancies and increasing demand. In line with the HCV HCP long term plan NLaG will prioritise:

- Improving retention, developing skills and generating the leaders to support our system of the future
- Developing and increasing the number of new roles linking with and increasing training places, developing apprenticeships and maximising recruitment
- Developing the workplace by focussing on employment practice, improving the wellbeing of our people and introducing new employment models and approaches
- Building the infrastructure and investment by understanding what we need and ensuring appropriate use of the funding available
- Working with education providers to align educational provision to meet the future roles that will become available for career pathways within the NHS, not just clinical
- Developing more support roles within the Trust to underpin clinical services
- Developing a more fluid and portable workforce across both health and social care and reduce barriers and terminology to allow more flexibility to move across each sector
- Supporting Care Homes though the apprenticeship levy funding to make attractive careers for staff working in care homes by upskilling with basic nursing skills to help support patients avoid unnecessary A&E attendances and admissions
- Using talent management processes to upskill current staff into identified vacancies within a five-year workforce plan.

The forecasted changes for workforce applying transformation will see a move away from the traditional staffing model, for both roles and how they are traditionally used, to a more flexible workforce through identifying gaps, removing hard to fill posts, reshaping and redesigning how tasks are undertaken within teams, introduction of new types of workers and the close alignment of workforce transformation to activity and finance to ensure the creation of a sustainable and upskilled workforce for the future.

Transport Strategy

NLaG latest Travel Plan dated 2019-2022 shows NLaG's commitment to sustainable transport. NLaG aims to implement the following measures to help reduce the need for staff to bring their car to work and promote awareness of the benefits of sustainable travel methods.

Table 68 - Transport Strategy timeline

Action	Due By	Site
Walking		
Information on walking routes	Nov 20	All
Promotion of walk to work week	Annually	All
Deliver pedestrian friendly site walking environments ensuring end of walking routes are safe for pedestrians	Nov 21	SGH
Regular walker's breakfast for staff and residents (where applicable)	Nov 21	All
Cycling		
Promotion of/sign up to the Department for Transport's Cycle to Work scheme	Annually	All
Promotion/participation of cycle to work day/scheme	Annually	All
Cycling maps available to staff/visitors	Nov 19	All
Installation of showering/changing facilities for staff across remaining sites	Nov 21	All
Installation of storage lockers across remaining sites	Nov 21	SGH/GDH
Host cycle maintenance/training/Doctor bike events across remaining sites	Nov 20	SGH/GDH
Public Transport		
Make public transport information available through appropriate channels to staff and visitors to each site	Nov 21	All
Improve bus stop waiting facilities at all sites	Nov 21	All
Ensure that all sites benefit from RTI screens displaying bus time information	Nov 21	GDH
Promotion of smart commute ticket	Nov 19	All
Review and refresh timetable for current staff shuttle bus	Nov 20	SGH/DPoW
Smarter Driving/Car Share		
Promote and participate in car free days	Annually	All
Investigate the provision of car sharing spaces	Nov 21	All
Review car parking charges for people car sharing and allocated car share bays	Nov 21	All
Smarter Working		
Increase the use of Smart working practices (i.e., tele/video and web conferencing)	Nov 21	All
Increase the use of flexible/home working/hot desking (work smart)	Nov 20	All
Policies & Procedures		
Create/review a travel policy for staff/visitors	Nov 21	All
Nominate sustainable travel plan champions	Nov 20	All
Travel plan welcome pack for new staff and new residents	Nov 21	All
Promotion, Communication & Events		
Promotion of the travel plans in appropriate newsletters and publications	Nov 19/20	All
Review '***how to find us***' guides for each site	Nov 21	All
Provide staff with personalised travel planning information	Nov 21	All
Staff travel survey, commuter challenge, active travel campaigns & annual travel plan review	Annually	All
Review & republish Travel Plan & Measures	Nov 21	All
Keep records of participation levels in sustainable travel schemes & incentives	Nov 20	All
Monitor usage of car parks	Nov 20	All
Monitor number of car sharers	Nov 20	All
Establish a Travel Plan Steering Group & Working Groups (e.g., parking, cycle user group etc.)	Nov 19	All
Additional Infrastructure Improvements		
Review on site crossing points to ensure standard design. Ensuring a continuous route of tactile crossings	Nov 21	SGH
Review Goole on site road services	Nov 21	GDH
Reduce impact of on street parking in surrounding site neighbourhoods	Nov 21	All

5.11 Constraints and Barriers

As with all large-scale strategic development there will be a number of constraints and barriers which will impact implementation which include, but are not limited to, the following:

- Previous lack of investment in buildings and critical infrastructure
- Availability of funding for whole scale transformation
- Ability to work successfully with other Trusts, CCGs and wider STP partners
- Co-operation of NHS PS and other landlords
- Willingness of other parties to support vision
- Future commissioning plans
- HR Policies, Procedures and required Management changes
- Workforce
- Technology
- Appetite.

All constraints and barriers identified throughout this process will be considered in more depth at Business Case Stage. However, plans to prevent some of these being a barrier to the transformation of the estate can be set in motion now.

5.12 Risk

The Estates Strategy must ensure that risk is minimised in all forms; that environments are safe and provide a high-quality experience for patients and visitors. The environment in which services are delivered should be maintained to a high standard and support staff to deliver high quality care.

The aim of this Estates Strategy is to eliminate, minimise or adequately control risks associated with the built environment and to ensure that any investment decisions are affordable, represent value for money, provide added value and support the Trust's financial plans.

Risk, individual to the schemes identified within this Estates Strategy will be analysed in more detail through the business case process.

The Trust have an overarching Governance and Risk Management Strategy 2019-2024. The Governance and Risk Management Strategy is an integral part of the Trust's approach to continuous quality improvement and is intended to support and assist the organisation in delivering the key objectives within the Trust's Quality Strategy as well as ensuring compliance with external standards, duties and legislative requirements including those relating to the Trust's License with NHSI as a Foundation Trust.

The overall objective of the Risk Management Strategy for the next five years, is to have an organisation which:

- is fully 'risk aware' – where risk management is embedded within the organisation's culture, is integrated into the working practices of all grades and disciplines of staff and encourages and empowers those staff to identify and control risk which could affect the Trust's ability to achieve its objectives, especially its strategic objectives
- encourages the open reporting of mistakes made, within a 'Just' culture, and ensures that lessons are learnt from those mistakes and that measures to prevent recurrence are promptly applied
- accepts that Risk Management is everyone's responsibility.

The Estates Strategy will be delivered within the framework of the Trust Governance and Risk Management Strategy.

5.13 Benefits

The strategic development of the estate will provide a number of tangible benefits for patients, staff, visitors, and commissioners and the wider health and social care economy and support the Trust to deliver its strategic framework. The estates anticipated high level benefits will include:

- A cost-effective quality estate which is safe, sustainable, efficient, and fit for purpose delivering services in the right place at the right time, which are patient centred and allows us to "live within our means"
- Alignment with Trust, regional and national objectives including the reduction of out of area placements, strengthening of community services and development of specialist services in preparation for further development of the STP and new models of care
- Alignment with the expectation of regulators e.g., NHSI/E, CQC, HSE
- An estate that better meets the current and future needs of the population served, which will allow service transformation and whole system thinking
- Improved flexibility to respond to new service developments or minimise the impact of service or activity retractions
- A working partnership with other providers and partner organisations across the region including working in partnership with PCN's
- Increased level and an enhancement of services in the community to ensure they are delivered in the right place at the right time
- An estate which meets national targets such as those indicated in the Carter Review and Carbon Reduction Commitment, the NHS Net Zero Carbon Plan etc.
- Demonstrable improvements in quality and patient experience linked to the delivery of the Trust's quality priorities
- A reduction in the frequency and severity of adverse incidents
- Improved environmental performance (including carbon reduction).

5.14 Recommendations

It is recommended that the Trust Board approve this estates strategy in conjunction with other supporting strategies and show commitment to progress with the alignment of this estates strategy with the outcomes from the HASR and share with the HCV HCP in order to commence discussions and negotiation with the wider health economy.

This will begin the process of a system wide transformational change which will ultimately deliver a sustainable, cost effective, safe and fit for purpose estate integrating health and social care services to support and improve health outcomes.

This will involve supporting the development of a Strategic Outline Case (SOC) to secure HIP funding which has been identified as being available to the Trust subject to robust plans.

Appendices

Appendix A - Glossary of Abbreviations and Acronyms

AAU	Acute Assessment Unit
A&E	Accident & Emergency
AI	Artificial Intelligence
AMR	Automatic Meter Reading
APIs	Application Processing Interfaces
BEIS	The Department for Business, Energy and Industrial Strategy
BI	Business Intelligence
BLM	Back Log Maintenance
BMA	British Medical Association
BMS	Building Management System
BREEAM	Building Research Establishment Environmental Assessment Method
CAFM	Computer Aided Facilities Management
CCG	Clinical Commissioning Group
CCIO	Chief Clinical Information Officer
CCU	Cardiac Care Unit
CHP	Combined Heat and Power
CIO	Chief Information Officer
CIP	Cost Improvement Programme
CIR	Critical Infrastructure Risk
CNIO	Chief Nursing Information Officer
COSHH	Compliance with Control of Substances Hazardous to Health
COVID-19	Coronavirus
CQC	Care Quality Commission
CT	Computerised Tomography
CTG	Cardiotocography
DHSC	Department of Health & Social Care
DHSC	Department of Health and Social Care
DPoW	Diana, Princess of Wales Hospital
ECC	Emergency Care Centre
ED	Emergency Department
EDs	Emergency Departments
E&F	Estates & Facilities
EHR	Electronic Health Record
EMAS	East Midlands Ambulance Service
ENT	Ear, Nose & Throat
EMRAM	Electronic Medical Record Adoption Model
EPC	Energy Performance Contract
ERIC	Estates Return Information Collection
ERoY	East Riding of Yorkshire
ESCO	Energy Service Companies
FGR	Fatal Growth Restriction
FRF	Financial Recovery Fund
FYFV	Five Year Forward View
GDH	Goole and District Hospital
GP	General Practitioner
GPs	General Practitioners
HASR	Humber Acute Services Review
HCV HCP	Humber, Coast and Vale Health and Care Partnership
HCP	Health Care Partnership
HCPs	Health Care Partnerships
HCV STP	Humber, Coast & Vale Health & Care Sustainability Transformation Partnership
HDO	Healthcare Delivery Organisation
HDU	High Dependency Unit
HED	Healthcare Evaluation Data
HIMSS	Health Information and Management Systems Society
HIP	Health Infrastructure Plan
HLHF	Healthy Lives, Healthy Futures
HR	Human Resources
HSAWA	Health and Safety at Work Act
HSE	Health & Safety Executive
HSMR	Hospital Standardised Mortality Ratio
HUTH	Hull University Teaching Hospital
HV	High Voltage
ICPs	Integrated Care Partnerships
ICS	Integrated Care System
ICSs	Integrated Care Systems
ICU	Intensive Care Unit
INFRAM	Infrastructure Adoption Model
IMDT	Integrated Multi-Disciplinary Team
IT	Information Technology
ITU	Intensive Therapy Unit
ITUs	Intensive Therapy Units
JAG	Joint Accreditation Group
LA	Local Authority
LED	Light-Emitting Diode

LTFM	Long Term Financial Model
NHS LTP	NHS 10 Year Long Term Plan
MDI	Multi-Disciplinary team
M&E	Mechanical & Electrical
MIU	Minor Injuries Unit
MRET	Marginal Rate Emergency Rule
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MTHW	Medium Temperature Hot Water
NEEF	NHS Energy Efficiency Fund
NEL	North East Lincolnshire
NEWS	Early Warning Score
NHSE	NHS England
NHSE/I	NHS England/Improvement
NHSI	NHS Improvement
NHS PS	NHS Property Services
NL	North Lincolnshire
NLaG	Northern Lincolnshire and Goole NHS Foundation Trust
OBC	Outline Business Case
ONS	Office of National Statistics
OPE	One Public Estate
PALS	Patient Liaison Service
PAS	Patient Administration System
PCBD	Pre-Consultation Business Case
PCNs	Primary Care Networks
PGME	Post Graduate Medical Education
PIU	Planned Investigation Unit
PLACE	Patient Led Assessment of the Care Environment
PPE	Personal Protective Equipment
PSCP	Principle Supply Chain Partner
PSF	Provider Sustainability Funding
QIPP	Quality, Innovation, Productivity and Prevention
QS	Quantity Surveyor
RABM	Risk Adjusted Backlog Maintenance
RAG	Red, Amber, Green
RAS	Referral Assessment Service
RDaSH	Rotherham Doncaster and South Humber NHS Foundation Trust
RICS	Royal Institute of Chartered Surveyors
RTI	Real-Time Innovations
RTT	Referral to Treatment
SCP	Supply Chain Partner
SDEC	Same Day Emergency Care
SGA	Small for Gestational Age
SGH	Scunthorpe General Hospital
SHMI	Summary Hospital Level Mortality Indicator
SOC	Strategic Outline Case
STP	Sustainability and Transformation Plan
STPs	Sustainability Transformation Partnerships
TBC	To Be Confirmed
TPs	Trust priorities
UPVC	Un-plasticised Poly Vinyl Chloride
UTC	Urgent Treatment Centre
VAT	Value Added Tax
VTE	Venous Thromboembolism
VCSE	Voluntary, Community and Social Enterprise
WRVS	Women's Royal Voluntary Service
WTE	Whole Time Equivalent

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Appendix B – List of Consultees

Internal

- Trust Secretary
- Directorate of Finance
- Chief Nurse Directorate
- Operations Directorate
- Medical Directors Office
- Directorate of Digital services
- Directorate of Strategic Development

External

- North Lincolnshire Council
- North East Lincolnshire Council
- East Riding Council
- North Lincolnshire CCG
- North East Lincolnshire CCG
- One Public Sector Estates – Lincolnshire
- NHSE/I
- Humber Vale & Coast PMO

Five Year Estate Strategy 2021-2026

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

January 2021

Contents

1 Introduction	Foreword	Trust Profile	
2 Where Are We Now?	The Estate	FM Costs	Six Facet Surveys
	Capital Investment	Backlog Maintenance	Trust Estate Summary
3 Where Do We Want To Be?	Priorities / Objectives	Strategic Alignment	Challenges
	A More Productive / Efficient Estate		
4 How Do We Get There?	Delivering the Estate Strategy Aims	Options for Estates Development	Implementation Plan
	Funding	Constraints and Barriers	Benefits

Foreword

We are pleased to be able to share our Five Year Estate Strategy for 2021 – 2026 which has been developed to offer an integrated approach to Northern Lincolnshire and Goole NHS Foundation Trust's estate, relative to proposed service models and aligned to both national and local strategies including the Humber, Coast & Vale Integrated Care System.

This strategy supports the Trust's ambition to provide a range of high-quality, ever-improving services in a dynamic and stimulating environment which attracts the best staff.

It describes how assets could change through investment, acquisition or disposal to meet future needs and how the Trust intends to position its estate and infrastructure as a key enabler in the delivery of clinical services that are safe, secure and appropriately located.

This strategy document is one of a number of enabling strategies that work in partnership to support delivery of the Trust's Annual Plan and Clinical Services Strategy.

Terry Moran
Chair

Peter Reading
Chief Executive

NLaG - Trust Profile

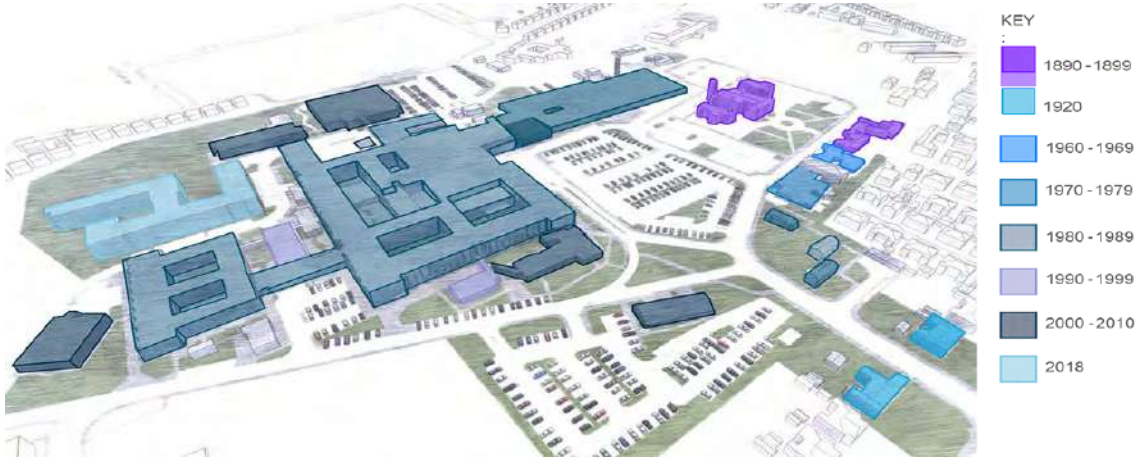
Serving a population of **450,000**	3 hospital sites **860** beds	**6,500** staff employed	Received **148,500** ED attendances	Delivered **4077** babies
Performed **112,000** surgical operations	Received **112,200** inpatient admissions	Received **397,100** outpatient attendances	Covering wide **142,535m²** geographical area	Delivering a range of hospital-based and community services

1 Where Are We Now?

The Estate

- NLaG operates from three main hospital sites and several community premises.

Diana Princess of Wales Hospital



Goole and District Hospital

Scunthorpe General Hospital

- 73% of DPoW site is 36+ years old;
- Almost half (44%) of SGH is 36+ years old;
- 100% of GDH built between 1985 and 1994;
- Over 11% of community estate pre-dates 1948.

Six Facet Surveys

- Six Facet Surveys were undertaken across the Trust in the first half of 2020.
- The estate was reviewed on the basis of:

- Physical Condition
- Statutory Compliance
- Space Utilisation
- Functional Suitability
- Quality
- Environment

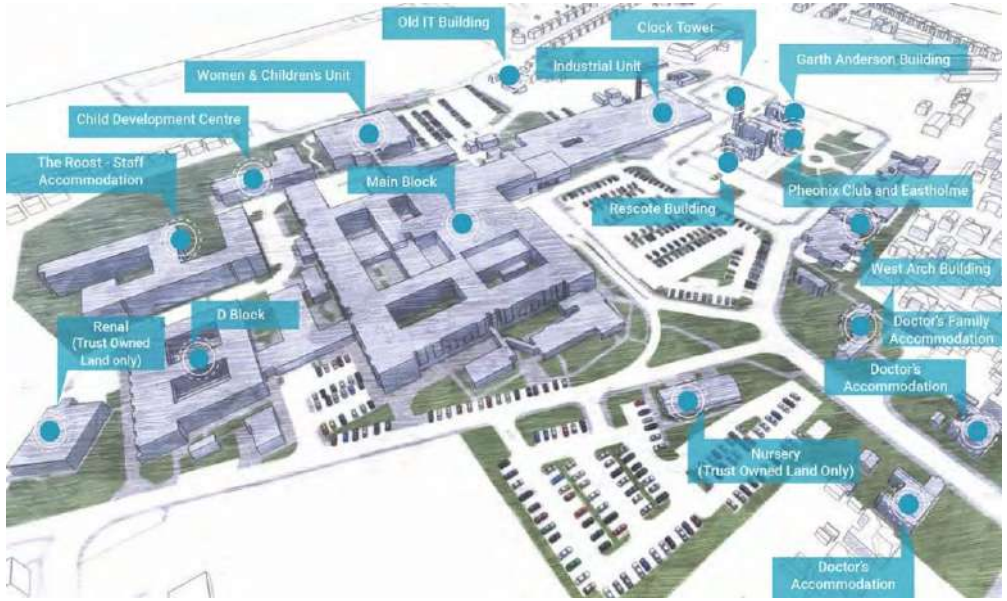
The Estate was ranked in accordance with the Department of Health's Estate Code whereby all buildings should be ranked as Condition B (or above) – Sound, operationally safe and exhibits only minor deterioration.

EstateCode Physical Condition rankings:

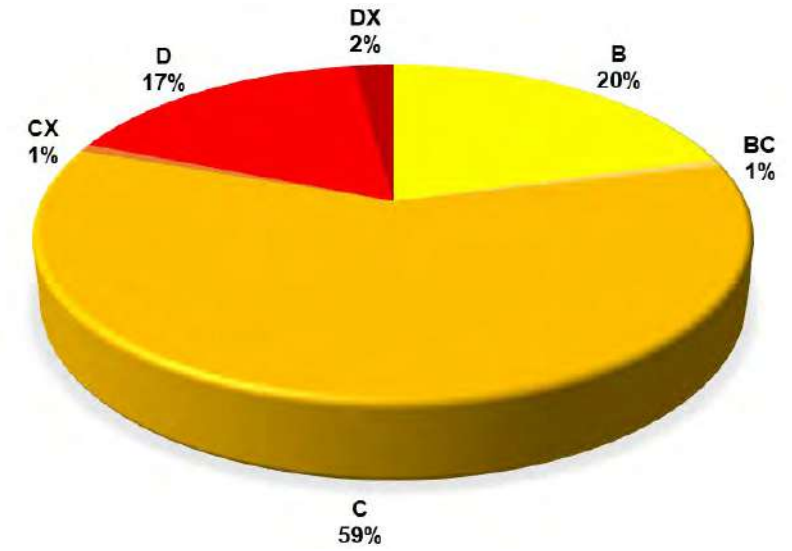
Rank	Description
A	As new (that is built within the last 2 years) and can be expected to perform adequately over its expected shelf life.
B	Sound, operationally safe and exhibits only minor deterioration.
B/C	Operationally safe, however falling into Condition C within 1 year.
C	Operational but major repair or replacement will be needed soon, that is within 3 years for building elements and 1 year for engineering elements.
CX	Operational but major repair or replacement will be needed soon, that is within 3 years for building elements and 1 year for engineering elements. Item will require total rebuild or relocation.
D	Runs a serious risk of imminent breakdown
DX	Runs a serious risk of imminent breakdown. Item will require total rebuild or relocation.

Costs identified in surveys exclude VAT.

Diana, Princess of Wales Hospital



Physical Condition



Net Cost per Facet – to improve condition of estate

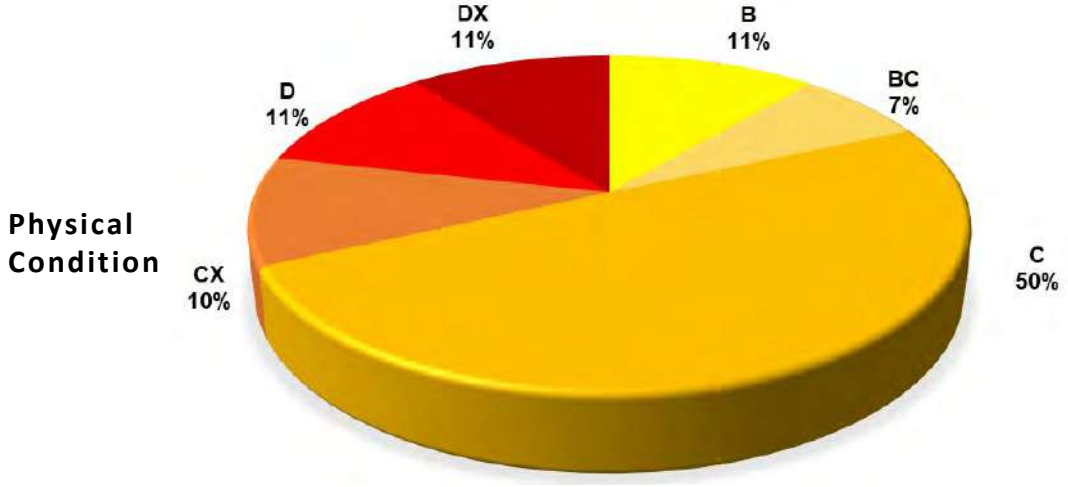
Physical Condition	£21,129,452
Statutory Compliance	£845,386
Quality	£415,200
Functional Suitability	£259,210
Environmental	£5,040,000
Space Utilisation	£0
TOTAL	**£27,689,248**

- **19%** of the total investment required to bring the estate up to a satisfactory condition is classified for elements '***running a serious risk of imminent breakdown***' (Category D and DX)
- **60%** of the estate **requires major repair or replacement works** (Category C and CX).
- Within one year an additional 1% of the costs will also fall into this category (Category B/C) resulting in **a total of 61% of the estate requiring major repair or replacement works.**
- The three sites requiring the **most significant investment** are the '*Main Block*', '*Industrial Zone*' and '*D Block*' which collectively covers 42,817m^2, totalling approximately **82% of the overall surveyed site area.**

Scunthorpe General Hospital

Net Cost per Facet – to improve condition of estate

Physical Condition	£47,633,491
Statutory Compliance	£1,343,880
Quality	£6,687,600
Functional Suitability	£2,718,000
Environmental	£1,800,000
Space Utilisation	£0
TOTAL	£60,182,971



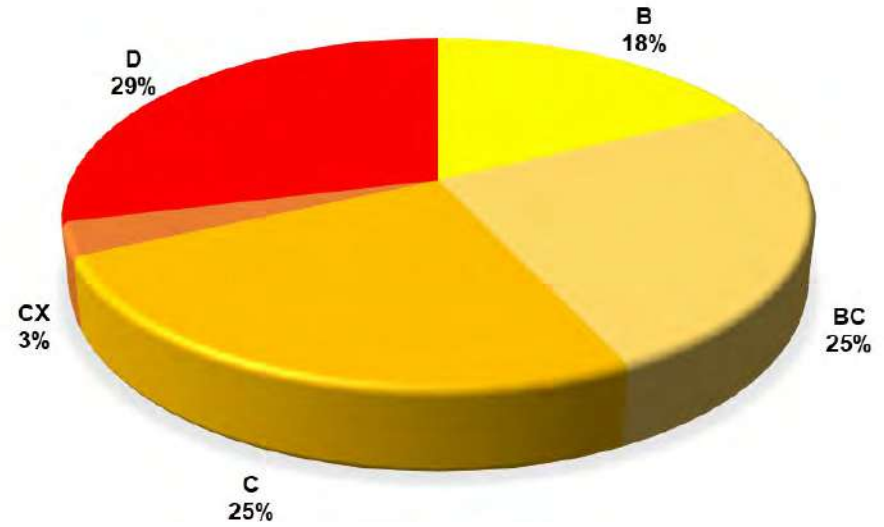
- **22%** of the total investment required to bring the estate up to a satisfactory condition is classified for elements '***running a serious risk of imminent breakdown'*** (Category D and DX).
- Out of the remaining 78%, **60% of the cost is for elements requiring major repair or replacement works** (Category C and CX).
- **Within one year an additional 7% will fall into this category** (now Category B/C). This will then total 67% of costs on elements requiring major repair or replacement works.

Goole and District Hospital

Net Cost per Facet – to improve condition of estate

Physical Condition	£7,813,472
Statutory Compliance	£889,440
Quality	£738,000
Functional Suitability	£102,000
Environmental	£288,000
Space Utilisation	£0
TOTAL	**£9,830,912**

Physical Condition



- There were six blocks surveyed at the Goole & District Hospital Site.
- **29%** of the total investment required to bring the estate up to a satisfactory condition is classified for elements ***'running a serious risk of imminent breakdown'*** (Category D).
- **28% of the costs are for elements requiring major repair or replacement works** (Category C and CX).
- **Within one year an additional 25% of costs will fall into this category (**Category B/C).
- This will then total 53% of the costs for elements requiring major repair or replacement works

Capital Investment: 2015-2020

- In 2018/19 NLaG's capital investment programme was focused on the use of the Trust's own capital, with the exception of a £1.3m cardiac project and £1.2m of essential replacements funded by urgent capital support funding.
- In late 2020 the Trust was able to confirm receipt of £29.26m of capital funding over the next five years as part of the HCV HCP capital bids
- The tables on this slide and the following one illustrate the **capital schemes that have been completed or scoped by the Trust over the last five years by site.**

Diana Princess of Wales Hospital

Ref	Project	Progress / Status	Date
1	Cardiology Day Case Unit	Complete	2015
2	Assisted Living Centre	Complete	2015
3	Retail Catering Reconfiguration	Complete	2016
4	Theatres 3,5 and 6	Complete	2016
5	Main Concourse	Complete	2017
6	Carter Review - Land Disposal	Complete	2018
7	Demolish and Reconfigure (Northside)	Complete	2018
8	New Staff Accommodation	Complete	2018
9	Home from Home facility on ward A1 Reconfiguration	Complete	2018
10	New 2 x 1.5T MRI facilities	Onsite	April 2021
tbc	Water System Upgrades	Ongoing	Ongoing
tbc	Theatres 7 and 8	Not Started	TBC
tbc	New Modular CT,	Complete	Jan 2021

Capital Investment: 2015-2020

Scunthorpe General Hospital

Ref	Project	Progress/ Status	Year
1	New endoscopy suite	Complete	2017
2	Theatre D refurbishment	Complete	2017/8
3	Wards 10 and 11 decant from Coronation Block to Queens Bldg	Complete	2018
4	Minor upgrade and reconfiguration of ECC	Complete	2018
5	Additional ED treatment rooms for GP Streamlining	Complete	2019
6	Relocate Belton House (Linked to SGH accomm).	Feasibility Stage	2019
7	Implement SGH Accommodation Strategy (Demolish Belton and Croxton House)	Feasibility Stage	2019
3	Re-purpose Coronation block (currently looking at refurbishing two floors for admin)	Feasibility Stage	2019
8	Renewal of the boilers at associated infrastructure	Feasibility Stage	2019
9	Development of CT	Complete	2019
10	Development of an additional MRI	Contract Awarded	2019
11	Ward 29 conversion into clinical ward	Complete	2020
12	Ward refurbishments as prioritised by clinical need	Awaiting Clinical Strategy	TBC
13	Relocate remaining clinical services in Coronation block to fully empty block	Awaiting Clinical Strategy	TBC

Goole and District Hospital

Project	Progress/ Status	Year
Disposal of six residential properties currently owned by the Trust	Complete	2018
Replacement of the coal fired boilers	Feasibility	2020

Community Properties

Project	Progress/ Status	Year
Dispose of several properties and acquire (leasehold) of Global House	Complete	2017

Backlog Maintenance

Total Backlog Maintenance

Total Backlog maintenance costs identified (at 31 March 2020) over the next five years are:

Site	Total Facet Survey Costs (works cost only)
Scunthorpe General Hospital	£60,182,971
Diana Princess of Wales	£27,689,248
Goole and District Hospital	£9.830,912
TOTAL	**£97,703,131**

Risk Adjusted Backlog Maintenance (RABM)

RABM is reported annually to DHSC via ERIC and is the cost associated with ensuring the estate is safe and fit for purpose and requires an ongoing annual capital investment, in conjunction with a team which is able to deliver the Capital Programme.

The surveys identified a **RABM cost/Critical Infrastructure risk of £51,124,069**. This cost is split between the three acute sites as follows:

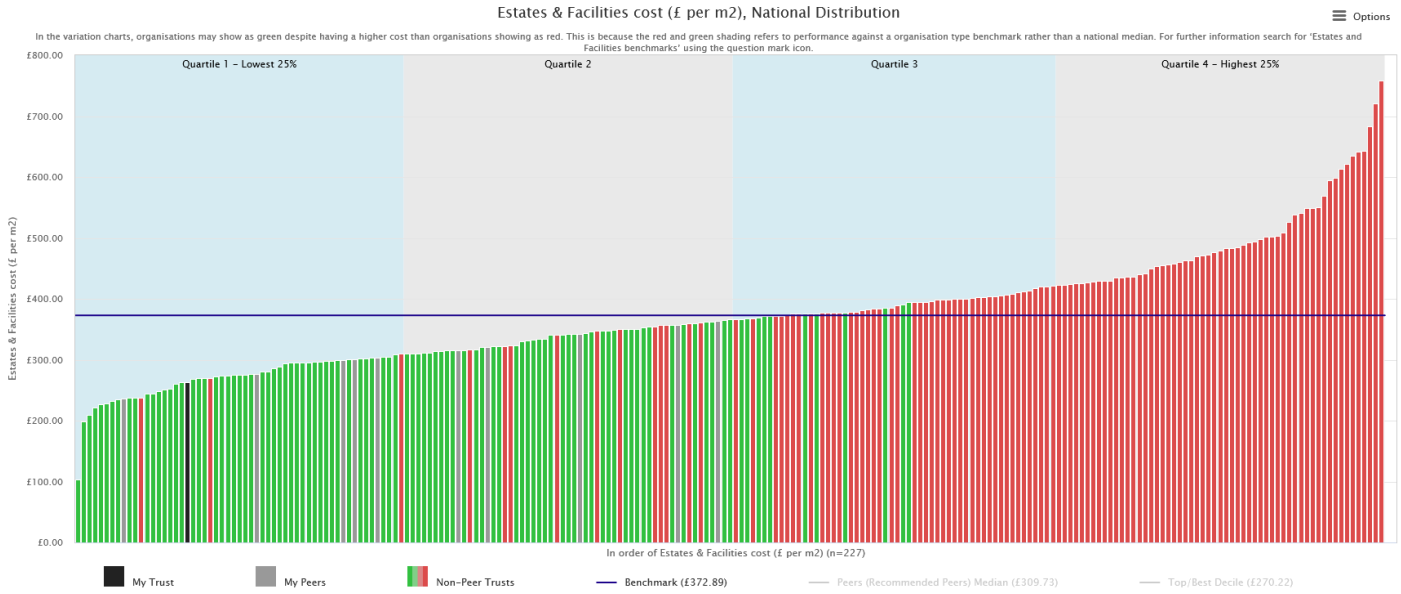
Site	Total Critical Infrastructure Risk / RABM Costs (net)
Scunthorpe General Hospital	£27,613,703
Diana Princess of Wales	£19,360,230
Goole and District Hospital	£4.150,136
TOTAL	**£51,124,069**

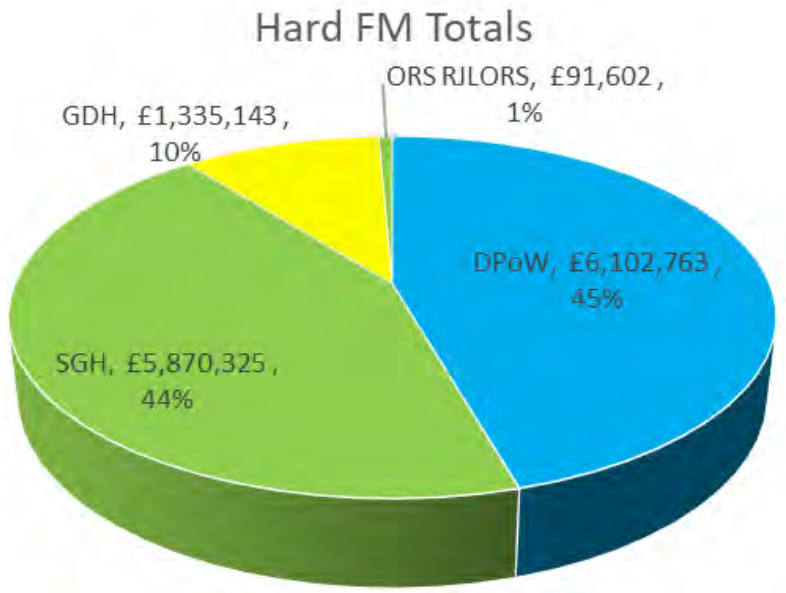
Critical Infrastructure Risk/RABM costs amount to over half of the forecasted capital expenditure/investment required over the next five years.

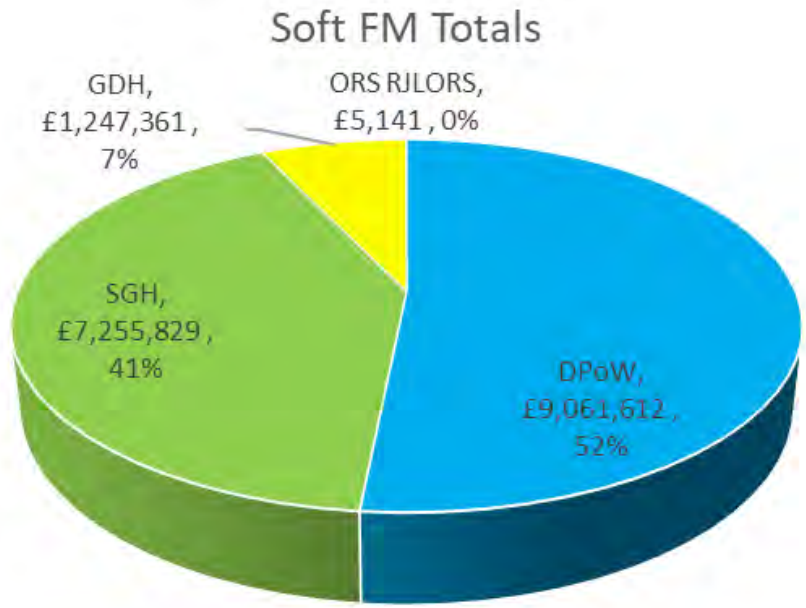
If there is no significant capital investment over the next few years this safety critical risk will increase year on year. RABM should therefore be a **key consideration when looking at an overall investment/dis-investment strategy.**

Facilities Management (FM) Costs

- Total FM Costs for 2019/20 were nearly **£39.5m**, split between Hard FM **(£13.4m**), Soft FM (**£17.55m**) and Finance Costs (**£8.1m**)
- A reduction in occupancy costs, particularly Hard FM, will be made through new developments, as buildings will be more operationally efficient and environmentally sustainable
- In addition, new builds will be designed to deliver new models of care and patient pathways which will reduce inefficiencies leading to a smaller overall floorplate.
- The chart below demonstrates that the estates and facilities costs (£ per m2) for NLaG (shown on the black bar) are in the lowest 25% of Trusts in England







Trust Estate Summary

- In many areas, the **physical condition of estate and quality of accommodation is not fit for purpose** and is a major financial risk
- The majority of buildings are **not appropriate for delivery of modern healthcare services,** e.g., they do not meet standards for en-suite facilities or the proportion of single rooms
- The estates backlog is **c.£97.7m** after years of under investment, of which **c.£51.1m** is Critical Infrastructure
- **Non-compliance with fire standards and water infrastructure** issues have led to the closure of clinical areas
- There are **clinical equipment deficits** – i.e. a requirement for additional scanners
- There is an **urgent need to ensure all hospitals have increased single room capacity on wards and appropriate space in waiting areas as a result of COVID**. This will include the need to separate emergency and elective pathways wherever possible and use digital processes as a way of minimising patient contact.
- For the longer term, the ongoing transformation schemes to support patient flow through the hospital within the **development of the Acute Assessment Units, and new builds to increase MRI and CT scanning capacity,** will ultimately help configure the estate to support the clinical capacity in fit for purpose facilities.
- The Trust is currently **developing plans to deliver new ED/AAU facilities at both DPoW and SGH** to the value of £54.86m.
- To address the high risks, NLaG is working in collaboration with the Integrated Care System and progressing with a **Strategic Outline Case (SOC)** in readiness to **secure large scale capital under the national Health Infrastructure Plan (HIP)**

2 Where Do We Want To Be?

Priorities/Objectives

2024 priorities - Trust will have:

- Integrated urgent and emergency care
- Transformed outpatient services
- Partnership working with PCNs
- Specialities reconfigured onto one site where appropriate
- Restructured Cancer Services
- Created a sustainable hospital at Goole

Covid Recovery

Recovery from COVID impact on activity; Restoration planning and resilience; Implementing beneficial transformation changes; Refining the 'new normal' model of care

Trust Quality Priorities

Patient Experience
- *Waiting lists* - QP1: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups
- *Patient Feedback* - QP6: Improve the quality and timeliness of complaints responses using a more individualised approach

Clinical Effectiveness
- *Mortality and End of Life* - QP2: Reduce mortality rates and strengthen end of life care

Patient Safety
- Improve the Management of Diabetes - QP3

Patient Experience & Clinical Effectiveness
- *Cancer Pathways* - QP4: Improve the effectiveness of cancer pathways focussing on time to diagnosis
- *Quality and Timeliness of safe Flow & Discharge* - QP5: Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon

Estates and Facilities

Improved quality, Reduction in operational costs; Reduction in backlog maintenance; Improved adjacencies and efficiencies

Humber Acute Services Review Priorities

Urgent Care

Providing access to advice and treatment 24/7 via NHS 111 or online, reducing the number of patients in hospital who do not need to be there, improving support for frail elderly people.

Maternity

Ensuring women can make informed choices, reducing the number of still births, increasing continuity of care.

Planned Care

Transforming hospital outpatients, continuing the national diabetes prevention programme, improving waiting times for planned surgery. Specific goals for Planned Care include:

- Prevention
- Empower patients & communities
- Digital
- Workforce
- Integrated care
- Reduce accessibility inequalities

Integrated Care System
- Help people to look after themselves and to stay well
- Provide services that are joined up across all aspects of health & care
- Improve care provided in key areas
- Make the most of all resources

Building better places

HCV CP is leading and coordinating the building better places project which lays out the ambition to build a healthier vision for the Humber region.

The following partners from across the public and private sector are involved in the programme:

Greater Lincolnshire Local Enterprise Trust	Hull City Council	Hull University Teaching Hospitals NHS Trust
Humber Local Enterprise Partnership	North Lincolnshire Council	NHS East Riding of Yorkshire CCG
NHS Hull CCG	NHS North Lincolnshire CCG	NHS North East Lincolnshire CCG
Shared Agenda	University of Hull	University of Lincoln

Investment Plans

HCAV HP's investment proposition is about much more than improving healthcare services and the places where they are delivered. Plans for improving healthcare include:

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

The Partnership's plans encompass eight unique visions, spanning the region's economy, healthcare services, buildings, workforce, digital infrastructure, sustainability, research and development, and long-term prosperity.

By driving a collaborative, region-wide approach to investment planning and implementation between Local Authorities (LA), NHS organisations, Local Enterprise Partnerships (LEP), universities, and private and public sector organisations, the partnership can achieve its bold ambitions and deliver a lasting legacy of transformative health improvements across the Humber, building great places to live, learn and work for generations to come.

Strategic Alignment

As the ICS strengthens **collaborative working across the health system** the priority in terms of '*Provide services that are joined up across all aspects of health and care*' will be underpinned by:

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

Challenges

This is all set in the context of an organisation facing the dual challenge of double special measures, both quality and financial, resulting in the rebuilding of many services. The latest Care Quality Commission (CQC) inspection report (published Feb 2020) showed some improvements but the Trust was rated as *'requires improvement'* overall. It is clear the Trust faces challenges on several fronts including:

It is important that NLaG plans to deliver within the overarching health and care landscape, within the context of the existing challenges, while addressing the new challenges that COVID-19 brings to the organisation.

A More Productive/Efficient Estate

In addition to understanding the organisational objectives and strategies impacting the estate, evaluation of the current position of the estate in terms of finance and performance has highlighted the need to improve the performance and productivity of the estate on a number of levels including:

- Improving utilisation of clinical space to reduce inefficiency and maximise the use of the highest quality assets for optimal income generation
- Reducing the amount of estate used for non-clinical activities and incentivise efficient use
- Improving the efficiency of long-term assets through disposal, demolition or reconfiguration
- Provide easily accessible services and facilities
- Supporting the provision of a technology led and enabled environment to enhance productivity and utilisation of resources (including space)
- Adopting a set of metrics which show both the cost and performance of built assets to support Service Line Management principles
- Reducing operating costs through effective use of resources, robust management and environmental performance improvements
- An implementation plan which is capable of being delivered in phases, each of which can 'stand-alone'
- Being productivity enabling whilst achieving return on investment
- Ensuring the physical condition of the estate is based on health and safety and business risk assessments
- Reflects the Trust's desired image and reputation

3 How Do We Get There?

Delivering the Estate Strategy Aims

The Trust has identified existing and future potential capital development options across the estate. In response to the issues with the current estate, the following range of options would facilitate the provision of a modern, high-quality, safe, clinical environment. The tables shown highlight the status and value of **current planned schemes**.

Project	Est. Value	Funding	Site Operational
Major Capital Still to be Approved			
New SGH Development - Pre-Consultation Business Case (PCBD) SOC	c.£400+m	DHSC/NHSE/I	Post 2030
Wave 5 National ICS/STP Bidding to incl. DPoW / GDH	c.£150+m	DHSC/NHSE/I	TBC
Trust Approved			
ED/AAU (ED x 2 and AAU x 2)	£54.86m	ETP and ED Funding	ED - 2021/22 AAU – 2022/23
SGH MRI	£4.88m	STP Wave 4 / Trust Capital	2021/22
DPoW MRI	£8m	DHSC Loan	2021
DPoW CT	£1.9m	DHSC Loan / Trust Capital	Dec 2020/Jan 2021
Critical Care	£1.4m	NHSE/I	Dec 2020/Jan 2021
Critical Infrastructure Risk (CIR)	£3.6m	NHSE/I	Mar 2021
COVID Equipment	£1m	COVID	Ongoing

Project	Est. Value	Funding	Site Operational
Awaiting Approval			
Goole Energy Scheme	£2.4m	Central Gov.	TBC
Trustwide Energy Performance Contract (EPC3)	TBC	PSDS scheme	TBC
Infection Prevention Control (IPC) - Phase 3/COVID/Winter)	£24m	NHSE/I	Winter 2020/21
Digital Accelerator	£5m	NHSE/I	TBC
Approved Core Capital and Completed Schemes			
Back Log Maintenance (BLM)	£1.8m	Core	March 21
IM&T	£1.4m	Core	March 21
Equipment	£1.3m	Core	March 21
Mental Health and Mortuary - CQC	£0.9m	Core	TBC
Endoscopy JAG Accreditation	£0.037m	Core	2021/22
SGH Ward 29	£2m	Core	Completed/ Open

Options for Estates Development *- Short to Medium Term*

Integrated Urgent and Emergency Care

- NLaG is developing plans for new A&E Departments and Acute Assessment Units at both DPoW and SGH.
- The new facilities will allow for service transformation and enable Urgent and Emergency care to come together in a multidisciplinary assessment area, co-locating surgical and medical assessment with same-day emergency care.
- The total estimated project budget is £54.86m.

Urgent Care Scheme - Diana Princess of Wales Hospital (DPoW) Scope

Urgent Care Scheme - Scunthorpe General Hospital (SGH) Scope

Options for Estates Development *- Longer Term*

Transformed Outpatients

- This programme will be delivered by enabling the use of technology, innovation and efficiency to support operational teams to maximise capacity in outpatients and deliver the transformational change of clinical pathways across primary and secondary care.
- The programme has been accelerated through COVID-19, due to the need to move to virtual assessment and review where safe to do so.
- It is anticipated that the outcome of the Humber Services Acute Review and the more developed future strategic direction of the HCV HCP will identify those services which can be amalgamated regionally and delivered across the whole regional health economy.

Work in Partnership with Primary Care Networks

- The right estate in the right place will play a key role in helping to facilitate the Transformation of Primary Care.
- To fully understand the clinical need and consequent opportunities to improve services, activity and capacity modelling of primary and community services, alongside those that could be provided out-of-hospital, should be undertaken.
- This will allow objective decisions to be made on the opportunities to provide services in the community closer to where people live and enable an estates strategy and implementation plan to be developed which will support the transition.
- NLaG will work with the HCV HCP and Primary Care Sector to understand how this transformation will develop and will update subsequent Estate Strategies accordingly.

Options for Estates Development – *Longer Term*

Restructured Cancer Services

- The Trust has invested, and continues to invest, in much-needed additional scanning capacity and has been successful in receiving capital funding to install CT and MRI facilities at Diana, Princess of Wales Hospital and an MRI suite at Scunthorpe General Hospital.
- NLaG is also part of the Humber, Coast & Vale Partnership Strategic Diagnostic Programme to achieve the development of regional diagnostics centres to support improvements in waiting times to diagnose and treat.
- This will also support achievement of the Trust's priorities for Integrated Urgent and Emergency Care, Outpatient Transformation and Restructured Cancer Services.

Create a Sustainable Hospital at Goole

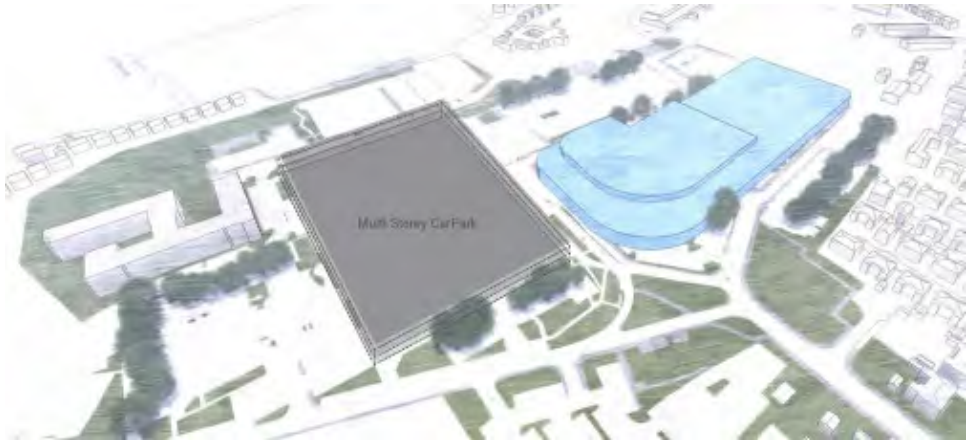
Goole and District Hospital's physical condition facet survey results highlighted that the whole site has either 'very poor facilities' or 'less than acceptable facilities' and 'requires capital investment or replacement' such as:

- Demolition of existing facilities
- New build 2-storey hospital
- New car parking facilities
- Land disposal

Options for Estates Development – *Whole Scale Transformation*
New Hospital Developments

- This Trust strategic priority also supports **HCAV HP's Investment Plan Vision, Building Better Places**.
- NLaG will look to secure future funding to **develop new hospitals** at Diana Princess of Wales Hospital (Grimsby), Scunthorpe General Hospital and Goole District Hospital.
- Options for these **new hospital developments** were proposed in the NLaG 2020-2050 Masterplan produced in early 2020.

- The long-term plan for the **Diana, Princess of Wales** Hospital is to demolish the existing hospital buildings and **build a new 3-storey hospital** with new car parking facilities.
- The Trust is also developing proposals to **build a brand new hospital** on a new site **in Scunthorpe** which would enable a faster, cheaper and much more efficient construction process. These findings have led to four new potential sites being identified by the Trust which are currently under evaluation.



Options for Estates Development – *Whole Scale Transformation*

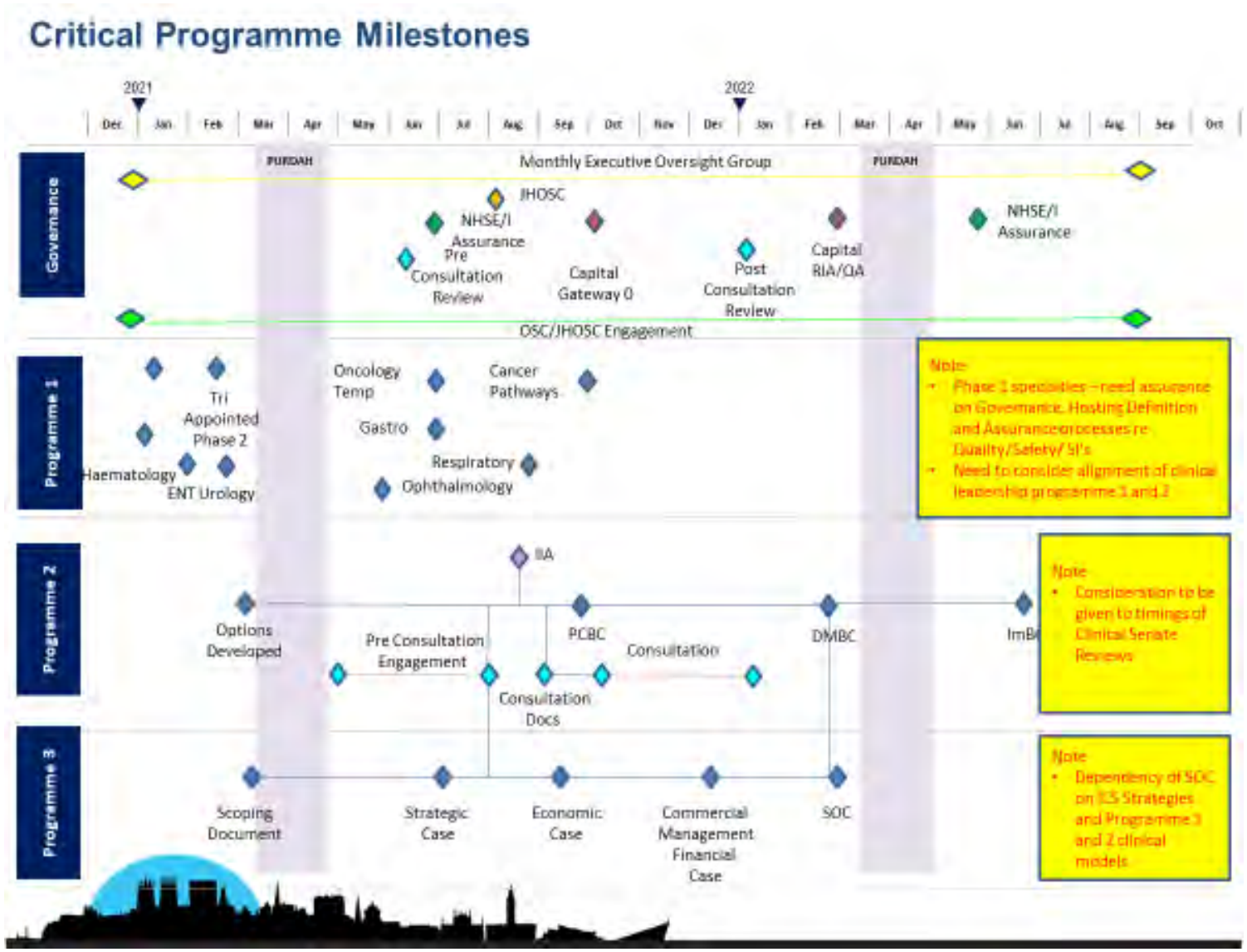
New Hospital Developments

Artist's impression of proposed Scunthorpe General Hospital development:

Implementation Plan

In order to deliver the whole scale transformation, which is required to continually provide, safe, effective and sustainable services, NLaG must have a clear implementation plan.

This Estate Strategy (and the approval of other supporting strategies) represents the first phase of this plan and this diagram identifies the subsequent steps necessary to deliver an estate which will meet current demands whilst also being able to respond to future needs.



Funding Routes

HIP Funding

In October 2020 the government confirmed that 40 hospitals will be built by 2030 as part of a package worth £3.7 billion, with eight further new schemes invited to bid. NLaG will need to be prepared to act on any funding that becomes available off the back of any HIP2 schemes not coming to fruition, and also look to be successful with future HIP funding opportunities.

ICS Funding

A new approach to NHS capital funding was introduced in 2020/21, the main purpose of which is the allocation of a capital envelope for each ICS. The aim of this is to provide greater clarity and confidence on the level of capital resource available; support system working and discussion on capital priorities; and enable faster access to national capital funding for critical safety issues.

Trust Capital

Trust capital is limited although it could provide an initial investment to kick start transformation. Whilst capital money is not readily available, and a portion of this capital is required to maintain statutory compliance whilst the transformation plan is being implemented, NLaG wll be expected to fund some of the proposed strategic development internally.

Decarbonisation Fund

NLaG will be applying to The Department for Business, Energy and Industrial Strategy (BEIS) Salix Public Sector Decarbonisation Scheme for a significant amount of funding to deliver a range of energy efficiency technologies and heat decarbonisation schemes within our Estate. This will help support a new Energy Performance Contract (EPC) predominantly aimed at SGH and DPoW.

In addition, Goole and District Hospital has been chosen as one of the four Pathfinder projects forming part of the Modern Energy Partners (MEP) Catapult Programme. BEIS will help fund a new sustainable energy centre at the site replacing coal boilers with a CHP and high efficiency gas heating system.

Along with other strategic energy efficiency technologies, these measures are planned to be completed by September 21 and will deliver substantial cost savings to the Trust reducing the carbon footprint of Goole and District Hospital by over 60%.

Constraints and Barriers

As with all large-scale strategic development there will be a number of constraints and barriers which will impact implementation including:

- Workforce
- Appetite
- Technology
- HR Policies, Procedures and required Management changes
- Availability of Funding
- Future commissioning plans
- Ability to work successfully with other Trusts, CCGs and wider STPs
- Willingness of other parties to support the vision
- Co-operation of NHS PS and other landlords

All constraints and barriers identified throughout this process will be considered in more depth at Business Case Stage. However, plans to prevent some of these being a barrier to the transformation of the estate can be set in motion now.

Estate Development - Benefits

The strategic development of the Estate will provide a number of tangible benefits for patients, staff, visitors, and commissioners and the wider health and social care economy. A **Benefits Realisation Plan** will be developed as part of any Business Case but at a high level it is anticipated benefits will include:

- **A cost-effective quality estate** which is safe, sustainable, efficient, and fit for purpose delivering services in the right place at the right time;
- **Alignment with Trust, Regional and National objectives** including the reduction of out of area placements, strengthening of community services and development of specialist services in preparation for further development of the STP and new models of care;
- **Alignment with the expectation of regulators** e.g., NHSI/E, CQC, HSE;
- An estate that better **meets the current and future needs of the population** served;
- Increased level of and **enhancement of services in the community;**
- Improved **flexibility to respond to new service developments** or minimise the impact of service or activity retractions;
- A working partnership with other providers and partner organisations across the region;
- **An estate which meets national targets** such as those indicated in the Carter Review and Carbon Reduction Commitment etc.;
- Demonstrable **improvements in quality and patient experience;**
- A reduction in the frequency and severity of adverse incidents;
- **Improved environmental performance** (including carbon reduction).

NLG(21)038

DATE	2nd February 2021
REPORT FOR	**Trust Board of Directors – Public**
REPORT FROM	Lee Bond – Chief Financial Officer
CONTACT OFFICER	Lee Bond
SUBJECT	**Annual Accounts 2020/21 – Delegation of Authority**
BACKGROUND DOCUMENT (if any)	NHS Accounts Timetable and Year-End Arrangements (NHSE/I, 15th January 2021)
PURPOSE OF REPORT	For Approval
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	In order to ensure the timely sign off of the Trust's audited accounts by the Chief Executive and the External Auditor, prior to submission to NHSE/I on the 15th June 2021, the Trust Board is requested to delegate formal authority to the Audit, Risk and Governance Committee at its meeting on the 3rd June 2021 to sign off the audited accounts and reports on its behalf.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates	N/A

to within the BAF)	
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: • Note the key dates in the final accounts process. • Delegate formal authority to the Audit, Risk and Governance Committee to sign off the 2020/21 audited accounts on behalf of the Trust Board.

Report to Trust Board – February 2021

ANNUAL ACCOUNTS 2020/21 - DELEGATION OF AUTHORITY

Introduction

The Audit, Risk and Governance Committee, under its delegated powers, reviews the draft accounts and reports before they are submitted to NHSE/I and the Auditors on behalf of the Trust Board (SFI 3.1.3 b). This will take place at their meeting on 22nd April 2021, ready for submission on 27th April 2021.

The Audit, Risk and Governance Committee also reviews the audited accounts and reports before they are submitted to the Trust Board for approval before final submission.

The key dates for the 2020/21 audited accounts, as confirmed by NHSE/I on the 15th January 2021, are as follows:-

Tuesday 1st June 2021	Trust Board meeting.
Thursday 3rd June 2021	Audit, Risk and Governance Committee meeting where the final audited accounts and reports will be reviewed in detail. The Chief Executive and Trust Chair are invited to attend this meeting.
Friday 4th June 2021	Chief Executive expected sign off date. Once signed will be passed to External Auditor for their formal sign off prior to return and submission to NHSE/I.
Tuesday 15th June 2021	Final audited accounts and reports to be formally submitted to NHSE/I by noon.

Given that the June 2021 Trust Board meeting falls early in the month, the audited accounts will not be ready for final review by that point. The Trust Board can therefore, as in previous years, delegate formal authority to the Audit, Risk and Governance Committee to approve the final accounts on its behalf before submission to the External Auditor and NHSI/E.

Recommendation

The Trust Board is asked to note the key dates in the final accounts process and is requested to delegate formal authority to the Audit, Risk and Governance Committee at its meeting on the 3rd June 2021 to sign off the 2020/21 audited accounts and reports on behalf of the Trust Board, prior to formal signing by the Chief Executive and the External Auditor.

Lee Bond
Chief Financial Officer
February 2021

NLG(21)039

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	2 February 2021
REPORT FOR	**Trust Board of Directors (Public)**
REPORT FROM	Lee Bond, Chief Financial Officer
CONTACT OFFICER	Brian Shipley, Deputy Director of Finance Matt Clements, Assistant Director of Finance, Financial Management
SUBJECT	**Finance Report 2020/21 – M09**
BACKGROUND DOCUMENT (if any)	**-**
PURPOSE OF REPORT	For discussion and review
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	This report highlights the reported financial position of Month 09 of the 2020/21 reporting period.

ACTION REQUIRED

Approval	Information	Discussion	Assurance	Review

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

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

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

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

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

Finance Report Month 9

December – 2020/21

Executive Summary Month 9 2020/21

The Trust reported a £0.84m surplus in December, a £1.3m underspend versus plan. The year-to-date surplus as at the end of December was £1.52m, which was £2.58m underspent versus plan.

The positive variance has been mainly driven by a reduction in both planned and unplanned care activity as a result of increased COVID-19 patients, and by slippage on the Capital programme and PDC payments.

The Trust will look to maximise its planned care capacity over the remaining months and has included £1.6m in its forecast position for extended weekend theatres and insourced outpatient capacity whilst the Trust also looks to support HUTH with capacity to help with system pressures such as in T&O.

In addition, as part of its plan, the Trust has included an increase to its annual leave provision as staff struggle to take their annual leave entitlement. This has been reviewed and increased by a further £1.0m.

In light of the above, the Trust is forecasting to deliver a marginal improvement to its planned deficit of £4.6m by £0.17m. It is expected that the annual leave adjustment is an allowable variation and therefore the Trust would deliver a £1.17m improvement on its planned position.

As required by NHSE&I, the year-to-date position does not yet include the estimated elective incentive scheme penalty estimated ot be £0.57m (£0.23m in month) due to lower activity then planned. The Trust incurred £1.9m additional expenditure relating to Covid-19 in month (£14.2m year-to-date).

The key variances in the month are:

- £0.24m above plan on Clinical Income – due to additional high cost drugs and community dental activity/income.
- £0.14m above plan on Other Income – mainly due to a run-rate increase on Path ULHT activity/income and on car parking income due to the return of patient/visitor parking charges.
- £0.4m underspent on Clinical Pay – £0.1m due to apprentice levy pay costs, and £0.3m mainly due to unutilised vacant pay budget across several areas including Midwifery, Paediatrics, Therapies and Cellular Pathology.
- £0.15m underspent on Clinical Non-pay - due to lower than expected diagnostic and inpatient activity, causing underspends mainly across theatres, Cardiology and Microbiology.
- £0.4m underspent on post EBITDA items – due to depreciation (£0.2m) as capital expenditure is below plan, but this is expected to increase in future months. PDC was also £0.17m lower than expected but is also forecast to increase.

Better payment practice code performance continues to improve. The percentage of non-NHS invoices paid within 30 days increased from 88% to 92%, and the percentage of NHS invoices paid within 30 days increased from 85% to 88%.

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Income & Expenditure to 31st December 2020

Income & Expenditure	Annual Plan to 31st March 2021 £'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	Primary Forecast £'000	Forecast Variance £'000
Clinical Income	378,413	34,482	34,784	302	274,966	275,479	513	380,012	1,599
Other Income	32,136	2,719	2,860	140	23,909	24,322	413	33,685	1,549
PSF/MRET and FRF and Top Up	27,092	0	0	0	27,092	27,092	0	27,092	0
Additional Top Up	5,833	0	0	0	5,833	5,833	0	5,833	(0)
Donated Income	101	0	0	0	47	318	271	318	217
Total Operating Income	**443,575**	**37,201**	**37,644**	**443**	**331,847**	**333,044**	**1,198**	**446,940**	**3,365**
Clinical Pay	(240,337)	(20,171)	(19,768)	402	(180,225)	(179,784)	441	(241,205)	(868)
Other Pay	(66,349)	(5,501)	(5,412)	89	(48,206)	(48,024)	182	(67,254)	(905)
Total Pay	**(306,685)**	**(25,671)**	**(25,181)**	**491**	**(228,431)**	**(227,809)**	**623**	**(308,459)**	**(1,774)**
Clinical Non Pay	(62,559)	(5,405)	(5,252)	153	(46,155)	(45,600)	555	(62,455)	104
Other Non Pay	(64,163)	(5,269)	(5,379)	(110)	(48,207)	(48,679)	(472)	(65,921)	(1,757)
Total Non Pay	**(126,722)**	**(10,674)**	**(10,631)**	**42**	**(94,362)**	**(94,279)**	**83**	**(128,375)**	**(1,653)**
Operating Expenditure	**(433,408)**	**(36,345)**	**(35,812)**	**533**	**(322,793)**	**(322,087)**	**705**	**(436,834)**	**(3,427)**
EBITDA	**10,167**	**857**	**1,832**	**976**	**9,054**	**10,957**	**1,903**	**10,105**	**(62)**
Depreciation	(10,442)	(974)	(776)	198	(7,294)	(6,835)	459	(9,318)	1,124
Interest Expenses & Other Costs	(233)	(20)	(2)	18	(175)	(156)	19	(214)	19
Dividend	(4,245)	(407)	(238)	169	(2,786)	(2,318)	468	(3,988)	257
Fixed Asset Impairments and Revaluations	0	0	0	0	0	0	0	(960)	(960)
Total Post EBITDA Items	**(14,920)**	**(1,401)**	**(1,015)**	**386**	**(10,255)**	**(9,308)**	**947**	**(14,480)**	**440**
Remove Capital Donated I&E Impact	159	0	24	24	145	(126)	(271)	(53)	(212)
I&E Surplus/ (Deficit)	**(4,594)**	**(545)**	**841**	**1,386**	**(1,056)**	**1,523**	**2,579**	**(4,427)**	**167**

COVID-19 Expenditure

Expenditure Category	Year-to-date 20-21		
	Pay (£k)	Non-pay (£k)	Total (£k)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	2,888	10	2,898
Existing workforce additional shifts	5,532	0	5,532
Backfill for higher sickness absence	1,668	0	1,668
NHS Staff Accommodation - if bought outside of national process	0	6	6
PPE - locally procured	0	199	199
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	0	170	170
PPE - other associated costs	0	11	11
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanica	0	665	665
Remote management of patients	0	9	9
Segregation of patient pathways	0	622	622
Decontamination	0	298	298
After care and support costs (community, mental health, primary care)	0	284	284
Remote working for non patient activities	0	392	392
Internal and external communication costs	-1	40	39
Direct Provision of Isolation Pod	0	41	41
Other	0	1,180	1,180
COVID-19 virus testing - rt-PCR virus testing	3	0	4
COVID-19 virus testing - Rapid / point of care testing	0	161	161
COVID-19 - Vaccination programme	2	6	8
COVID-19 Nightingale Harrogate Setup Cost Total (Gross)	1	0	1
COVID-19 Nightingale Harrogate Running Cost Total (Gross)	32	2	34
COVID-19 Nightingale Harrogate Running Cost (Incremental)	4	2	6
Total COVID-19 Expenditure	10,130	4,100	14,229
Total Trust Operating Expenditure (including COVID-19 expenditure and all other operating expenditure	227,809	94,279	322,087
COVID-19 % of Total Trust Operating Expenditure	4.4%	4.3%	4.4%

2020/21 CIP DELIVERY BY WORKSTREAM & DIVISION/DIRECTORATE

Workstream	Annual Plan £000s	Current Month - December 20				Year to Date at December 20				Forecast Year-end		
		Plan £000s	Actual £000s	Variance £000s	Risk RAG	Plan £000s	Actual £000s	Variance £000s	Risk RAG	Actual £000s	Variance £000s	Risk RAG
Clinical Workforce - Medical Staff	3,102	320	189	-131		2,146	1,506	-640		2,207	-895	
Clinical Workforce - Nursing and Midwifery	1,234	183	185	2		721	1,025	304		1,725	491	
Clinical Workforce - AHP Staff	433	36	88	51		325	679	354		914	481	
Clinical Productivity	407	36	28	-8		298	249	-49		320	-87	
Clinical Strategy	952	78	62	-17		716	601	-115		768	-184	
Corporate and Non-Clinical Workforce	1,049	81	252	171		806	1,767	962		2,177	1,129	
Estates & Facilities	476	43	44	0		347	386	39		493	17	
Non-Pay and Procurement	1,442	94	68	-26		1,155	906	-249		1,291	-151	
Income	868	72	72	0		651	651	0		868	0	
Grip & Control	21	2	9	7		16	66	50		76	55	
Unidentified	3,992	334	0	-334		2,986	0	-2,986		0	-3,992	
Risk Mitigation	-3,575	-297	-5	292		-2,676	-5	2,671		-55	3,520	
Grand Total	**10,400**	**982**	**991**	**9**		**7,490**	**7,831**	**342**		**10,785**	**385**	
Recurrent	8,750	856	500	-356		6,218	4,774	-1,444		7,086	-1,664	
Non-recurrent	1,650	126	491	365		1,272	3,058	1,786		3,699	2,049	
Grand Total	**10,400**	**982**	**991**	**9**		**7,490**	**7,831**	**342**		**10,785**	**385**	
Medicine	3,577	400	213	-187		2,411	1,933	-478		3,043	-535	
Surgery & Critical Care	2,248	187	147	-40		1,687	1,218	-469		1,740	-507	
Family Services	1,245	107	154	48		924	590	-334		722	-522	
Clinical Support Services	684	67	12	-55		484	480	-3		690	6	
Community & Therapy Services	818	71	90	18		604	713	109		974	156	
Operations Directorate	78	6	2	-4		58	20	-38		27	-51	
Total Operations	**8,649**	**839**	**619**	**-219**		**6,168**	**4,955**	**-1,213**		**7,196**	**-1,453**	
Medical Director's Office	181	13	52	40		143	393	250		510	329	
Chief Executive's Office	10	1	5	4		7	120	113		128	118	
Chief Nurse Directorate	226	18	55	37		170	249	79		272	47	
Finance	96	8	42	34		72	245	174		343	248	
People & OE	234	19	35	16		177	318	142		352	118	
Strategic Development	7	1	11	11		5	80	75		97	90	
Digital Services	506	39	131	92		388	1,089	700		1,442	936	
Total Corporate Directorates	**1,259**	**99**	**332**	**233**		**963**	**2,495**	**1,532**		**3,145**	**1,886**	
Estates & Facilities	491	44	44	0		358	387	28		497	5	
Trust	7	0	0	0		0	0	0		2	-5	
Risk Mitigation	-7	0	-5	-5		0	-5	-5		-55	-48	
Grand Total	**10,400**	**982**	**991**	**9**		**7,490**	**7,831**	**342**		**10,785**	**385**	

COMMENTARY

YEAR TO DATE POSITION	**The December 20 (month 9) Year To Date delivery for 2020/21 savings is £7.83m against a plan of £7.49m**
IN MONTH POSITION	**In-month delivery was £991k against a plan of £982k an over delivery of £009k**
FORECAST YEAR-END POSITION	**The Trust is forecasting an over delivery against its £10.40m annual plan by £385k**

RISKS AND ISSUES

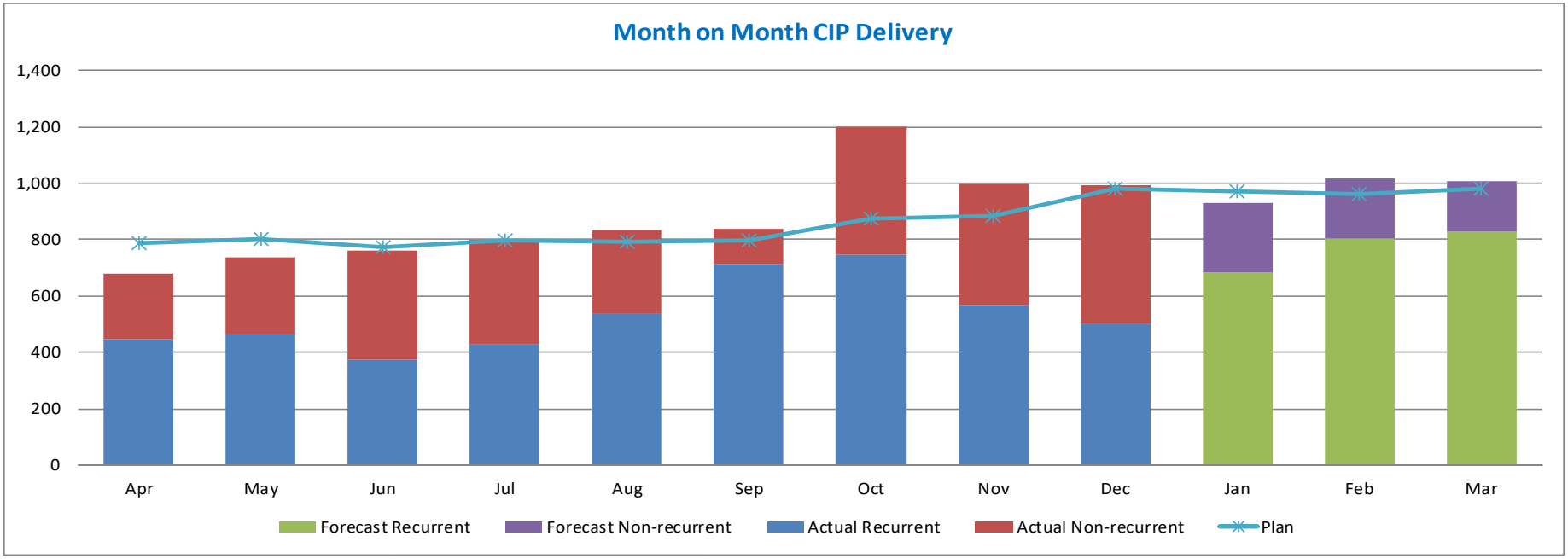
Currently the programme is forecast to over deliver by £385k, the forecast is robust and possibly conservative particularly around the filling of vacancies. The risks to the programme come from the pandemic and in particular the requirement for temporary staffing. To date this has been absorbed but in-month has seen an increase in the use of Although the programme is forecasting to over deliver the main issue remains the value of non-recurrent schemes within the progrmme. In December non-recurrent savings were £3.7m (34% of the programme). This is a £600k increase on the previous month and in the main is due to the fact that CNST savings although declared have still not been secured and consequently moved out of recurrent. Non-recurrent savings will potentially impact the 2021/22 savings requirement.

DECEMBER 20 (MONTH 9) SUMMARY

Trends established during the financial year have continued in December with corporate, estates and allied health professional vacancies (non-recurrent) along with nursing recruitment mitigating against unidentified and shortfalls on medical staff recruitment, procurement and divisional schemes relating to SLA renoegotiation, additional session reduction and changes to point of delivery.

In-month saw the shift of CNST related savings, totalling £409k, in maternity to non-recurrent. This is because the actions required by the Trust have not yet been completed and we have until July to do this. In addition £41k of category towers savings relating to audiology have been removed as the calculation of these by the Supply Chain were

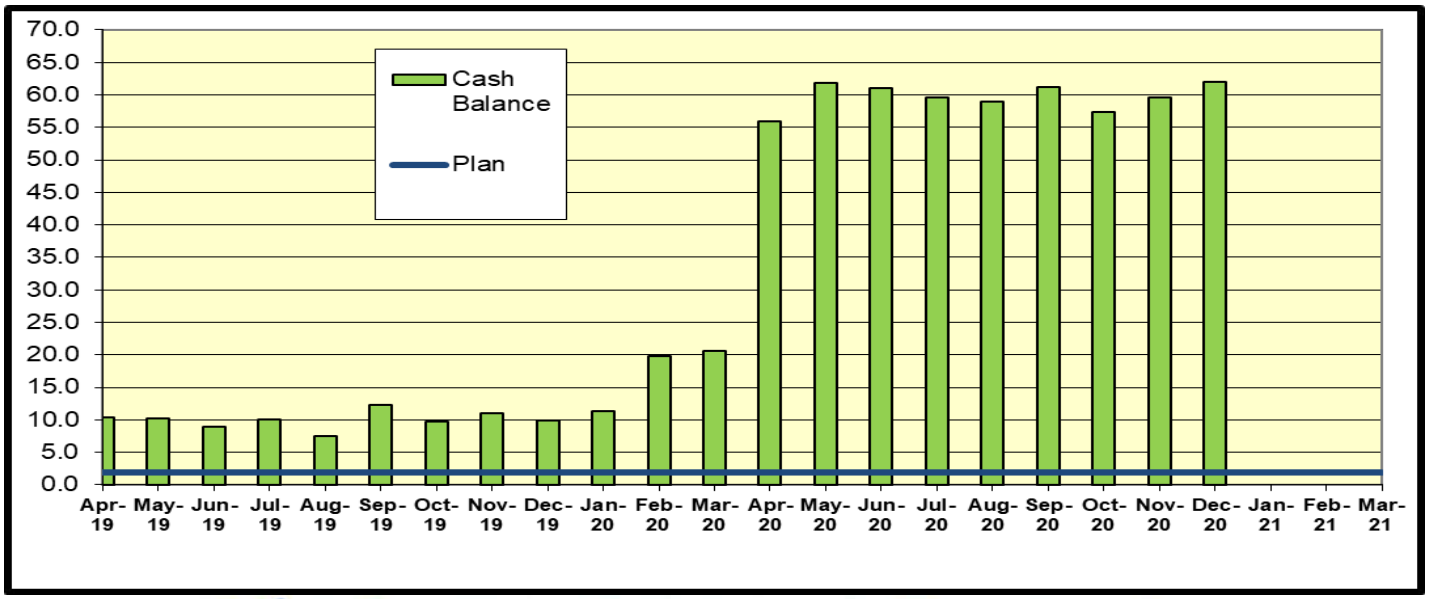
All corporate areas and estates and facilities will hit their annual target although not recurrently. As will community and therapy services and clinical support services



Cash

The cash balance at 31st December was £62.07m, an in month increase of £2.44m.

	£m	£m
Cash Balance as at 31st December		**62.07**
Commitments:		
WebV bank account	0.02	
Income received in advance	37.48	
Capital creditors	4.66	
In year capital underspend	4.92	
Capital loan repayments	0.17	
PDC Dividend payment	1.05	
Dec PAYE/NI/Pension	10.15	
Invoices due for payment not yet authorised	1.72	
To support future months creditors	0.00	
		(60.16)
NHSi minimum balance		**1.90**



Balance Sheet as at 31st December 2020

	Last Month	This Month
	£mil	£mil
Total Fixed Assets	**179.20**	**182.38**
Stocks & WIP	3.02	3.73
Debtors	12.59	10.34
Prepayments	6.43	6.36
Cash	59.63	62.07
Total Current Assets	**81.67**	**82.50**
Creditors : Revenue	29.50	27.86
Creditors : Capital	1.44	4.66
Accruals	15.06	16.03
Deferred Income	37.07	37.48
Finance Lease Obligations	0.00	0.00
Loans < 1 year	0.01	1.36
Provisions	0.71	0.78
Total Current Liabilities	**83.79**	**88.17**
Net Current Assets/(Liabilities)	**(2.12)**	**(5.68)**
Debtors Due > 1 Year	0.00	0.00
Creditors Due > 1 Year	0.00	0.00
Loans > 1 Year	10.87	9.54
Finance Lease Obligations > 1 Year	0.02	0.02
Provisions - Non Current	5.25	5.38
TOTAL ASSETS/(LIABILITIES)	**160.94**	**161.76**
TOTAL CAPITAL & RESERVES	**160.94**	**161.76**

- The increase in stock relates to pathology, pharmacy and theatre stocks.
- Debtors have reduced again this month. The Trust has now received the outstanding month 6 covid top up monies.
- Revenue creditors and accruals remain stable. The BPPC figures for December showed an improvement. The percentage of non-NHS invoices paid within 30 days increased from 88% to 92%, and the percentage of NHS invoices paid within 30 days increased from 85% to 88%.
- The increase in capital creditors reflects the increase in capital spend on the major schemes.
- Deferred income reflects January block payments received in advance. The Trust also received in advance Health Education income January.
- The Trust has now paid all capital loan repayments due this year. The loan balance <1 year relates to the payments due within the next year.

2020/21 I&E Forecast

	M09 YTD Position £m	Best Case Forecast £m
20/21 Plan Surplus/(Deficit)	**(1.06)**	**(4.59)**
Clinical Income	0.51	1.60
Non Clinical Income	0.41	1.55
Donated Income	0.27	0.22
Clinical Pay	0.44	(0.87)
Non Clinical Pay	0.18	0.09
Drugs	(0.28)	(0.83)
Clinical Supplies	0.83	0.94
Other Non-Pay	(0.47)	(1.76)
Post EBITDA (Depreciation & Interest)	0.95	1.40
Post EBITDA (Impairment)	0.00	(0.96)
Annual Leave Provision	0.00	(1.00)
Remove Excluded Items (Donated Income)	(0.27)	(0.21)
Surplus / (Deficit)	**1.52**	**(4.43)**
Variance to Plan	**2.58**	**0.17**
Add back Annual Leave Adjustment	0.00	1.00
Surplus / (Deficit)	**2.58**	**1.17**

Risks

- Assumes no claw back for the reduction in activity under the Elective Incentive Scheme. This is estimated to be **£1.25m.**
- No provision for the ongoing "Flowers" legal case. This is estimated to be **£0.50m.**
- Potential **£0.13m** further annual leave provision requirement.

Mitigations

- Health Education England funding surplus of **£0.40m.**
- Planned additional capacity slippage **£0.70m.**
- Planned demolition work Impairment slippage **£0.96m.**

NLG(21)040

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	Tuesday 2nd February 2021
REPORT FOR	Trust Board of Directors
REPORT FROM	Executive Team
CONTACT OFFICER	Helen Harris, Trust Secretary
SUBJECT	Revised Integrated Performance Report - Access and Flow, Workforce further elements under development.
BACKGROUND DOCUMENT (if any)	The Board underwent a 'Making Data Count' development session in August 2020 supported by Samantha Riley from NHS England/Improvement. The session focussed predominantly on moving Trust Board performance reporting away from traditional RED-Amber-Green (RAG) reporting towards the use of Statistical Process Control (SPC) charts, using longitudinal data and statistical theory to inform judgement and provide assurance.
PURPOSE OF THE REPORT	To provide assurance to the trust board on delivery againt national indicators and trust priorities
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Not Applicable
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	**Situation** The Board has committed to developing the information it receives, with particular regard to the presentation and analysis of information and information reporting. **Assessment** The Board committed to move SPC for reporting of performance information within the Trust Board Integrated Performance Report (IPR) commencing October 2020. In October 2020 the Board supported the proposed template utilising SPC dashboard icons across all metrics with full SPC charts and accompanying narrative exception reports for any metrics triggering an exception under SPC rules. This developmental version of the IPR was presented in November and December and is expected to be finalised in March 2021. **Recommendation** The Board of Directors is recommended to: Receive the IPR, endorse the format of the new report acknowledging the Quality and Safety section is now in development and will be shared at the next Board. Receive assurance against those metrics not triggering SPC exception rules and note the exception narrative and associated plans in place for those metrics triggering SPC exception rules.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	The Board is asked to note the progress to date.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Contents

1. Executive Summary
2. Access and Flow
3. Workforce
4. Quality and Safety Scorecard
5 Additional KPI's

Access and Flow - SRO Shaun Stacey
Objective: To give great care
The Emergency Department are currently seeing the levels of patient which is just below that of the pre-Covid levels and are working with the new pressures coming from zoning in the department. There has been higher levels of walk-ins that have presented with higher acuity then previously seen along with a number of ambulance arrivals that are low acuity and either being discharged directly from the Emergency Department or are being admitted and discharges with a length of stay less than 1. Performance of the 12 hour trolley wait standard is directly attributable to the challenge faced since October on flow within the Emergency Department and the Inpatient exit block compounded by the acuity of patients requiring longer length of stays. This is shown with the Ambulance handovers over 60 minutes (black breaches). RTT continues to see a rise in referrals with performance currently for the trust at 64%, with 853 patients waiting over 52 weeks at the end of December. The Performance is as a direct result of the continued reduced elective operating capacity due to the theatre and anaesthetic response to supporting the high acuity of COVID-19 patients and the social distancing and patient choice. Cancer performance for 2 Week Wait Referral to First seen 12 days is currently 97.7% which is a small increase on November and is a direct correlation of getting patients treated over the Christmas period. Diagnostic services has seen a further decrease in performance and that is related to treating patients due to COVID-19 and the capacity within each modality, which will be partially addressed through the opening of the new scanning facilities at DPoW in January and the further opening of additional capacity in May 2021.
Workforce - SRO Christine Brereton
Objective: To be a good employer
The People and Organisational Directorate continue to focus their attention on responding to Covid-19 mainly through the roll out of the covid vaccination programme which launched on 4th January 2021 and the lateral flow testing which launched in November 2020. We have also closed down our Flu Campaign to concentrate all efforts on the Vaccine roll out. Directorate staff are heavily deployed in these major programmes of work which impact significantly on the delivery of business as usual. Also to support Covid, focus has been on the development and roll out of our Health and Wellbeing offer for all of our staff. This has included ensuring that risk assessments for all staff, especially those that are high risk are completed. This is to ensure that we provide the right level of support and redeployment where necessary to protect staff. There is still concern about the numbers of risk assessments outstanding and we have taken a proactive approach this month including engaging directly with staff and joint communications with our trade union colleagues. It is noted that sickness levels due to anxiety and depression continue to rise as we enter into wave 3 and our intention is to refresh our Health and Wellbeing offer and engage directly with staff across the Trust to remind them of the tools and support available for them during these challenging and difficult times. Caring for our staff is a priority area for the Trust and our Directorate. In addition to providing Covid support, our attention on recruitment and retention continues, specifically for Healthcare Support Assistants (HCSA, also known as Healthcare Support Workers HSCW) as this is a national initiative with an ambition to have zero vacancies by 31st March 2020. We have a programme of work aimed at attracting HCSA given that our non-registered nursing vacancies continue to rise. Also our plans for international recruitment to attract oversees nurses will get back underway working closely with our system partners. This has been supported externally with funding being allocated to NLAG by NHSI for both HSCA and nurse recruitment. Wherever possible, we continue to deliver our workforce projects aimed at improving our service to the Trust or enhancing the employee experience, were relevant these are detailed in the report.

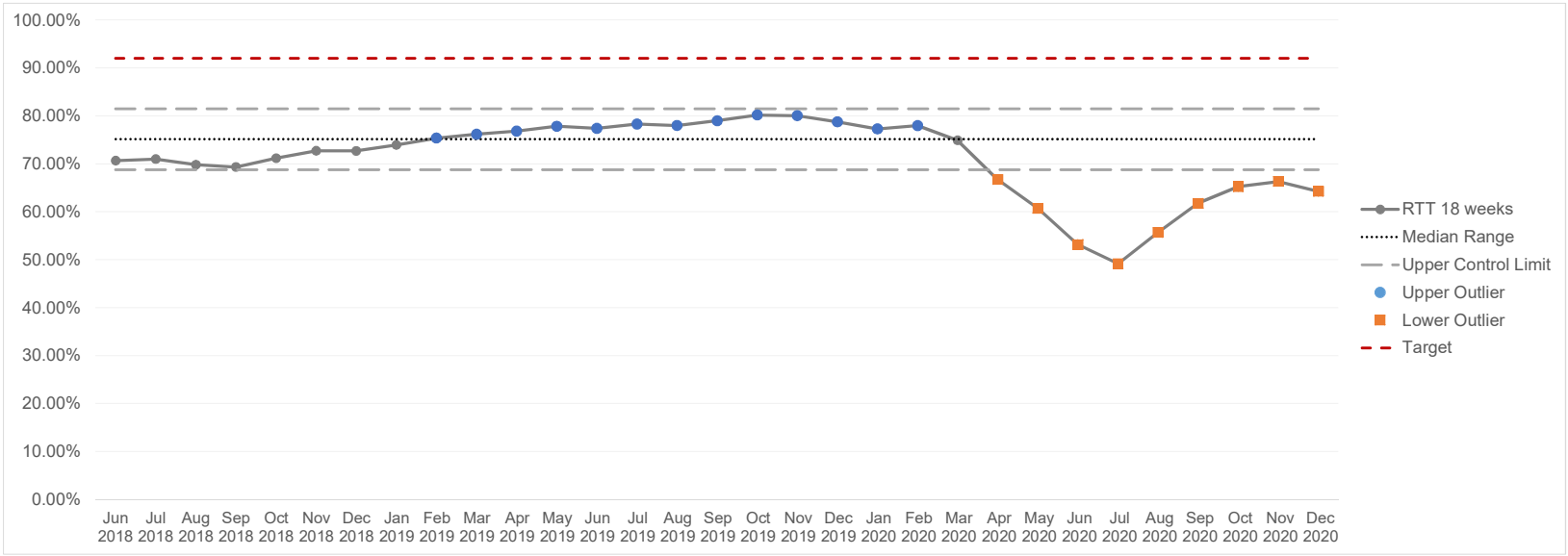
Statistical Process Control Images

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

Ref	Metrics	Dec 2020	Target / Trajectory	Variation	Assurance
	RTT waiting times for non-urgent consultant-led treatment				
1	Maximum time of 18 weeks from point of Referral To Treatment (RTT) in aggregate - patients on an incomplete pathway. 18 week %	64.26%	92%		
2	Number of incomplete RTT pathways 52 weeks	853	0		
3	30 day emergency re-admission rate	7.83%			
4	Maximum 6-week wait for diagnostic procedures (Diagnostic Measurement 01)	43.77%	<=1%		
	A&E waits				
5	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge (4 hour target)	72.0%	92%		
6	Count of Ambulance Handover delays 15-30mins	1134	0		
7	Count of Ambulance Handover delays 30-60mins	438	0		
8	Count of Ambulance Handover delays 60+ mins	242	0		
9	Waits in A+E not longer than 12 hours from Decision To Admit	27	0		
	Cancer waits				
10	Cancer Waiting Times - 2 week wait	97.7%	93%		
11	Cancer 2 week wait (breast symptoms)	97.7%	93%		
12	Percentage of Service Users waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer	69.5%	75%		
13	Cancer Waiting Times - 31 Day First Treatment	92.2%	96%		
14	Cancer Waiting Times - 31 Day Surgery	70.0%	94%		
15	Cancer Waiting Times - 31 Day Drugs	100.0%	98%		
16	Cancer Waiting Times - Radiotherapy	N/A	94%		
17	Cancer Waiting Times - 62 day GP referral	66.1%	85%		
18	Cancer Waiting Times - 62 day Screening	20.0%	90%		
	Cancelled Operations				
19	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	deprecated	100%		
20	No urgent operation should be cancelled for a second time	deprecated	100%		
	Trust Priorities - Improve the Trust's waiting list with a focus on 40 week waits, total list size and out patient follow ups				
21	The number of delays due to delayed transfers of care	deprecated			
22	The number of patients overdue their follow up for an outpatient review.	30646	9000		
24	Overall size of the RTT waiting list	27959			
25	50% of out-patient summary letters to be with GPs within 7 days	40.3%	50%		
26	Reduce the number of face to face follow up appointments by 10% by 31 March 2021.	9935	15903		
	Trust Priorities - Improve the effectiveness of cancer pathways focussing on time to diagnosis				
27	Cancer waiting times - 104+ day backlog	35	0		
28	Care of patients with confirmed diagnosis transferred by day 38 to be at 75%	20.0%	75%		
29	100% Request to test report to be no more than 14 days	86.0%	100%		
	Trust Priorities - Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon				
32	Average Length of Stay (all)	4.5	4.0		
33	% of patients who were discharged on the same day as admission (non-elective)	28.8%	32%		
35	Non elective Length of Stay	4.6	4.1		
36	Elective Length of Stay	1.9	2.4		
37	Number of Medical Outliers	1824	-		
38	85% of discharge letters to be completed within 24 hours post discharge	92.13%	85%		
39	Progressive improvement in the number of golden discharges from April 2020	18.0%	35%		
40	Increase in A&E performance to 83.5%	72.0%	83.5%		
41	Reduction of non emergency patient transfers at night after 10pm by 10%	165	48		
42	Reduction in average ward moves for non elective patients for non clinical reasons by 7%	370	128		
43	Number of early supported discharges to increase by 10%				
44	Improvement in the number of patients that have admission prevention services provided by the community services in the North and North East Lincolnshire (target to be agreed)				
45	All patients requiring mental health support in ED will be assessed within 4 hours of referral				
46	Patients on in-patient wards will be assessed and have a plan in place within 24 hours				

Indicator: **RTT 18 weeks**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	64.3%	92%	N/A		

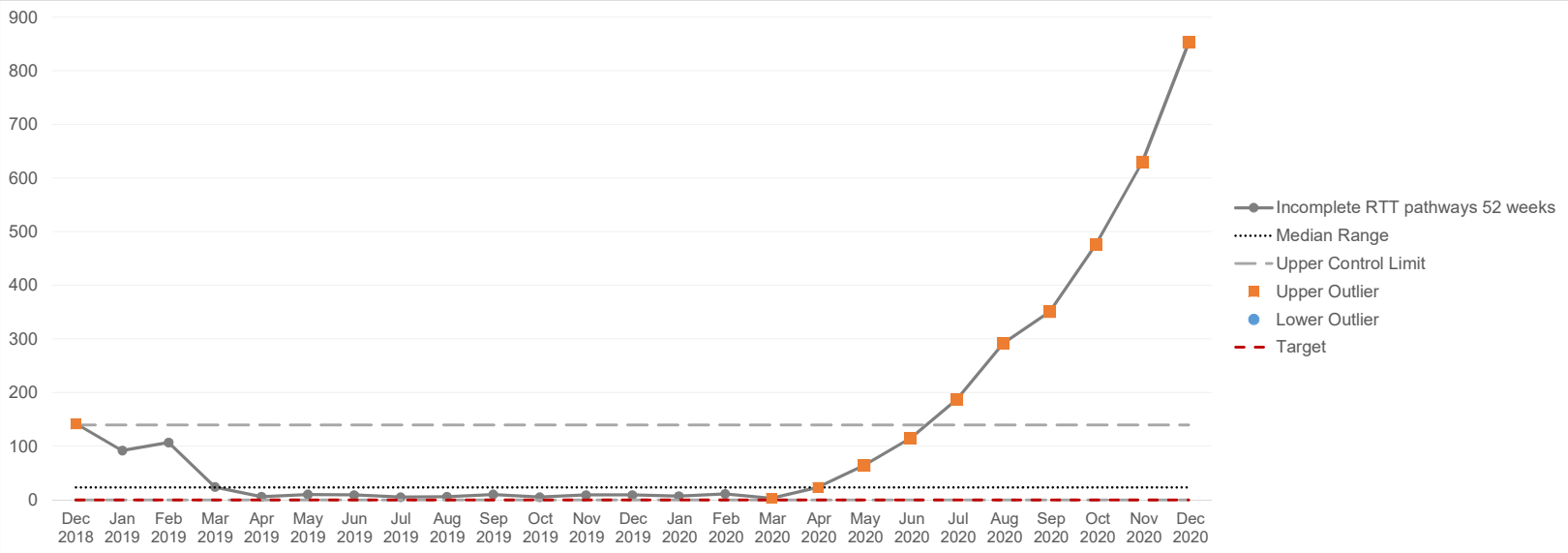


What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart is showing that delivery against RTT is below the median and continues to be below target.	The 18 Weeks RTT is a whole journey waiting time standard from initial referral to the start of treatment. The number of patients waiting on an incomplete pathway continues on an upward trajectory primarily as a result of reduced capacity and the need to treat urgent and cancer patients as a priority.	Additional capacity has been sourced at St Hugh's from January to March utilising the new Independent Sector Framework. In addition, the Trust plans to use Medinet to provide support, though this will be at a cost to the Trust. Patients on the inpatient list are being risk stratified, current performance shows patients admitted before or on their risk stratification date is at 84.7%.	A national procurement framework with the independent sector is now in place to enable patients to be treated elsewhere as pressure on the NHS increases. In addition the Trust is sourcing capacity from other providers.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Number of 52 Week RTT Incomplete Breaches**

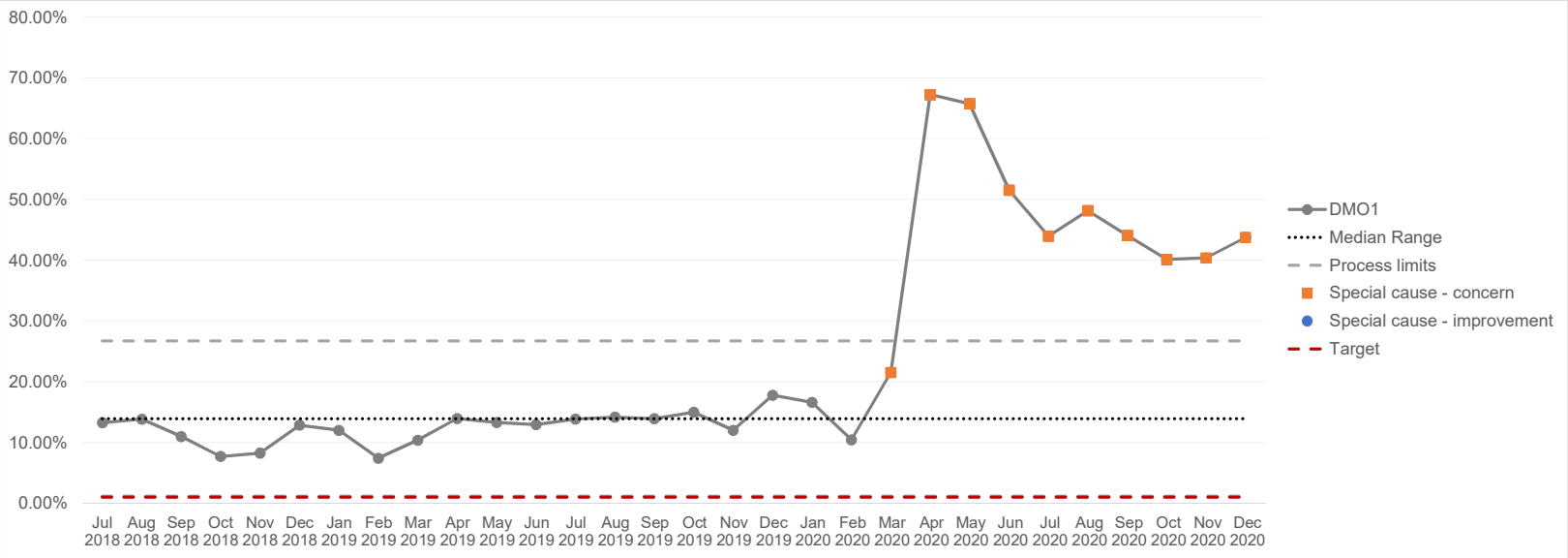
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	853	0	N/A		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart indicates that the number of patients waiting in excess of 52 weeks is on an upward trajectory and the position is unlikely to recover in year.	The number of patients has increased by 213 patients in month. Given that pre-pandemic levels were very low it is evident changes in practice implmented following receipt of national guidance has resulted in reduced capacity and a backlog has developed.	All patients are being risk stratified and those in the highest clinical priority are being treated first. Additional capacity has been created at Goole District Hospital through weekend working and capacityhas been sourced in the local independent sector for surgical and diagnostic procedures. PTL meetings are held weekly, focussing on managing urgent, cancer and long wait patients according to NHS E/I guidance during Covid-19.	Primarily those patients waiting in excess of 52 weeks are considered relatively low risk,a a risk stratifcation review is undertaken to maintain patient safety whilst waiting.

Indicator: **Diagnostic Measurement 01**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**43.8%**	**99%**	**N/A**		

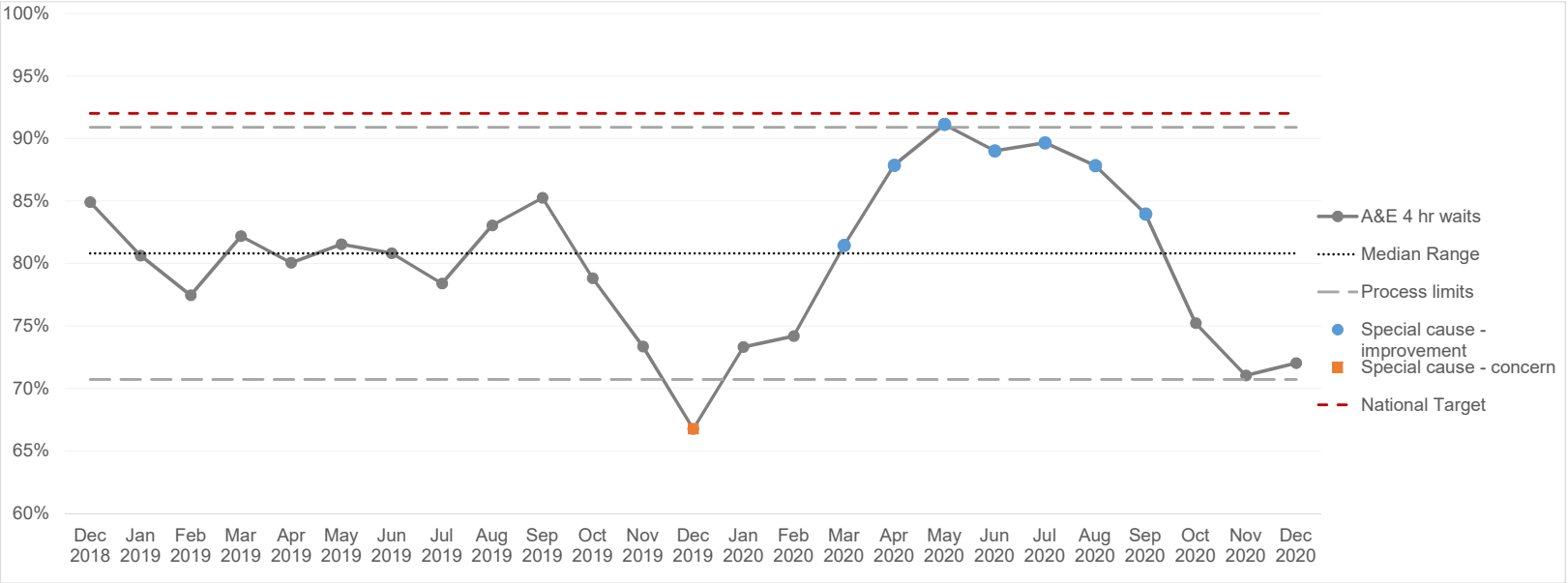


What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
43.8% of the 15 diagnostic tests reported have breached the 6 week wait time for test, the chart indicates that there is a special cause which in this instance is the impact of the pandemic.	The purpose of this collection is to measure waits and monitor activity for 15 key diagnostic tests. Imaging - MRI, CT, NOUS, BE and DEXA Physiological Measurement - Audiology assessmenmt, echocardiography, electrophysiology peripheral neurophysiology, sleep studies and urdoynamic pressure and flows. Endoscopy - Colonoscopy, Flexi sigmoidoscopy, Cystoscopy and Gastroscopy In December capacity was reduced and there was poor patient compliance due to holidays and lockdown.	Audiology and ENT have revised pathways: Audiology will now receive referrals ahead of the ENT appointment. A private sector provider for NOUS has been identified to provide additional capacity, negotiations are in progress. CT colonoscopy capacity continues to be of concern and the division is exploring the feasibility of undertaking Capsule Endoscopy.	The teams are working together to model the backlog conversions in audiology . It is anticipated the impact of the change will be in 3-4weeks time and the service has plans to temporarily increase capacity to work through the increase in activity. Increasing Capsule endospoy capacity will increase capacity to undertake colonoscopies.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Percentage of patients who are seen and treated within 4 hours of arrival - National requirement**

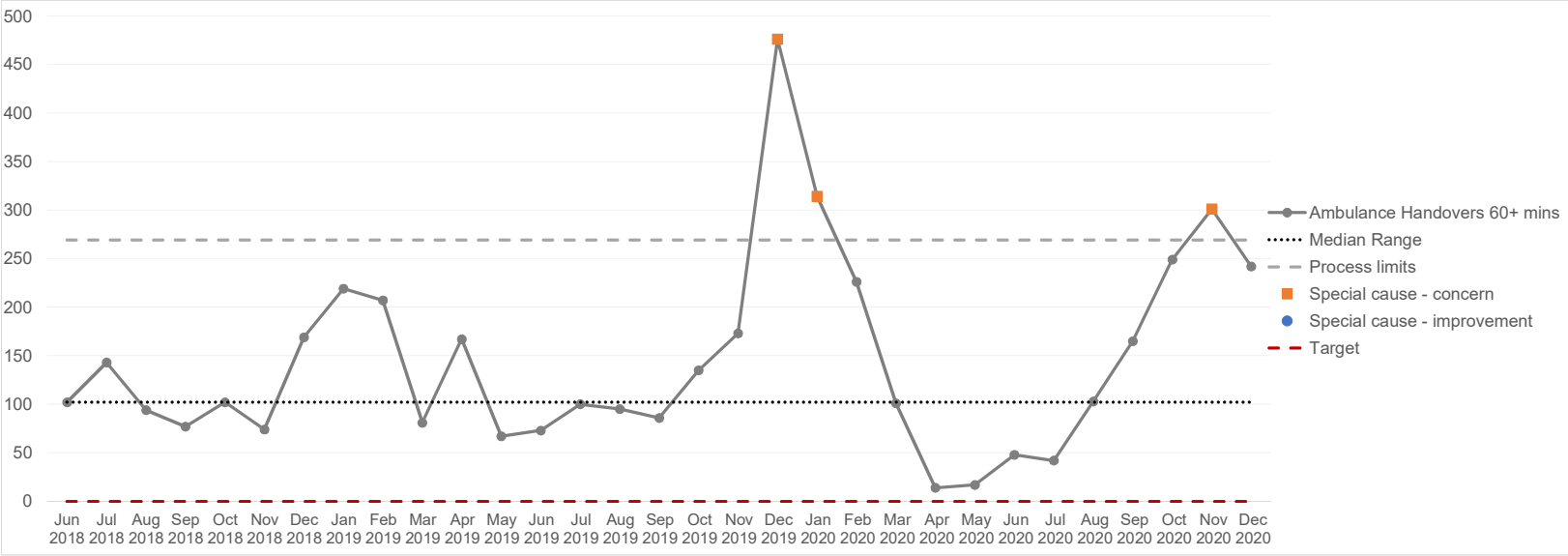
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**72.0%**	**92%**	**N/A**		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
Performance is below target, however the Trust will not meet the national 92% or the local target of 85.3% if performance continues on this trajectory.	A&E Departments target have four hours in which to treat and discharge or admit or transfer a patient. Challenges in bed occupancy and patient flow, exacerbated by the covid-19 zoning, caused significant exit block to both EDs during December which resulted in extended waiting times for admitted patients.	There are multiple improvement plans in place to reduce the occurrence of DTA breaches and ambulance black breaches as well as improving the overall performance against the 4 hour target. The Discharge to Assess (D2A) programme and Integrated Acute Assessment Units (IAAU) are improving the patient flow to reduce exit block in ED and to increase the number of same day emergency care (SDEC) to avoid unnecessary admissions.	Any delay in implementing new pathways will impact on A&E performance. A&E performance continues to be monitored by the Incident Control Centre.

Indicator: **Ambulance Handover Delays 60+ minutes**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	242	0	N/A		

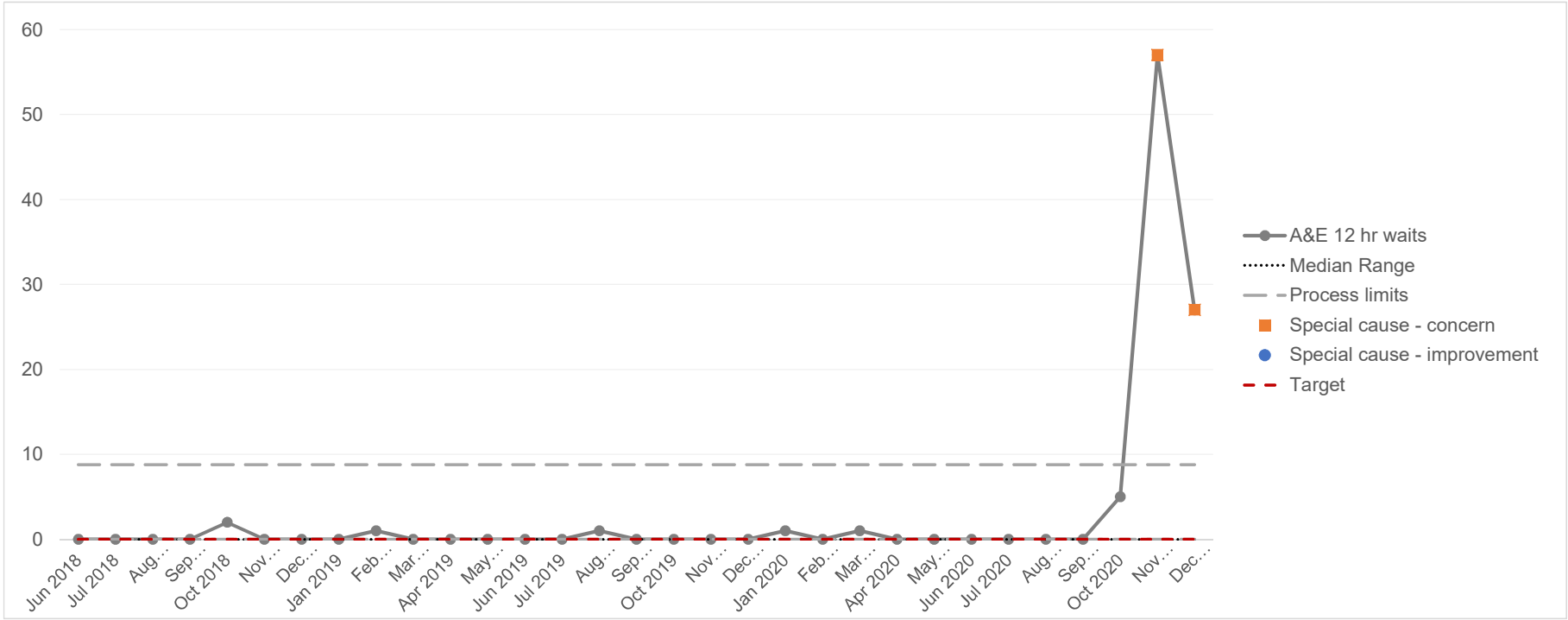


What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
There is a high level of variation in the number of handover delays. The chart indicates that 242 breaches of 60+ minutes ambulance handovers occurred during December, these are known as 'black breaches' .	The target time for an ambulance handover is 15 minutes, of which there were 1134 and 438 ambulance handovers that were delayed between +30-60 minutes.	There are multiple improvement plans in place to improve ambulance handover, which include the Discharge to Assess program and the implementation of Integrated Acute Assessment Units (IAAU) on both sites.	ED and new digital triage systems have gone live within ED to improve the efficiency and safety of the ambulance handover process.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **A&E Decision to Admit 12+ hours**

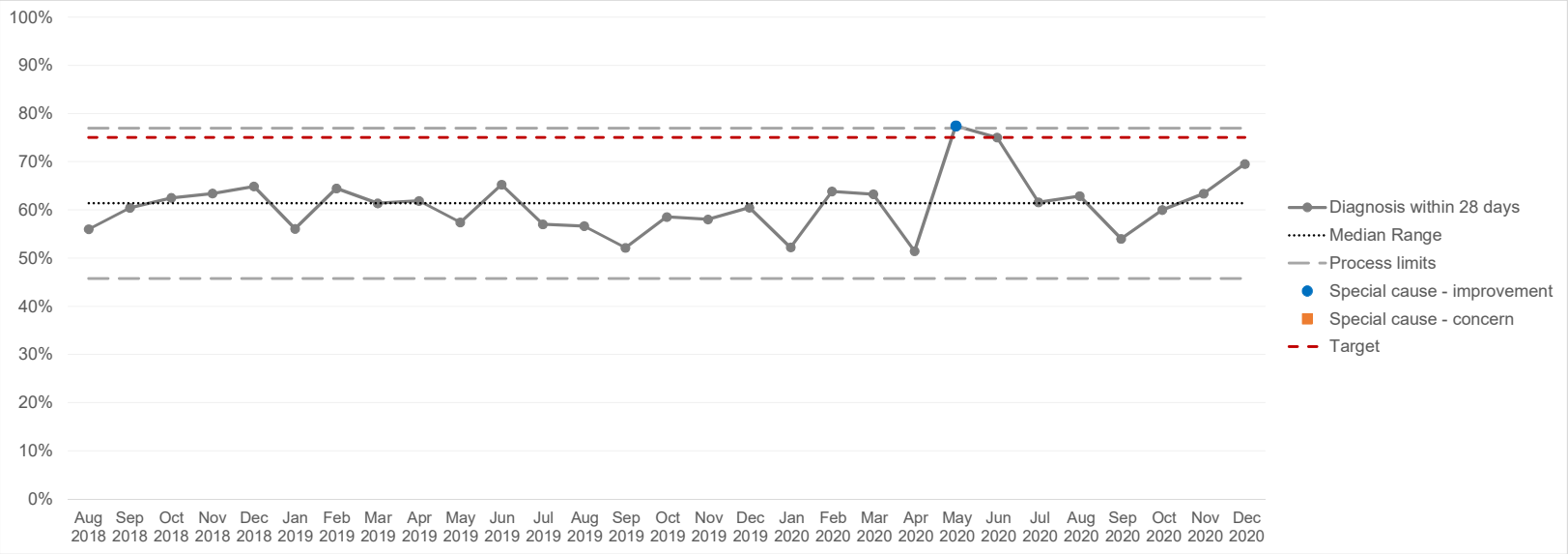
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	27	0	N/A		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart shows there have been 27 breaches agianst the target of 0 in month. This is considered a cause for concern.	A breach occurs when a patient waits over 12 hours from the time a decision is made that they require admission to their transfer to an inpatient bed	All 12 hour patients with a decision to admit are reviewed and clinically validated. A nursing review is also undertaken to review the level of care that was delivered to the patient during there extended time in the ED.	Challenges in patient flow impacts on exit block within ED and can result in a lack of clincial cubicle capacity within the ED and delays in being able to off load patients from incoming ambulances. The situation is under constant review with over site by the Incident Command Centre (ICC).

Indicator: **Diagnosis within 28 days**

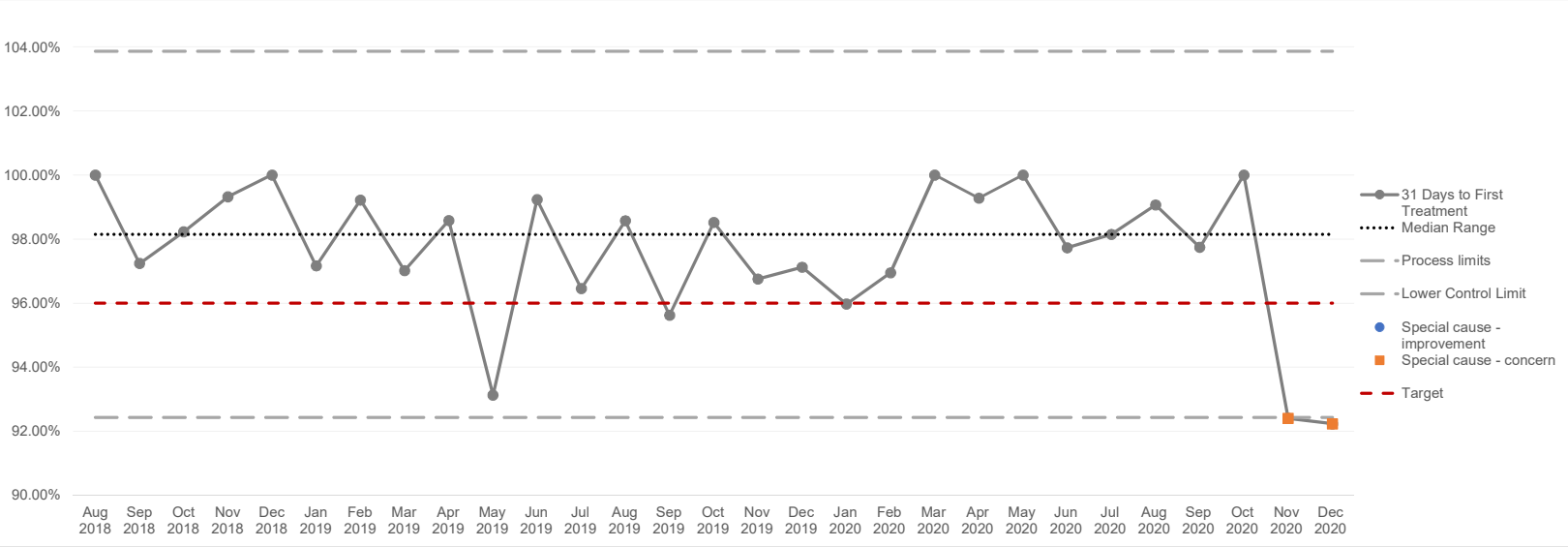
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	70%	75%	N/A		



What Is The Chart Telling Us	Background	Actions	Risks and Mitigation
The chart indicates that performance is within the process limits and though on an upward trajectory is slightly below target.	This is a new standard which monitors a faster diagnosis within 28 days. Due to the national reporting processs these figures are unvalidated.	All tumour sites are working towards delivering this standard and performance for all is improving with the expection of Haematology (December).	A Cancer Transformation Team is in development, the role of which will be to develop new and efficient pathways across the system. As anticipated the pandemic has had a negative impact on the waiting lists and the delivery of targets associated with them. In line with national guidance, to ensure patients remain safe whilst waiting, a process of patient risk stratification has been implemented and the Trust continues to treat urgent and cancer cases as a priority.

Indicator: **Cancer waiting times - 31 days 1st treatment**

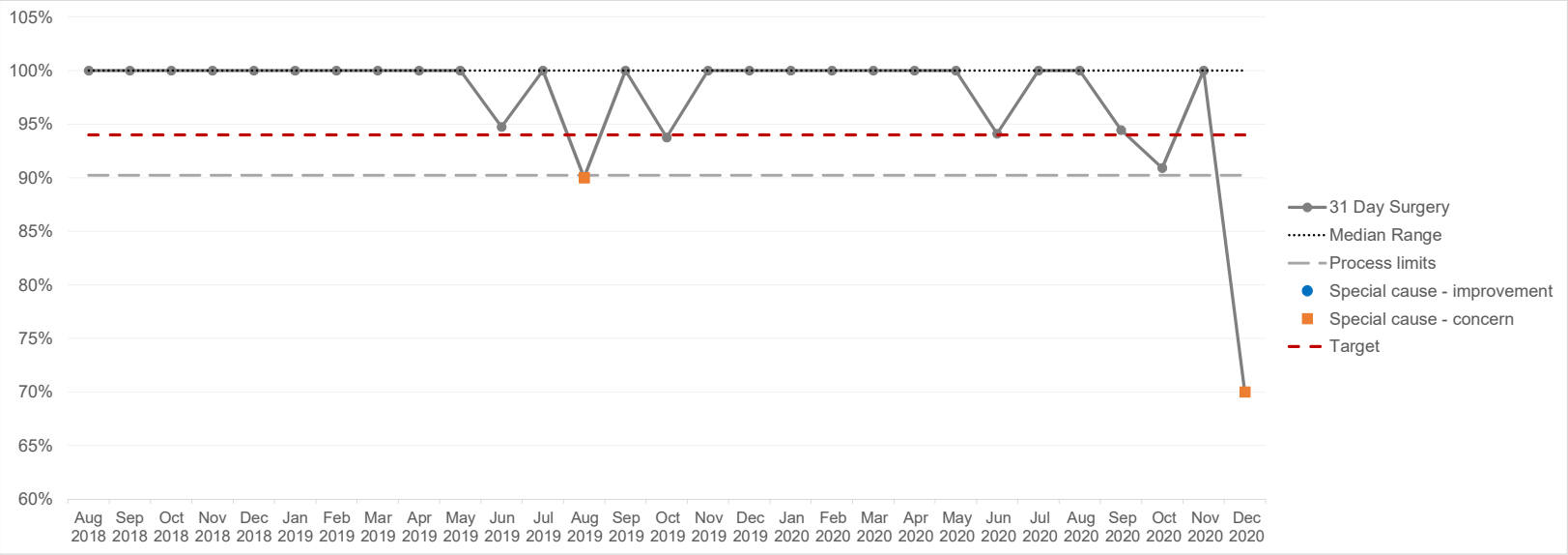
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	92%	96%	N/A		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart shows that performance is variable and is slightly below target.	This standard requires a maximum 1 month (31-day) wait from the date a decision to treat is made to the first definitive treatment for all cancers.	Cancer cases are treated as a priority and additional capacity has been accessed by some specialties, though not all at St Hughes Hospital during December. The current national contract wih the independent sector is due to terminate on 24 December 2020 and negotiations are underway to source capacity for January 2021. Further capacity will be made available at Goole Hospital from Janaury 2021.	Failure to secure capacity in the independent sector could potentially impact on the ability to deliver cancer surgical treatments therefore internal options are currently being explored.

Indicator: **31 Days Surgery**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**70.0%**	**94%**	**N/A**		

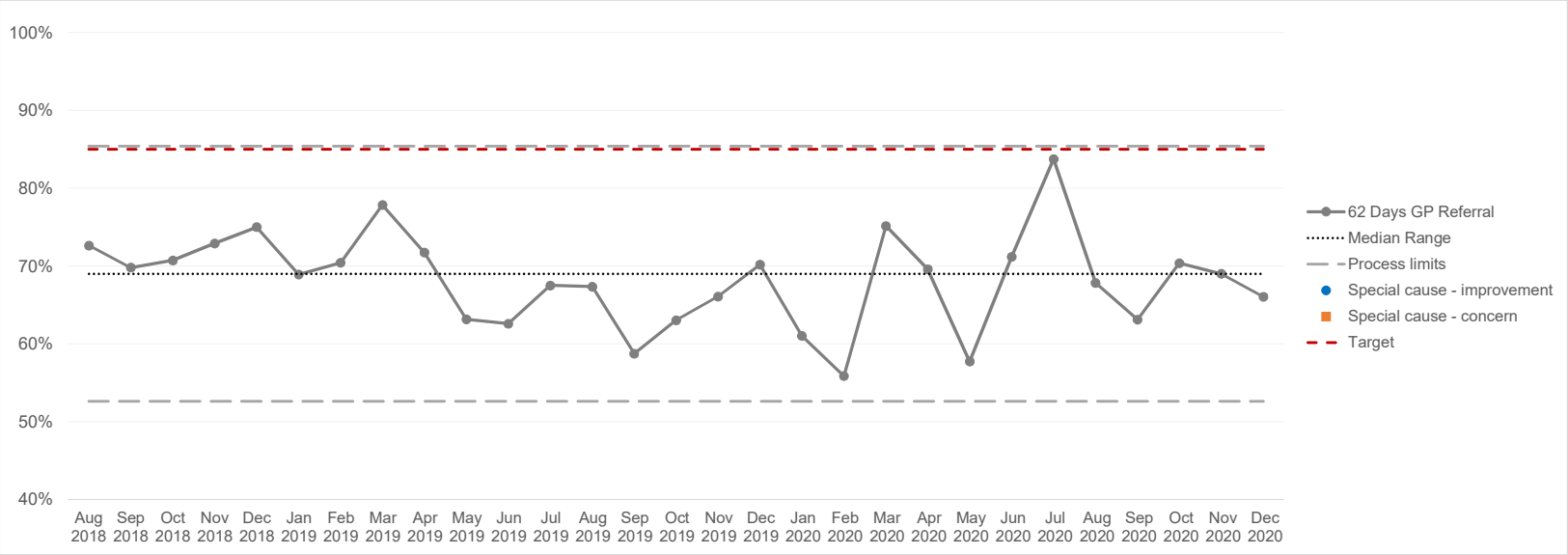


What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
Indicative performance has dipped In December and is likely to be due to patients willingness to have treatment over the festive period.It is not currently a cause for concern.	This indicator is predicated upon a one month (31-day) wait from diagnosis to first definitive surgical treatment. Due to the national reporting processs these figures are unvalidated.	December saw a reduction in Surgical treatments (including tertiary providers) to 55%. December is a difficult month to encourage patients to attend, coupled with a reduction in capacity during the holiday period these factors have contributed to the position. Capacity was also reduced by the independant sector in December as a result of the introduction of Independant Sector capacity framework which has had an impact however capacity is being sourced in January to assist with recovery.	Surgical recovery plans include use of the Independent Sector and maximising capacity at Goole District Hospital to include additional weekend working will support a delivery improvement in January 2021.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Cancer 62 Day GP Referral**

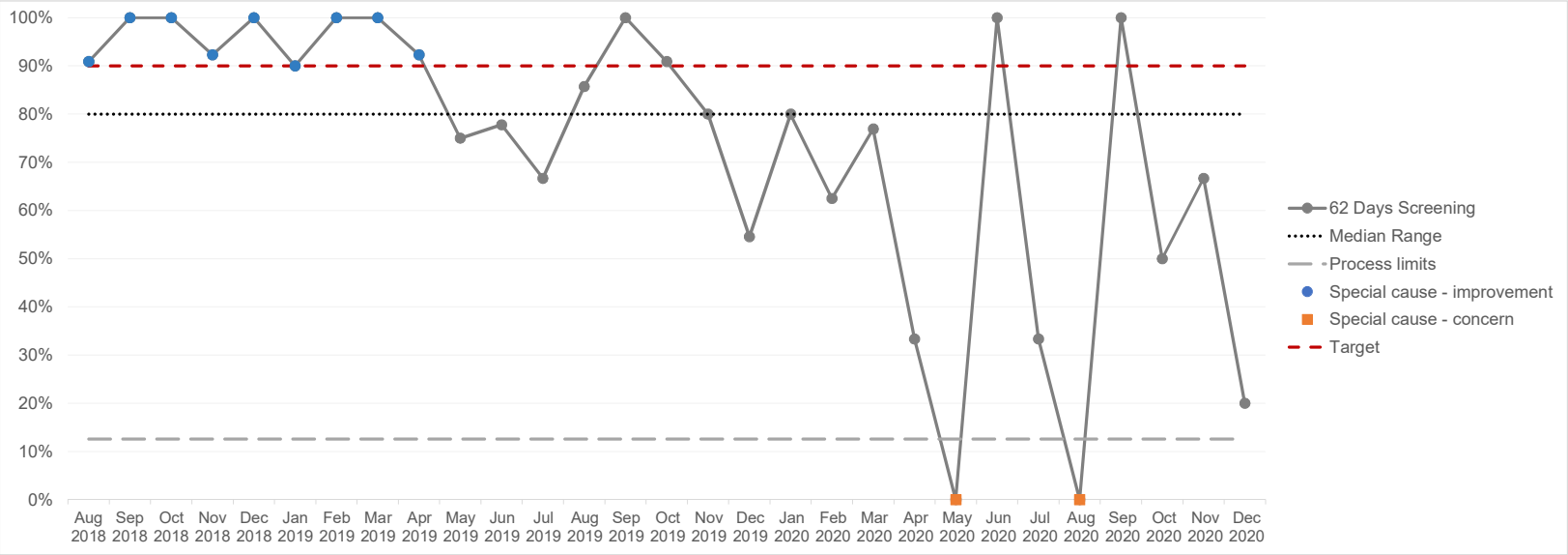
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	66%	85%	N/A		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
This chart indicates that performance is within the control parameters and continues to be variable. Performance is below the national standard and has remained so for more than 2 years..	This indicator is predicated upon a two month (62-day) wait from urgent referral to first definitive treatment. Due to the national reporting timetable the figures reported are unvalidated. The total >62 day backlog is at 171. The backlog is split 37 confirmed cancers (12 >104 days), and 134 suspected cancers (36 >104 days). A large proportion of the backlog are suspected cancer pathways with the biggest cohort being Colorectal (84) of which there are 76 suspected cancer/8 confirmed cancer . Due to the national reporting timetable the figures reported are unvalidated.	Though Colorectal Surgery was showing an improvement in 62 day performance from September 2020 (51.4%) to November (72.7%), this reduced in December to (17.4%) due to the cancellation of elective surgery in response to the COVID-19 surge in the 1st 2 weeks of November, this resulted in an increased number of breaches in December. Additional theatre capacity is being sourced in January to support delivery.	Delays in the Colorectal/Upper GI pathways are occuring due to the restricted capacity within CT Colon modality. A recovery plan is being developed within endoscopy. The FIT pathway has commenced in Humber Coast and Vale (including N/NE Lincs) and requests for FIT test have been implemented within NLAG (to risk stratify the backlog of patients waiting for diagnosis).Oncology outpatient capacity – continues to be a problem due to consultant sickness/vacancy factor and therefore continues to be a risk that will impact on length of pathways and 62 day breaches. We are continuing to work closely with HUTH (through the Humber Cancer Board) to minimise the impact on patients.

Indicator: **Cancer 62 Day Screening**

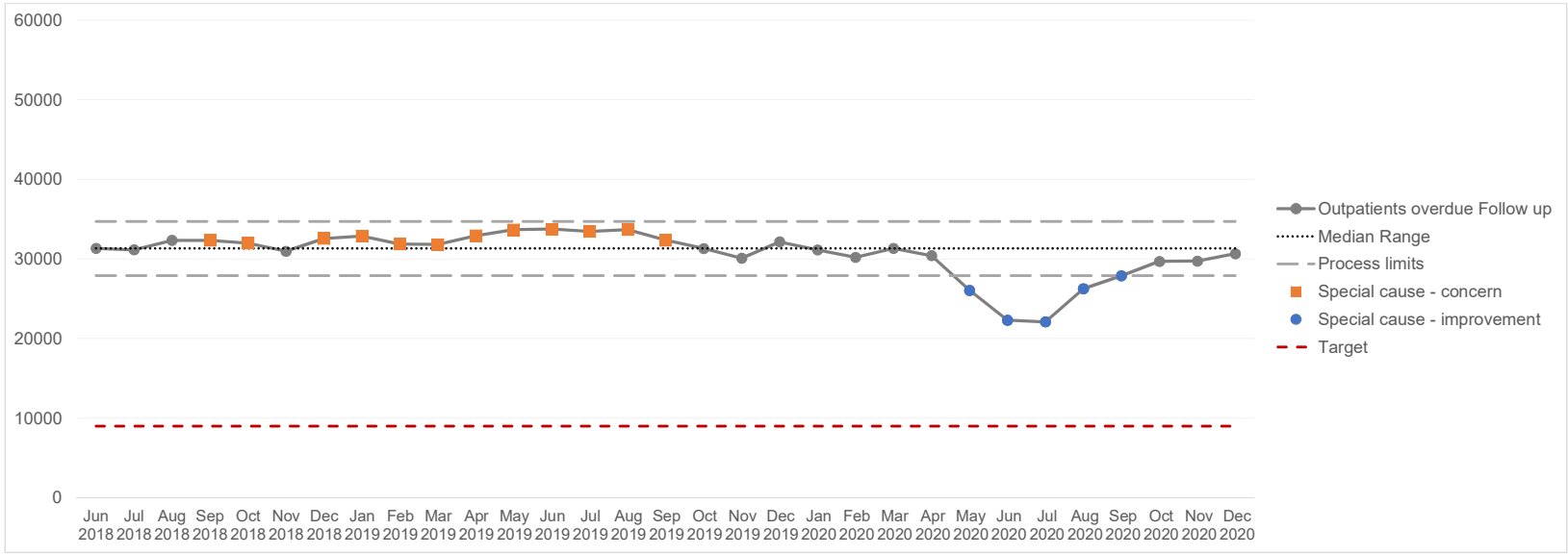
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**20%**	**90%**	**N/A**		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart indicates that current performance is within the process limits. There is significant variation indicated throughout the year though this is due to the small number of patients in this category. Performance suggests that the control limits should be reviewed.	Whilst performance appears variable, this is due to the small number of patients involved. The 62 day screening performance is below national standard. Due to the national reporting processs these figures are unvalidated.	Proposals to create additional capacity within Endoscopy are being submitted to TMB.	COVID is playing a large part at present due to limitations in Endoscopy and Radiology for CT Colon as well as theatre capacity, elective capacity as high observation beds are required in many of these major cancer cases and Oncology capacity issues).

Indicator: **Outpatients overdue follow up**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	30,646	9,000	N/A		

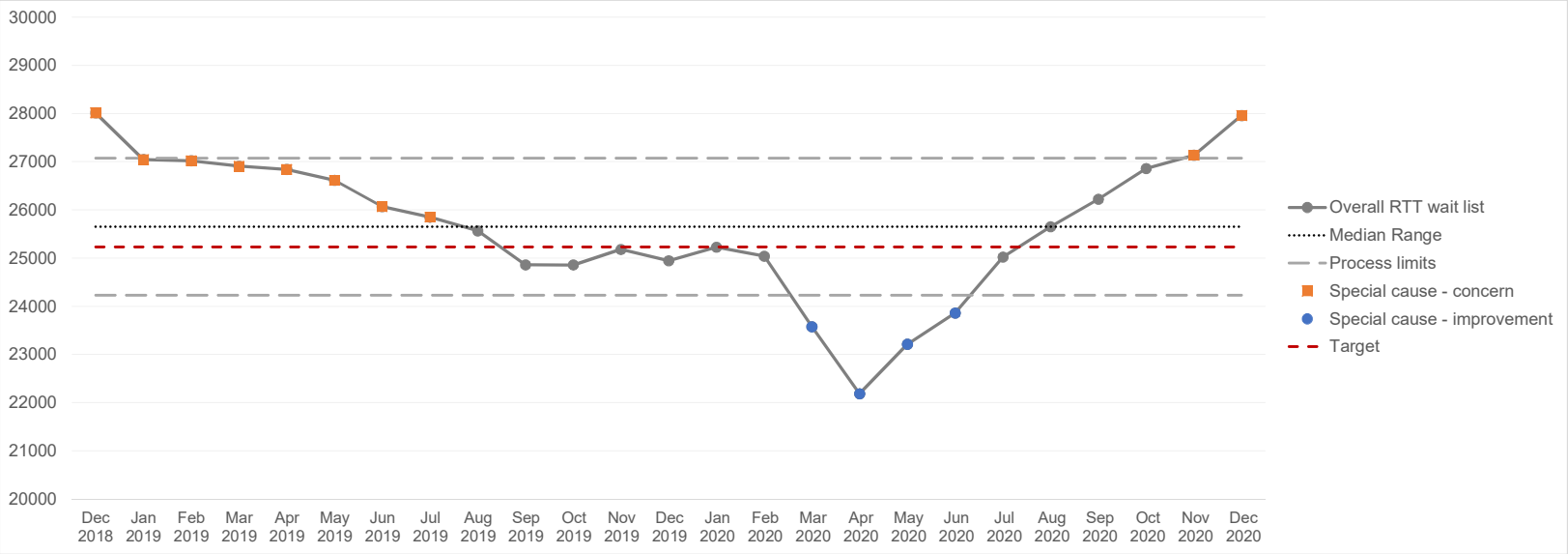


What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart above shows a period of relatively static performance. From April 2020 services changed thier operating model in response to the impact to the pandemic. Performance remains close to the process median.	The aim to reduce the size of the waiting list for overdue follow up patients remains a Trust priority. The impct of the pandemic has significantly delayed progress.	Non-face to face telephone appointments and video consultations have been introduced. The impact of the system wide outpatient transformation work to implement a system of patient initiated follow-ups is expected to have a positive impact in quarter 4.	All specialties have implemented Patient Initiated Follow Up (PIFU) though to date numbers are small. Specialties continue to work with clinical teams to roll out. Virtual appointments and PIFU.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **The Number of patients on an incomplete RTT pathway awaiting treatment at the end of the month**

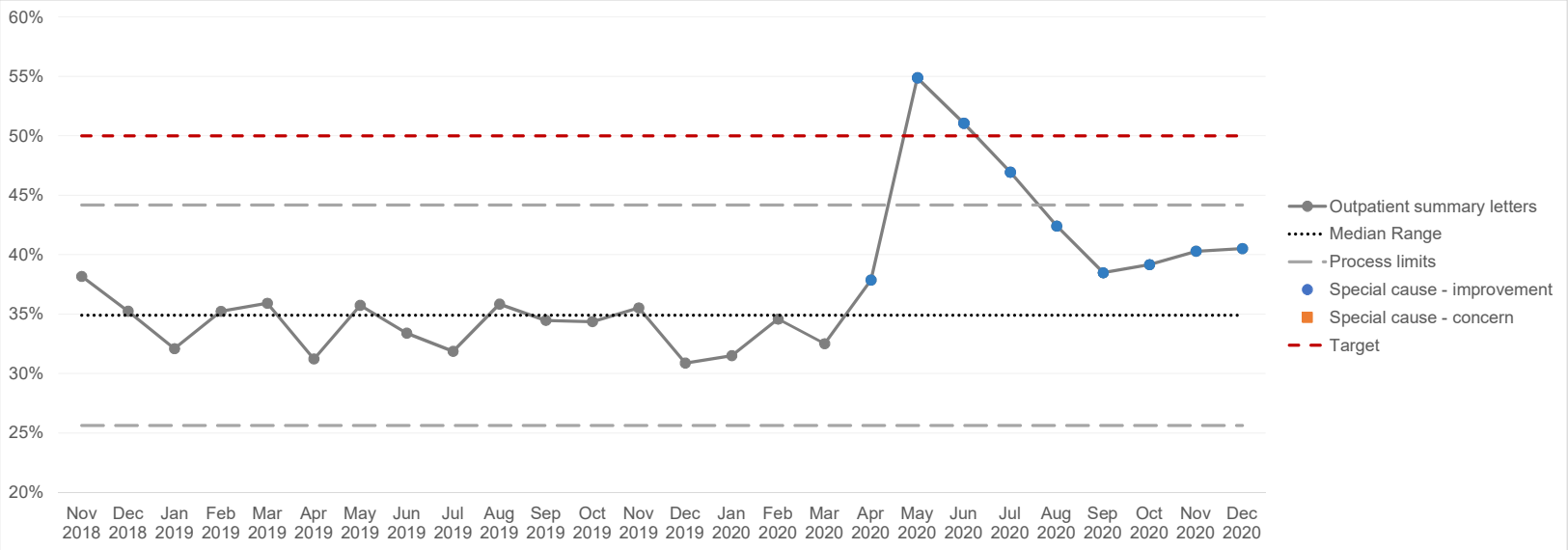
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**27,959**		**N/A**		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart it showing that there has been a growth in the number of patient on the RTT waiting list since April 2020, this puts the delivery of the target at significant risk.	The intention of this measure is to maintain the size of the waiting list as at March 2020 in line with national business planning guidance. In April 2020 the waiting list was below target at 22,184 but has steadily increased throughout the year to date and continues on an upward trajectory.	The divisions/specialties are currently reviewing their performance against the Phase 3 plans and developing action plans to mitigate the position, maintaining focus on Cancer Urgent cases and +40 week waiters..	In order to deliver against the target a sustainable reduction of 2,732 patients is required and whilst this maybe deliverable we can not lose sight of those patients being added to the waiting list following outpatient consultation. Therefore this is extremely challenging in the current circumstances.

Indicator: **Outpatient letters**

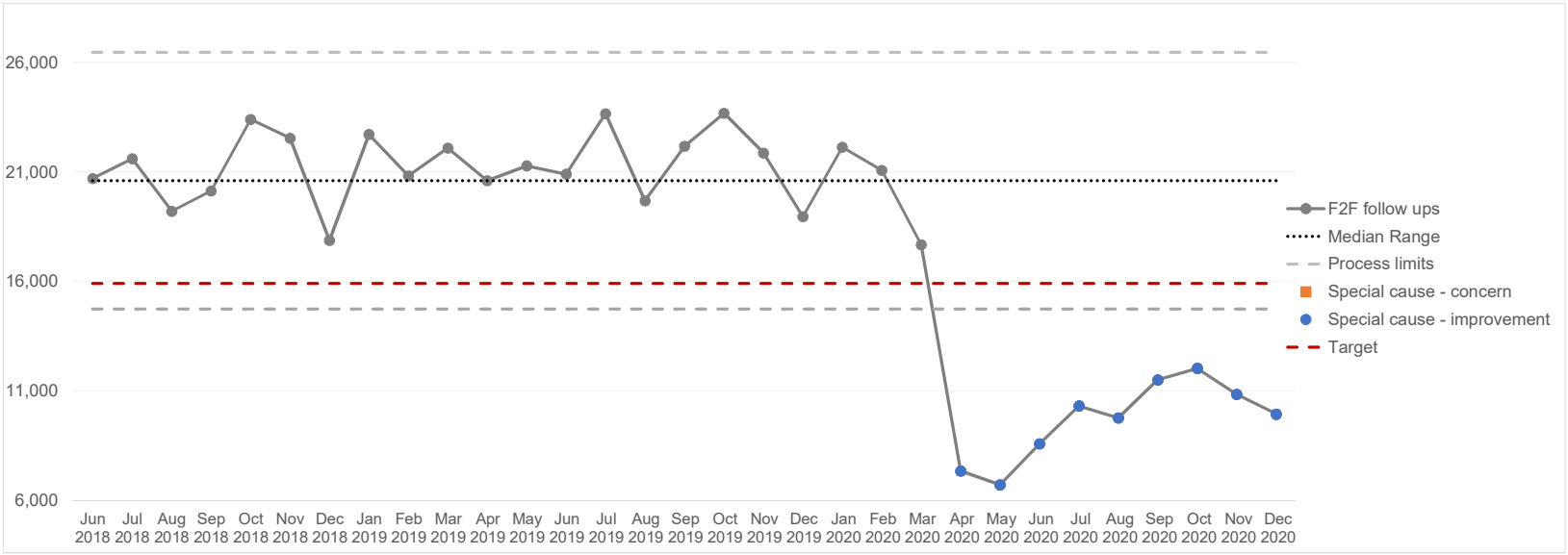
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	40.51%	50%	N/A		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart indicates that performance is in improving and is on an upward trajectory.	50% of out-patient summary letters to be with GPs within 7 days of patient attendance	Letters with the longest delays are raised weekly at the PTL meeting with AGM's. Out-patient functionality is being developed on WebV as a potential alternative solution to DictateIT. A proposal is in development to utilise back end speech recognition for all typing in Dictate IT (cost neutral) Performance and Operational reports are available to each Division All Clinicians have identified a deputy / deputies who can sign on their behalf If a Clinician is on leave, ensure there is a lead clinician or registrar who can sign on their behalf where numbers of patients exceed normal capacity (extra activity) ensure further administration is created for clinicians to action	Some clinician job plans only have 1 admin session per week scheduled – this will be addressed in the 20/21 job planning reviews. The overall process of dictattion, transcribing, administrative review, e-approve, distribution, does not lend itself to a 7 day turnaround – Business Case principleshave been agreed, though must remain cost neutral. There is a proposal is in development to utilise back end speech recognition for all typing in Dictate IT.

Indicator: **Reduce face to face follow ups by 10%**

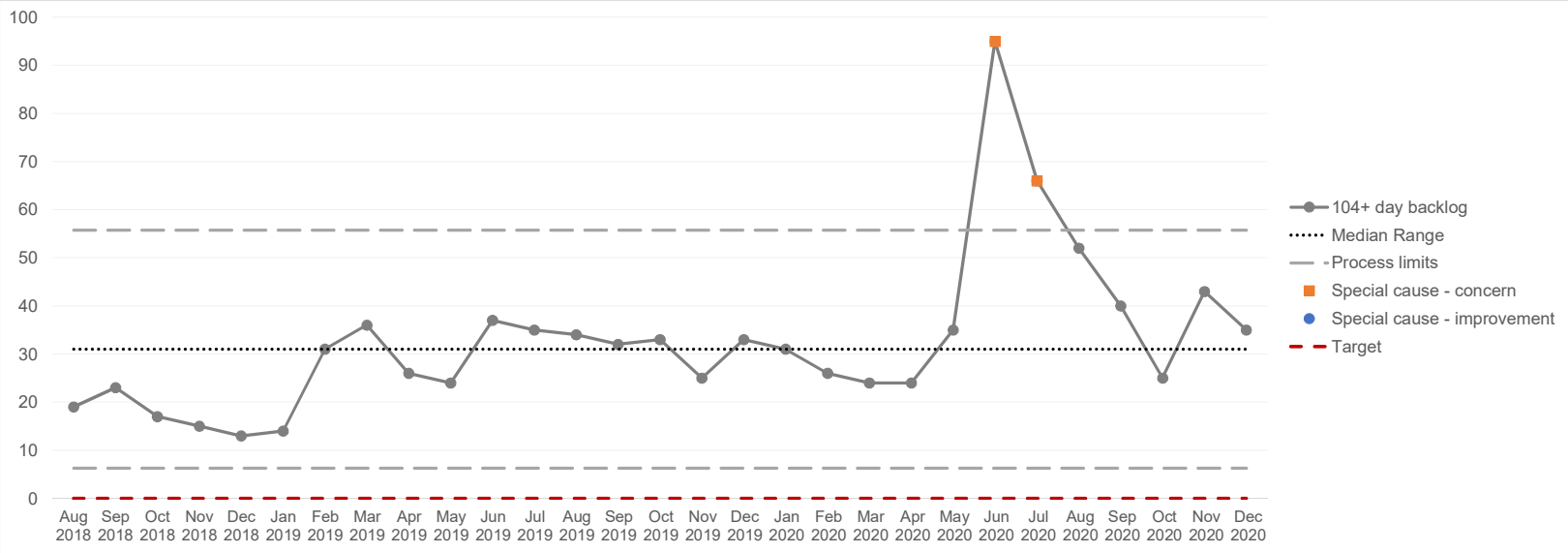
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	9935	15903	N/A		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart shows that there has been siginficant improvement and performance has exceeded the target.	Through the Outpatient Transformation Programme there is a plan to reduce the number of patients seen on a face to face basis where appropriate. .	However there has been an increase in video and telephone appointments over the course of the year, there were 9,935 virtual follow-up appointments in December.	Initial risks included access to IT equipment – this has been provided in the clinic rooms and some laptops have been made available. Clinical engagement is key and specialties are working together to implement the required changes.

Indicator: **Cancer 104+ days**

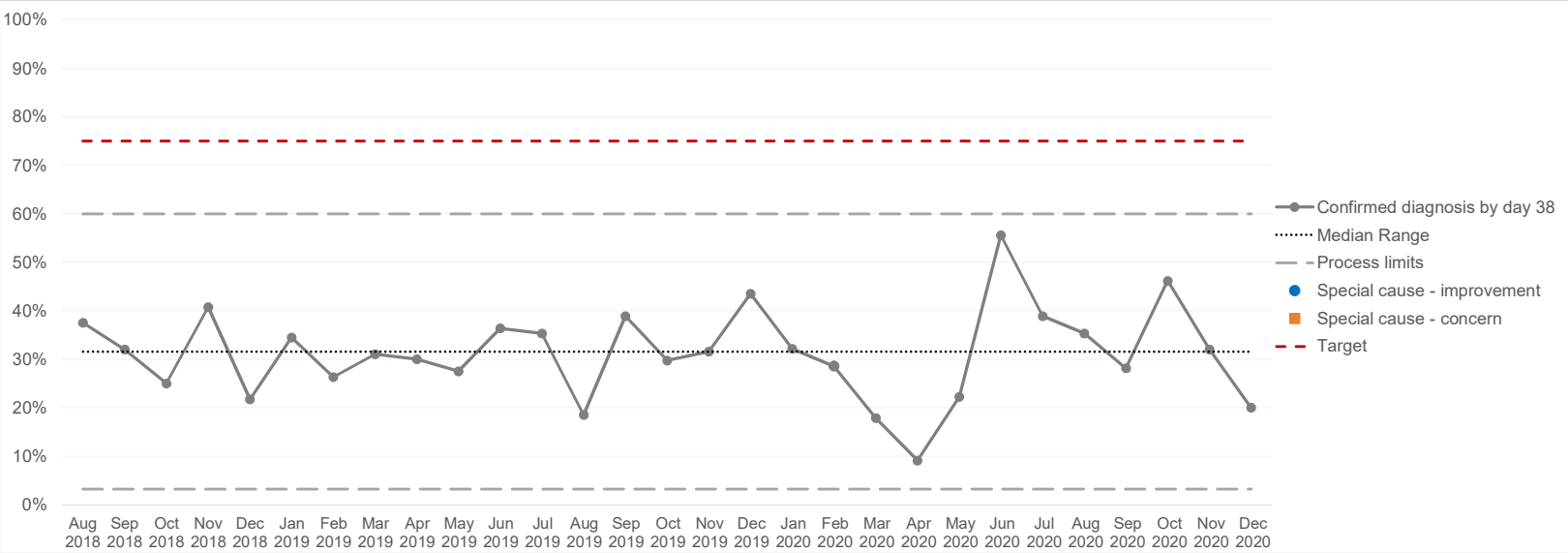
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	35	0	N/A		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The number of patients waiting 104+ days is within the expected range and close to the median. The current position indicates that 35 patients have waited in excess of 104 days.	Patients, that exceed a wait of 104 days may have cancer confirmed or may still be undiagnosed. Due to the national reporting timetable the figures reported are unvalidated.	Extended waiting times for endoscopy and CT Colons is due to the reduction in capacity for scoping procedures following the implementation of infection control measures. System wide monitoring is in place and were possible, additional capacity is being sourced in the independent sector.	The FIT pathway has commenced in Humber Coast and Vale (including N/NE Lincolnshire) and requests for FIT test have been implemented within NLaG (to risk stratify the backlog of patients waiting). Action plans are in development to address the shortfall in endoscopy capacity.

Indicator: **Care of patients with confirmed diagnosis transferred by day 38 to be at 75%**

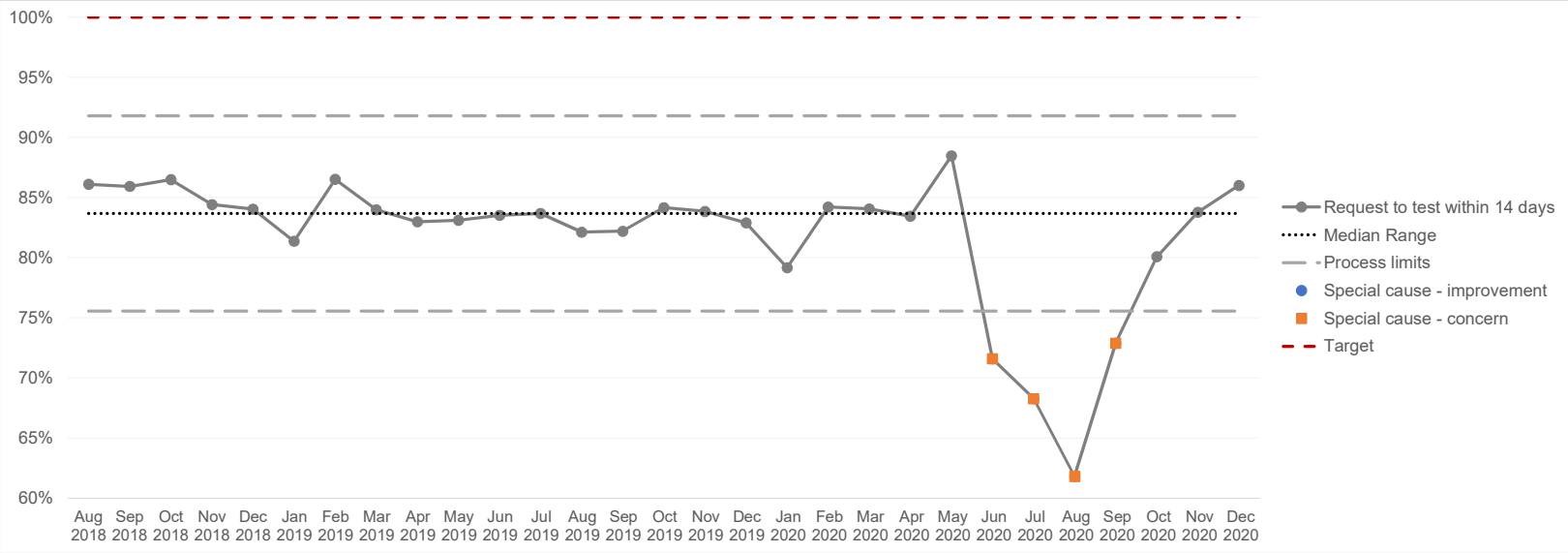
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**20%**	**75%**	**N/A**		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart shows that performance is signifcantly below target and it is unlikely that this standard will be achieved in year.	The aim of this measure is to monitor the time taken to transfer patients from the Trust to the cancer hub . Difficulties continue in achieving the transfer of patients by day 38. Due to the national reporting timetable the figures reported are unvalidated.	Delays in local and tertiary hub diagnostics impacts on this timeline. Availability of clinic outpatient outpatients for the hub consultants delays Inter provider Transfer beyond Day 38 for all urology surgical patients – of which for prostate this is circa 70% of patients. Oncology waiting times for consultant appointment are 21+ days (across all tumour sites	The Humber Cancer Pathway Transformation Programme is now in place to address some of these issues.

Indicator: **Request to test in 14 days**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**86.0%**	**100%**	**N/A**		

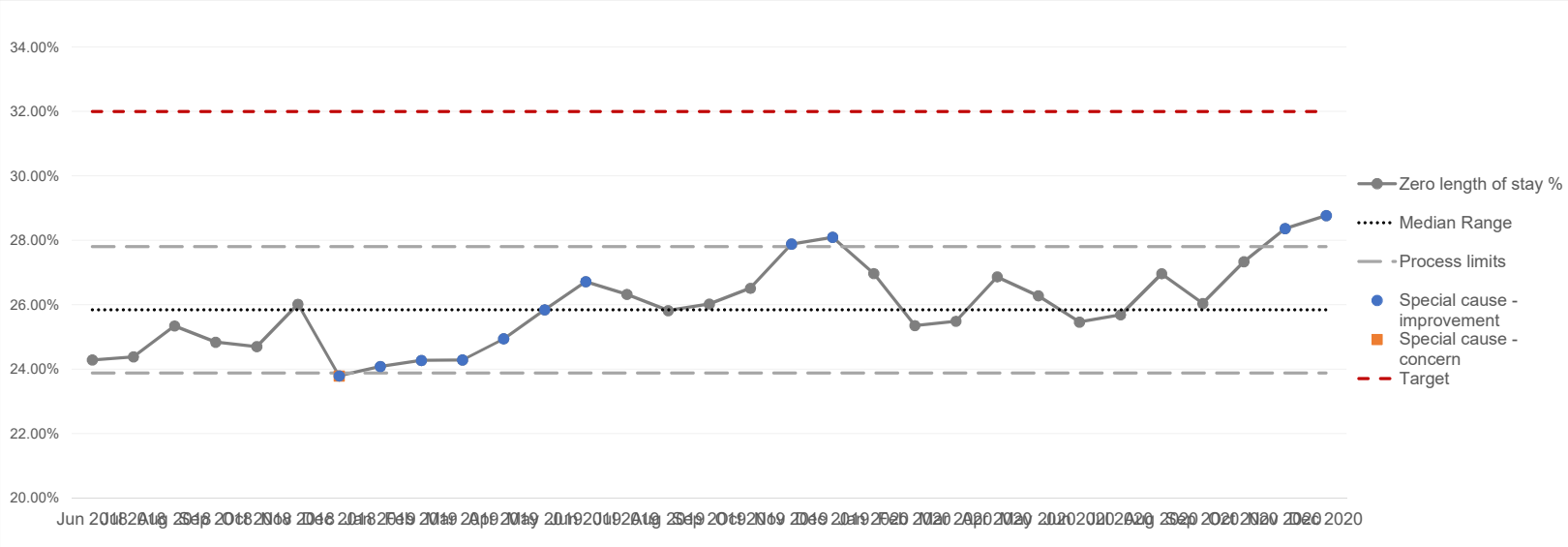


What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart is showing that the process is within control however the target has not been met; though performance is on an upward trajectory.	This indicator is designed to support the achievement of faster diagnosis for all cancers, with the aim of requesting diagnostic tests within 14 days of commencement on the pathway.	Improvements have been implemented maximise capacity to meet request the test within 7 days. The report turnaround time for 31/62 day pathways is 4 days and will actually achieve request to report in 14 days.	Services have work collobratively with the cancer team to introduce a process of clear identification of 31/62 day referrals. The was piloted within CT and is a priority for roll out once the impact of the pandemic subsides.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Increase zero length of stay to 32%**

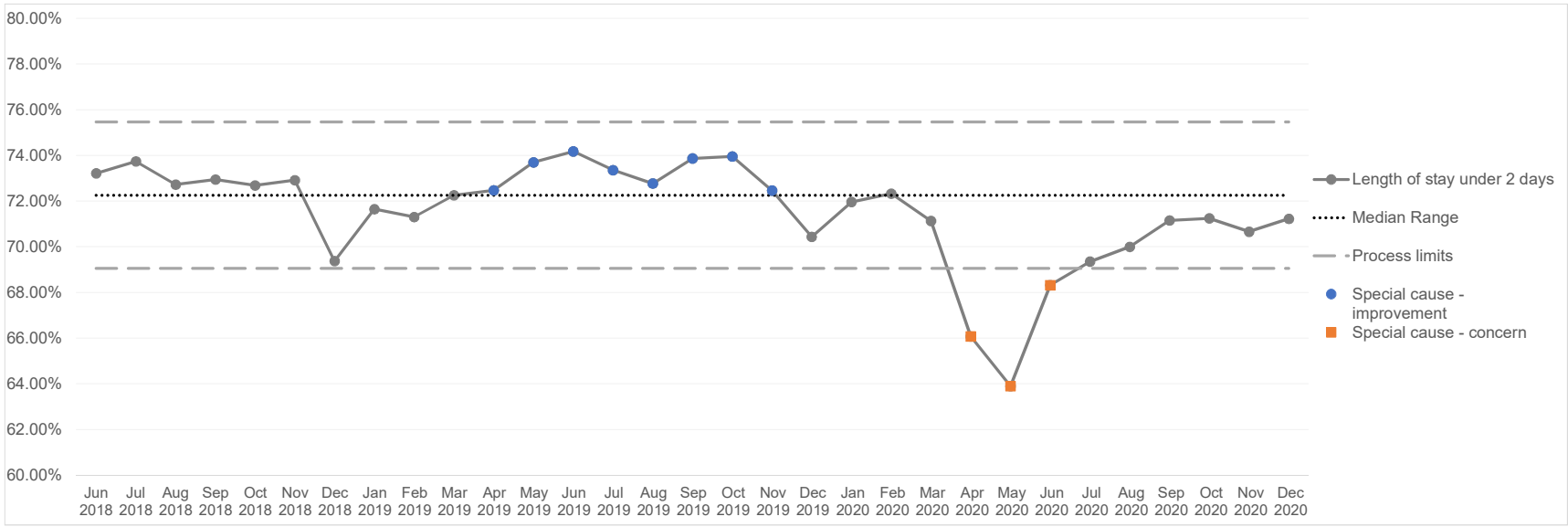
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**28.8%**	**32%**	**N/A**		



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart indicates that the number of admitted patients staying at the Trust less than 1 day is increasing. This is a positive outcome.	Same day emergency care (SDEC) is the provision of same day care for emergency patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided. It aims to benefit both patients and the healthcare system by reducing waiting times and unnecessary hospital admissions.	The Integrated Acute Assessment Units (IAAU) were opened at both hospital sites in October 2020.Their implementation has improved the patient flow to reduce exit block in ED and to increase the number of same day emergency care (SDEC) to avoid unnecessary admissions. SDEC activity has improved to 30%.	Flow through the hospital continues to be monitored through the Incident Control Centre.

Indicator: **Sustained improvement in the 0-1 day length of stay**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**28.8%**		**N/A**		

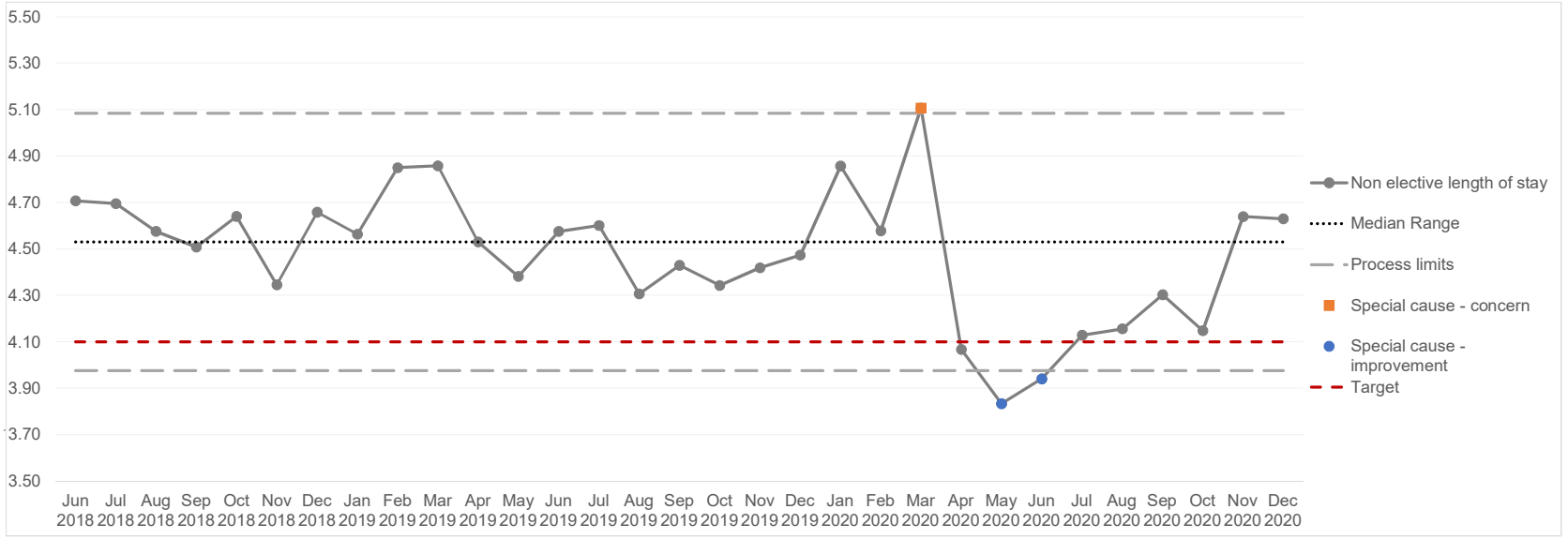


What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart is showing that there has been a sustained improvement in general in the number of patients with a length of stay of less than one day.	Same day emergency care (SDEC) is the provision of same day care for emergency patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.	The IAAU was opened and new pathways implemented at the end of October and close monitoring of performance over the coming months to demonstrate its success is expected.	A further wave of the pandemic could impact on the use of ward areas. The IAAU open and used as an assessment facility is required to achieve this standard.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Reduction in non-elective length of stay to <4.1 days**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**4.6**	**4.1**	**N/A**		

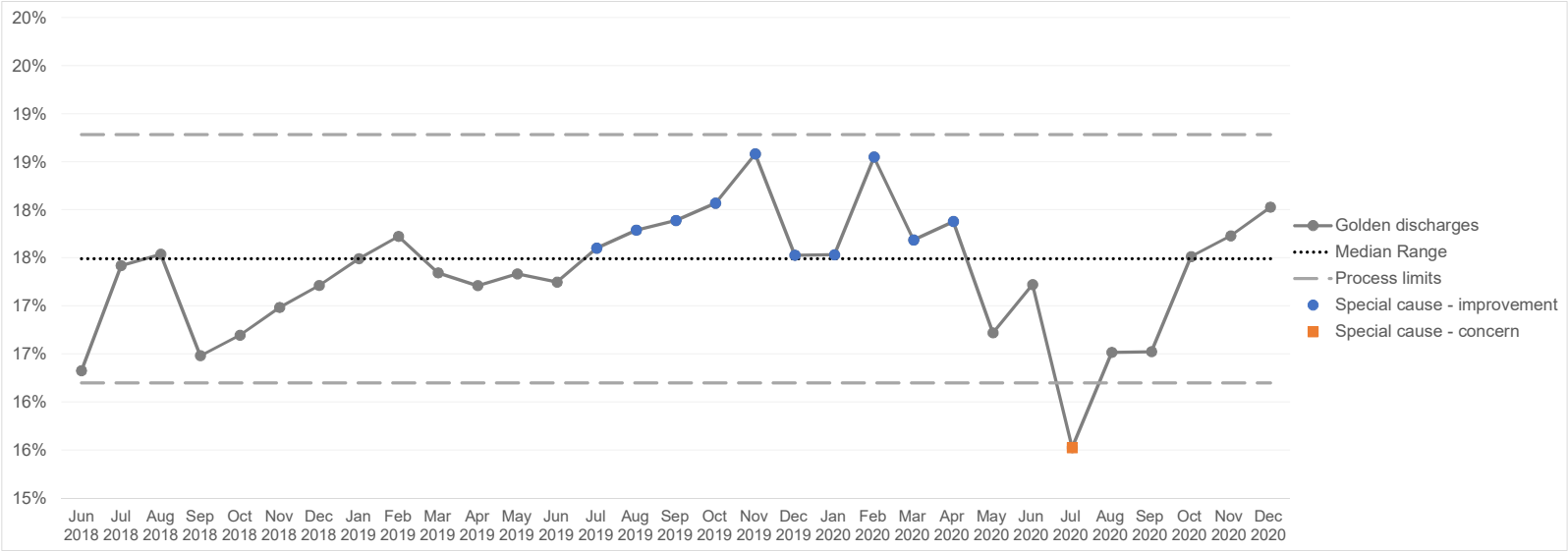


What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart indicates that those patients admitted non-electively are staying longer than expected.This has been a deteriorating position since the pandemic began.	The aim of this indicator is to ensure emergency patients are seen, treated and discharged without delay.	The new Discharge to Assess Policy is being rolled out and embedded with support from ECIST. This means identifying through board rounds patients that no longer meet the criteria to reside in an acute hospital bed. Patients are medically optimised and can return to their usual place of residence. The Trust held a accelerated system-wide event in December with a further seven day event planned in January	Success is predicated on improved communications across all stakeholders and regular engagement is taking place through board rounds to maintain this.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Progressive improvement in the rate of golden discharges**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**18.0%**	Progressive improvement	**N/A**		

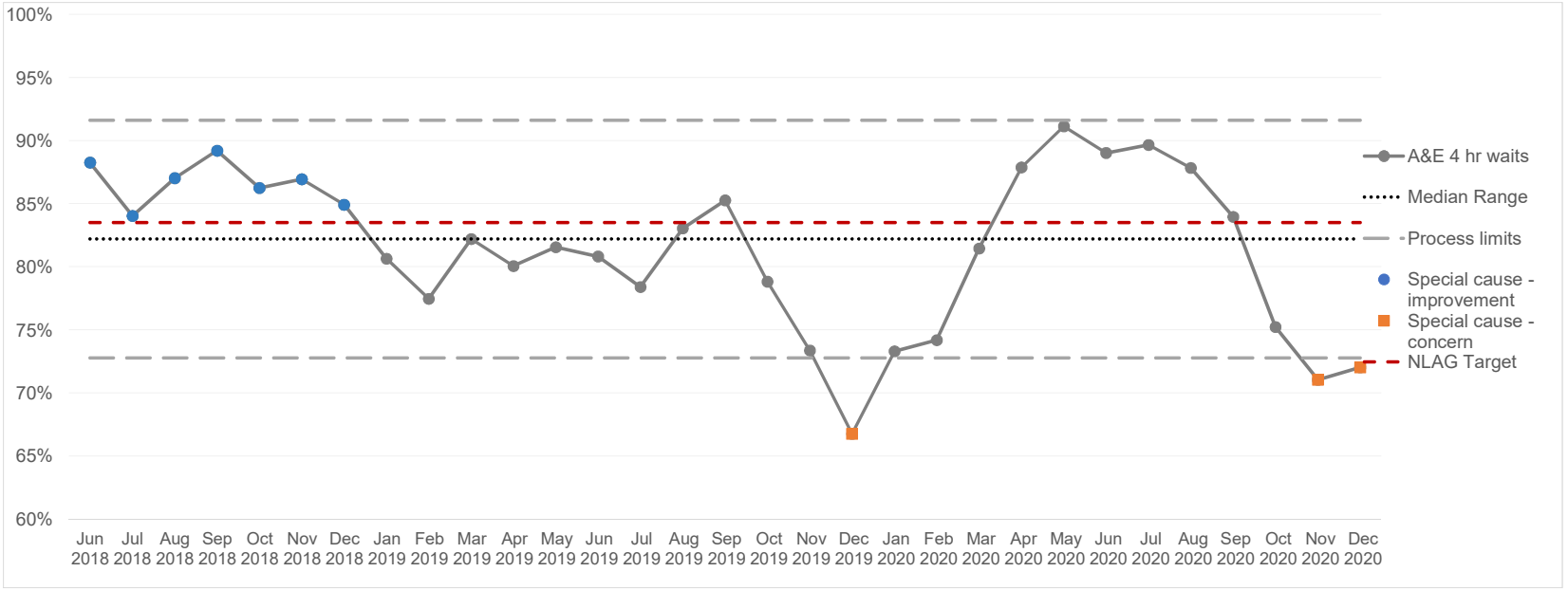


What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart is showing that the number of golden discharges is increasing month on month, performance is currently at 18% against a planned target of 35%.	The aim of this indicator is to ensure all steps are in place to enable fully optimised patients to be discharged in a timely manner; before 12 noon.	Each day the wards identify these patients on the basis that: patients who are medically optimised and can return to their usual place of residence with no ongoing care (Pathway 0) these patients are then taken to the discharge lounge within 1 hour of identification and TTO's Discharge letters are then sought to enable return home Patients who are medically optimised who may require a level of ongoing care (Pathway 1-4) for these patients the ward complete a discharge to assess form with patient detail via web V, the discharge to assess team then action this ensuring a plan for discharge is made within 24 hours, the aim is to assess the patient once they return home rather than in an acute setting	Engagement with clinical teams has improved and board rounds are being rolled out across all wards..

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Percentage of patients seen and treated within 4 hours of arrival at A&E - Trust priority**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**72.0%**	**83.5%**	**N/A**		



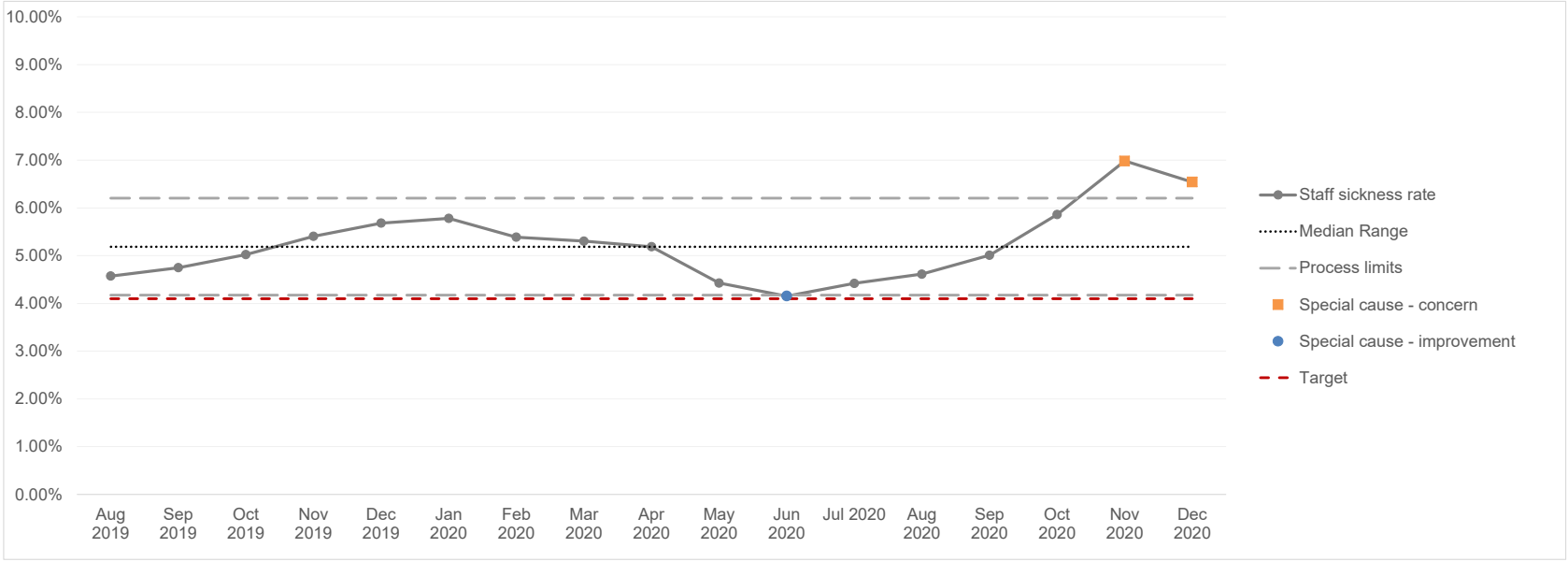
What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
Delivery appears to be within the control parameters. It is below the local target of 83.5% and the target will not be achieved if the performance continues on this trajectory.	There have been challenges with flow, mostly related to an increasing number of COVID symptomatic and positive patients, which has resulted in reviews of zoning and additional admission areas for symptomatic patients. This is impacted on by the timeframe for receiving COVID swab results. All sites have experienced COVID outbreaks and multiple bay closures due to COVID contacts which has created additional challenges with regard to capacity and flow.	New pathways have been implemented following the opening of the Integrated Acute Assessment Units (IAAU) on each site in late October.	Any delay in implementing the new pathways in the new IAAU will impact on A&E performance.

Ref	Metrics	Dec 2020	Target / Trajectory	Variation	Assurance
	National Requirements				
1	Staff sickness rate	6.5%	<4.10%		
2	Staff turnover rate	0.82%	0.78%		
3	Proportion of temporary staff				
4	Staffing levels on wards/department meet national minimum requirements	0.0%	TBA		
	Trust Priorities				
5	Improve rate of staff retention (vacancy factor)	10.4%	<7.0%		
6	Number of staff leavers reported within the period	51	50		
	Improve the number of applicants who report a positive experience of the recruitment process				
	Reduce intervention time for 1st support mechanism from 28 days to 14 days with sickness absence recorded as MH, anxiety and stress		14		
	Number of managers to be trained in Mental Health awareness in year				
	Survey to measure satisfaction of occupational health service by staff presenting MH/anxiety/stress				
7	Maintain the combined medical and dental vacancy rate at 15% with overall ambition to reduce by 1.5%	14.2%	<15.0%		
8	Maintain the total nurse vacancy rate	11.7%	7.7%		
9	Maintain safe staff fill rate greater than 90%		90%		
	Ensure that safe staffing report actions are linked to strategic workforce plan				
	Full implementation of safe care live to reduce the unnecessary agency costs in nursing by the workforce rosters reflecting the clinical demand				
	Participate in any national reviews for safe staffing levels				
	Creation of a Wellbeing Board				
10	Reduction in unregistered nurse vacancy rate to 2.0%	14.7%	<2.0%		

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Staff Sickness Rate**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	6.5%	<4.10%			

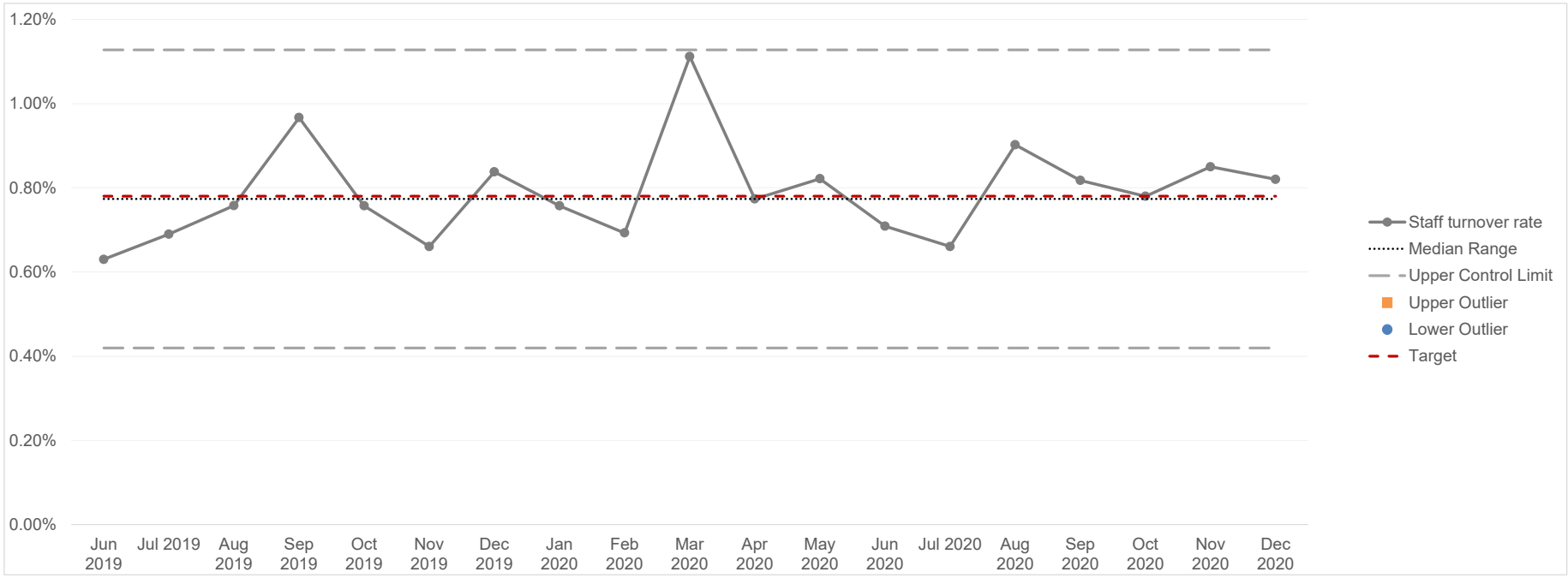


What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The charts shows indicates that concerning special cause variation has been seen for two consecutive months with November and December performance breaching the process limits. This follows a period of relatively stable sickness levels. It is not possible to currently achieve the target.	Covid 19 continues to be the main reason for sickness. Anxiety / Stress / Depression and Gastrointestinal are the secondary highest causes of sickness and are higher in relation to the same reference period in the previous year	*Regular long term sickness meetings taking place – over virtual media platforms. *Case reviews being undertaken again over virtual media platforms. *Early interventions from Occupational Health, Vivup and Remploy and other support groups i.e.Headspace. *Redeployment options considered where appropriate and feasible, including working from home. *Regular conversations with staff working remotely to support health and wellbeing and keeping in touch. *Extend policy provision for those experience the effects of covid. *Regular advice and guidance available in written format i.e. manager and staff updates. *HR Helpdesk providing guidance and advice, plus analysis of queries to focus on more informed guidance documents. *Responding to Staff Facebook page to provide timely advice when issues/themes are raised	Risks: Inability to provide effective service. Impact on service delivery. Impact on teams where high non- attendance is being experienced. Increase in costs. Trust providing additional support above normal sickness periods due to COVID related ill health and delays in treatments/interventions. Mitigation: For staff that are affected indirectly by COVID delaying treatment HR are working with these staff to support 20% enhancement for additional hours via the Bank for filling gaps in rotas Re-prioritise tasks and slim down services where possible, putting staff where the greatest need is in line with service requirements Supporting regular breaks and taking of Annual Leave but also alignment to the carry over of annual in line with national agreements

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Staff Turnover Rate**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**0.82%**	**0.78%**			

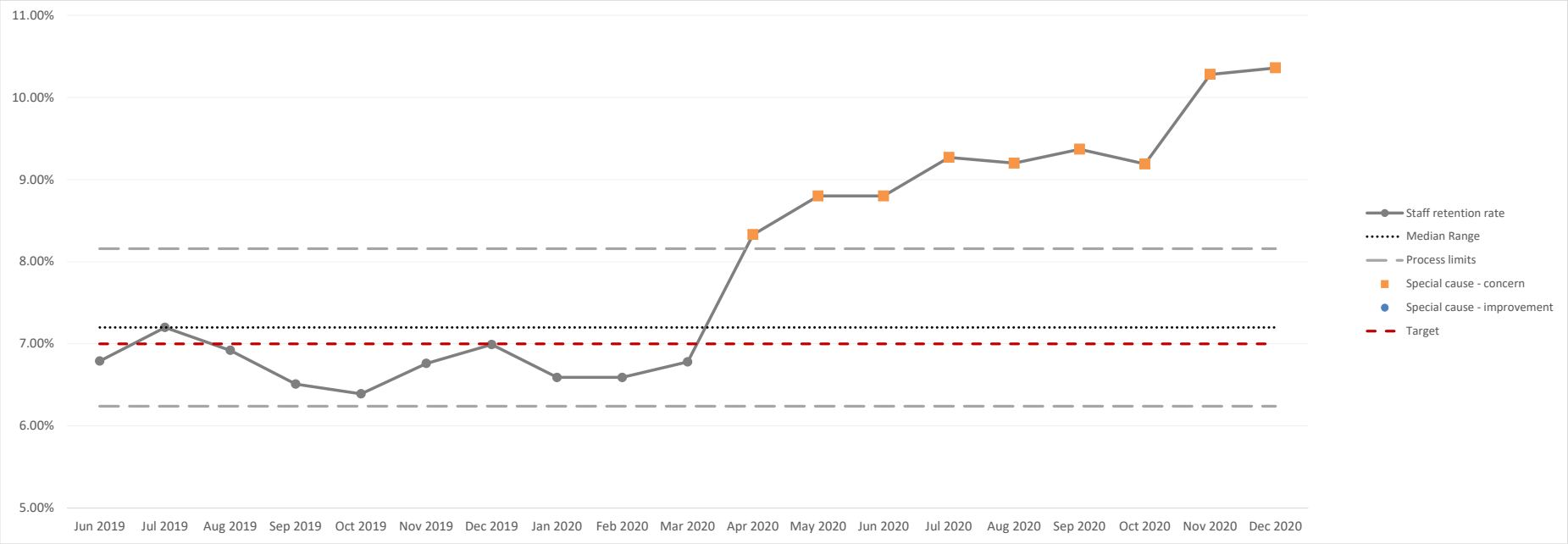


What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
Staff turnover has remained stable since June 2019. Variation of 0.4-1.1% can be expected. The target will be achieved and non achieved randomly (due to the target being inbetween the process limits)	Overall turnover remains within control limits of targets set Staff group specific work is taking place to identify and understand areas of higher turnover such as Allied Health Professionals	Evaluation of staff leaver data to identify reasons for turnover and trends Increase flexible working and remote working offer Increased Health and Wellbeing offering to support during the pandemic with the aim of increase resilience	Risks: Pandemic increasing turnover because of difficult and busy working environments Mitigation: Increased well-being offer to be produced Jan 2021 to further improve and enable access to Health and Well Being provision

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Staff Retention Rate**

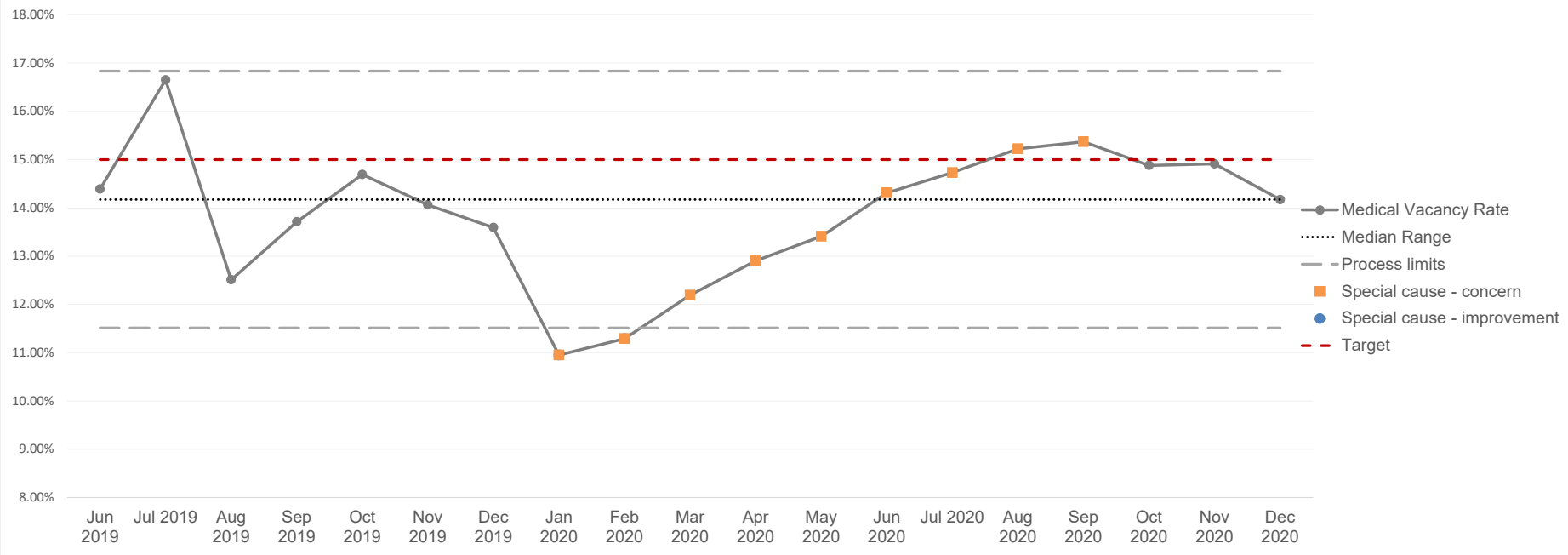
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**10.4%**	**<7.0%**			



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
There has been a concerning pattern of special cause variation for 9 months since April 2020. This follows a period of stable performance. The target of 7% is unachievable with turnover is December 2020 at 10.4%	The Trust monitors exit interviews but doesn't have a specific programme in relation to the improvement of retention.	Immediate assessment of reasons for staff exits to shape a retention response 2x funding bids (ICS and Charities Together) have been successful with an additional £185K available to support local HWB activities and HWB resource Significant investment made in HWB to support staff during the pandemic, esp in psychological wellbeing	Risk: Adverse impact on workforce numbers, resilience of current staff, to provide safe patient care Mitigation: The Trust has appointed a Senior OD Practitioner with a focus on retention, to start 01 April 2021 Risk: POE resource to focus on dedicated retention is diminished due to resources being realigned to focus on pandemic related activities Risk: Continue higher LTR% could drive further turnover through reduced workforce resilience

Indicator: **Maintain the medical and dental vacancy rate at 15% with an overall ambition to reduce by 1.5%**

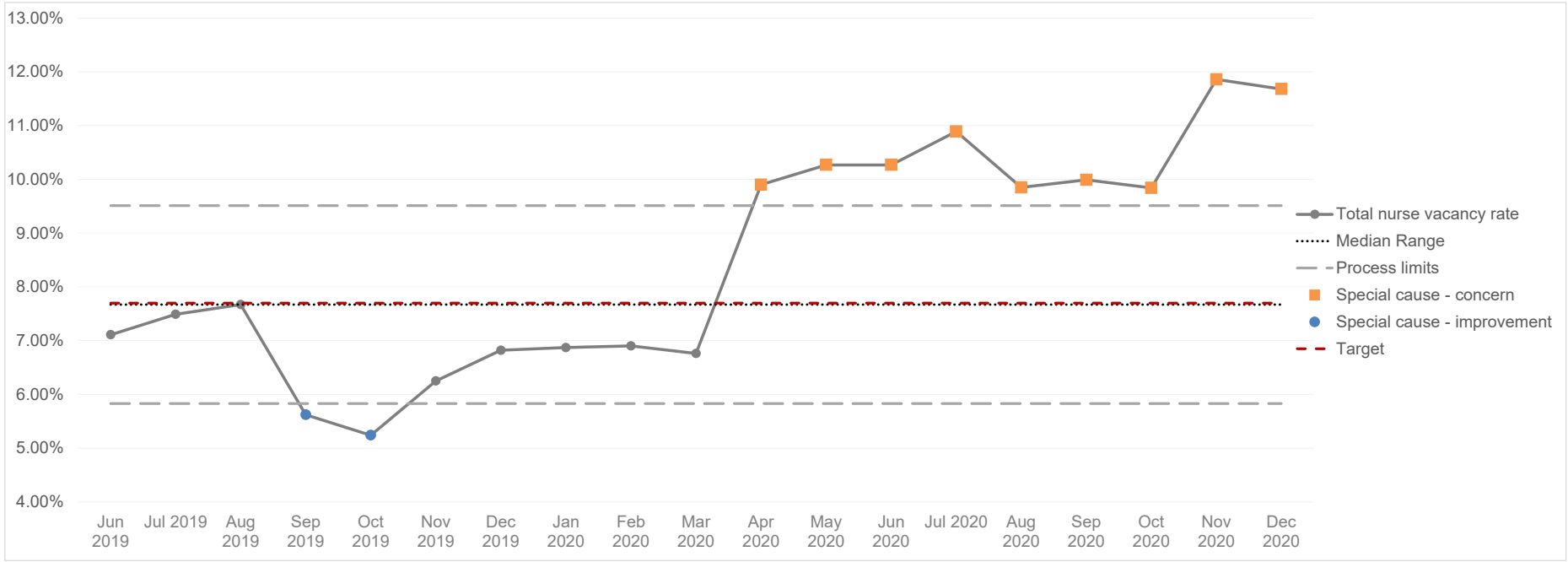
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**14.2%**	**<15.0%**			



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
October is the first month to return to common cause variation following a 9 month period of increasing vacancy rates.	Throughout the course of the year the medical vacancy rate has been on an increasing trajectory.	Continue to work with the medical pipeline to ensure start dates in the early part of 2021 Continue to source candidates via various methodologies to ensure a continued reduction in vacancy position	Risk: Covid 19 restrictions may elongate recruitment processes Mitigation: Processes are redesigned constantly to adapt to Covid legislation, candidates and managers are kept informed

Indicator: **Nurse Vacancy Rate**

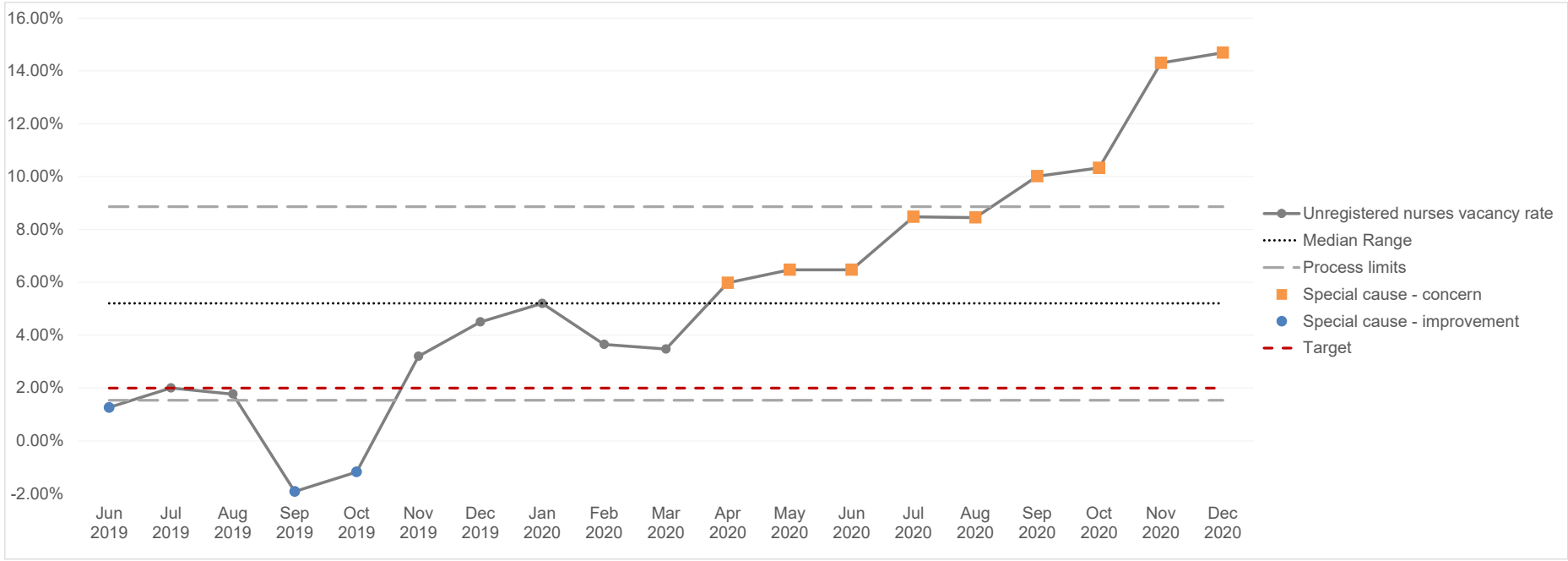
Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**11.7%**	**7.7%**			



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
Since April, the vacancy rate has been at a significantly higher level than seen previously. The current level of performance makes the target of 7.7% It is suggested that the process limits are recalculated to reflect this current level of performance	Increased establishments and the ability to start candidates from overseas has been impacted due to COVID, However overseas candidates are arriving. The recruitment team are continuing to work closely with all appointed candidates to facilicate dates as early as possible The impact of the pandemic has delayed the commencement of overseas recruits.	20 pre-registration nurses recruited from overseas have commenced in November following the regulatory 14 day isolation period. A further 20 new recruits are planned to arrive in December 2020.	In the event of insufficent staff being available the trust would use agency staff to supplement the staff rotas. However, still a risk as not all shifts can be filled via Bank / Agency

Indicator: **Unregistered Nurse Vacancies**

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	**14.7%**	**<2.0%**			



What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
There has been a concering month on month increase since April 2020. It is recommended that the process limits are recalculated to reflect the current level of performance. The target of 2% cannot be achieved with current performance at 14.7%. There is the potential to set an interim target is set as perfomance is so far above the current target.	Work is ongoing to attract recruits from various sources	Recruitment plans are in place to reduce the number of vacancies with a view to achieving a zero vacancy rate by the end of March 2021. Funding has been sourced to facilitate this and work is underway with Indeed to source candidates without previous formal NHS experience	In the event of insufficent staff being available the trust would use agency staff to supplement the staff rotas.

Ref	Metrics	Dec 2020 unless otherwise stated	Target /
	National Requirements		
1	Mixed-sex accommodation breaches	deprecated	0
2	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	1	0
3	Methicillin - susceptible Staphylococcus aureus (MSSA) bacteraemias	1	0
4	Escherichia coli (E.coli) bacteraemia bloodstream infection (BSI)	7	0
5	Trust attributed C-Diff	2	no target
6	Number of gram-negative bloodstream infections	0	no target
7	Venous Thrombelism (VTE) risk assessment	73.47%	95%
8	Duty of candour	100.00%	no target
9	Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider (other than those dealing with children, teenagers and young adults) across all tumour sites	Process not fully rolled out	No data
10	Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	No electronic data	90%
11	Emergency C-section rate	12.10%	<=15.2%
12	Patient Safety Alerts to be actioned by specified deadlines	100.00%	no target
13	Serious incidents - Raised in month	2	No target
14	Occurrence of any Never Event	0	0
15	Dementia assessment and referral: the number of patients aged 75 and over admitted as an emergency for more than 72 hours: **a)** who have a diagnosis of dementia or delirium or to whom case finding is applied	Deprecated	90%
16	Dementia assessment and referral: the number of patients aged 75 and over admitted as an emergency for more than 72 hours: **b)** who, if identified as potentially having dementia or delirium, are appropriately assessed	Deprecated	90%
17	Dementia assessment and referral: the number of patients aged 75 and over admitted as an emergency for more than 72 hours: **c)** where the outcome of b0 was positive or inconclusive, are referred on to specialist services	Deprecated	90%
18	Inpatient scores from Friends and Family test - % positive	no data this month	No target
19	A&E scores from Friends and Family test - % positive	no data this month	No target
20	Maternity Scores from Friends and Family Test - % positive	no data this month	No target
21	Community Services Score from Friends and Family Test - % positive	no data this month	No target
22	Staff Friends and Family Test %	no data this month	No target
23	Hospital Standardised Mortality Ratio (HSMR) - **Data is for November 2020**	136	100
24	Summary Hospital level Mortality Indicator (SHMI) - **Data is for August 2020**	105	100
25	Written Complaints Rate	4.5	no target
	Trust Priorities		
26	Mortality Screen of 50% of deaths	46.0%	50%
27	Structured judgment review (SJR) in 100% of those requiring a review	80.0%	100%
28	Adults: Timeliness of observations within 30 minutes of due time	86.74%	>85%
29	Children: Timeliness of observations within 30 minutes of due time	100.00%	>85%
30	Improve frequency of sepsis screening and robustness of reporting	5.34%	Improvement
31	5% reduction in insulin errors causing significant harm in 20/21	0	0
32	Diabetes role specific training compliance	81.8%	>85%

Additional KPIs

Key Performance Indicator	Current	Group by	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Clinical Effectiveness															
Adherence to NICE guidance (exc. Quality Standards)		Trust	82.6%	84.9%	85.7%	85.7%	85.2%	84.8%	86.7%	87.5%	87.6%	88.1%	88.5%	88.5%	87.6%
		Trajectory													
	Comments:														
Documents in compliance within document control system		Trust	88.2%	88.8%	88.8%	88.8%	87.1%	89.6%	89.7%	90.7%	88.7%	88.7%	89.2%	90.7%	90.4%
		Trajectory													
	Comments:														
Patient Safety															
Patient Safety Alerts to be actioned by the specified deadlines		Trust	88.0%	88.0%	88.0%	88.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		Trajectory													
	Comments:														
CCG incidents responded to within 20 working days		Trust	43.0%	38.0%	31.0%	29.4%	29.4%	26.0%	32.0%	42.0%	75.0%	50.0%	44.0%	42.0%	52.0%
		Trajectory													
	Comments:														
SI responded to within the required 12 week timescale		Trust	50.0%	0.0%	0.0%	0.0%	9.0%	87.0%	58.0%	58.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		Trajectory													
	Comments:														
SI responded to within the re-negotiated timescale		Trust	45.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	70.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		Trajectory													
	Comments:														
Duty of candour met in line with Trust policy (SIs)		Trust	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.0%	100.0%	100.0%
		Trajectory													
	Comments:														
SIs reported to commissioners within 48 hours of SI being confirmed		Trust	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		Trajectory													
	Comments:														
Safer Staffing															
Safer Staffing fill rate - Registered Staff		Trust	96.4%	99.3%	97.0%	97.0%	97.1%	95.3%	94.3%	95.0%	98.0%	95.0%	100.0%	101.0%	91.0%
		Trajectory													
	Comments:														
Safer Staffing fill rate - Carer Staff		Trust	92.2%	93..1%	92.1%	92.1%	91.4%	107.0%	111.0%	106.0%	98.0%	104.0%	101.0%	102.0%	99.0%
		Trajectory													
	Comments:														
Care Hours per Patient per Day (CHPPD)		Trust	7.3	7.6	7.7	7.7	25.9	23.5	10.6	10.6	9.3	8.4	8.1	8.9	10
		Trajectory													
	Comments:														

NLG(21)042

DATE	02 February 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Christine Brereton, Director of People
CONTACT OFFICER	Harriet Stephens , Head of Education, Training and Development
SUBJECT	Self-Assessment Review – Health Education England
BACKGROUND DOCUMENT (if any)	Annual Self-Assessment review required by Health education England to asses and measure the impact of medical education/training in the Trust
PURPOSE OF REPORT	To approve the Self-Assessment Review – Health Education England and note its submission to HEE on 22/1/2021
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Executive Team
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	Due to timescales this report has been submitted to Health Education England as the deadline for submission was prior to the Board meeting. This is an annual self-assessment review which measures the impact of clinical workload on delivery of clinical training. The purpose is to: • Mitigate how the balance is managed between training and service delivery • Ensure Health Education England are kept updated with broader clinical changes and the impact this has on clinical training opportunities • Provide assurance that undergraduate and postgraduate medical trainees have placements that meet their learning outcomes and they are supported throughout these placements. • Provide assurance that our nursing, midwifery and AHPs have a positive clinical placement which meets their learning outcomes • How the Trust approaches any difficulties in achieving training outcomes **Risks identified:** The risks identified are the Trust having sufficient consultants due to a vacancy in gastroenterology to provide educational supervision. The board have previously been made aware of this and work continues to recruit to the post. There were no other significant risks identified in this review

ACTION REQUIRED					
Approval	**Information**	**Discussion**	**Assurance**	**Review**	
LINK TO STRATEGIC OBJECTIVES					
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**	
TRUST PRIORITIES					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**
BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	This links to being a 'Good Employer' strategic objective 2				
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: Review and Approve the Self-Assessment Review – Health Education England				

Self-Assessment Report (SAR)2020

Declaration

Trust Name

Northern Lincolnshire & Goole Hospitals Foundation Trust

Name of Board Level Director responsible for Education and Training within your organisation:

Christine Brereton, Director of People

Report compiled by (responsible for completion):

Harriet Stephens, Head of Education, Training and Development
Lynn Young, Medical Education Manager

Date seen at or scheduled for Board meeting?

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

08/10.2020

Approved by/ on behalf of the trust Board (Name):

Christine Brereton, Director of People

Date approved by/ on behalf of the trust Board:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

HEE Priorities

Please consider HEE's priorities for 2019/2020 for both medical and healthcare professionals.

HEE Domain 1 Learning Environment and Culture, HEE priority for 2019/20 reporting in this domain is:

In your organisation, in which clinical service areas does clinical workload regularly impact adversely on your ability to deliver clinical training?

Medical

Division of Medicine

Gastroenterology
The newly appointed Gastroenterologist has taken up post & it is our expectation that we will have a full establishment of Gastroenterologists early 2021 resulting even more Consultant presence on the wards.

Endoscopy
The Trust continues to work on meeting training requirements for hands on endoscopy experience. We are currently making changes to trainees' service commitment to enable protected educational time.

Respiratory
The Trust has a full establishment of Consultants in Respiratory at SGH and instructions have been given to all Medical Teams to ensure that trainees do not review patients on their own.

Nursing and Midwifery
This does not occur regularly, but does arise during times of significant operational pressures during the winter period. The need to cancel planned training is assessed according to patient throughput (OPEL status) and occupancy on a day-to-day basis.

Pharmacy
Within pharmacy there has been delays to NMP training requiring extensions to the hand in dates for portfolios at both sites.

We have had recent staffing shortages which have affected our ability to support pre-registration student's clinical rotations. Staff turn-over has meant several tutor changes for some pre-registration pharmacists.

Diploma students have had their study time reduced or cancelled on several weeks so that we can continue to deliver the clinical service.

What strategies do you employ to maintain both clinical service and training on a daily basis?

Medical

- Exception reporting for missed training opportunities. This is monitored by the DME on a weekly basis and systems developed to prevent recurring training issues.
- Risk Management – PGME has developed and operates an Incident Reporting Tool that is reviewed by DME/MEM during weekly team meetings. PGME has also developed an on line tool for FY1s to self- report incidents of unsupervised ward rounds.
- Rota management such that skill mix is taken into consideration in allocating trainees where they would most benefit educationally but also apply their accumulative skills and acquire new skills.

Nursing and Midwifery

This is achieved by planning training in advance and through the employment of dedicated educators and trainers.

Pharmacy

We try to allocate study time fairly where possible. This may mean that in some weeks, study time is cancelled for some students to allow others to attend clinics or study days. We have reduced our clinical service during periods of severe staff shortages.

HEE Domain 2 Educational Governance and Leadership, HEE priority for 2019/20 reporting in this domain is:

Many clinical services are undergoing review and change as part of the NHS Long Term Plan & People Plan, what governance steps have you put in place to ensure the required notification of any change in service is given to both HEE and the HEIs to ensure continued clinical placements within your organisation?

Medical

The Director of Medical Education is a member of the Trust Management Board and liaises on a regular basis with HEE.

Nursing and Midwifery

This would be discussed at Strategic Partnership, Humber Coast and Vale meetings chaired and attended by the NLaG Chief Nurse.

Please describe how your organisation ensures the governance of education. Please email a copy of the organisational diagram or visual that describes the governance and team structures relating to education and training to the North Quality Analyst Team at nqat@hee.nhs.uk.

Please see attached Medical Directors Office Structure that shows the governance and education and training links. *(Appendix 1)*

HEE Domain 3 Supporting and Empowering Learners, HEE priority for 2019/20 reporting in this domain is:

Please describe how your organisation provides support to medical trainees who submit Exception Reports or Code of Practice concerns?

How do you encourage trainees to identify Educational Exception Reports (e.g. loss of specific training session to cover clinical service gap) from ERs relating to working beyond regular hours?

All Medical Trainees are encouraged to submit – Exception Reports for hours worked where we monitor any differences in the total hours worked from what is on their work schedule– these are dealt with by the Guardian of Safe Working who regularly meets with the DME and Assistant Medical Director.

- Hours.
- Exception Reports in relation to missed training opportunities are investigated & dealt with by PGME.
- Code of Practice concerns are placed on the PGME Risk Register and investigated. If PGME is unable to resolve the issue then this is then forwarded to the Medical Director via the Trust Risk Register.

How have you used the 'Rest Monies' allocated to you from central funding to support doctors in training?

The Rest Monies allocated to NLAG (£60,833) have been used to update and provide rest facilities for the Junior Doctors on both the Grimsby and Scunthorpe sites.

This has included refurbishment of the Mess Facilities, Refurbishment of a current rest room in Medicine at DPOW along with a number of reclining chairs for a number of departments on both sites. The Trust has acted on recommendations made by the Trainees via surveys, Junior Doctors Huddles etc.

Please describe how your organisation provides support to learners to ensure they can access rest facilities, IT resources and pastoral support during their placement.

All Trainees are provided information and encouraged to Exception Report loss of training opportunities at Induction, Junior Doctors Forum (led by the Guardian) and Junior Doctors Huddles (led by DME). The Trust Board has oversight of the Exception Reports and both the Guardian of Safe Working Hours and the DME have to report any progress or issues with trainees learning experience.

All Rota Co-ordinators also encourage the Trainees to Exception Report whether it be for working hours or training opportunities missed.

Medical

Access codes are given to access rest facilities

- 24 hour Library access which includes IT Resources
- PGME has an open doors policy to all Junior Doctors should they require guidance and support.
- The Trust has a 'Freedom to Speak up Guardian'

Nursing and Midwifery

Nursing: Students are able to access Trust library and IT facilities. In terms of pastoral support, they can access the Professional Development team on a 1-1 basis or via advertised Student forums.

How do you support academic learners?

Medical
Academic Trainees are not currently based at NLAG

Nursing and Midwifery
Nursing: this is the remit of the HEI with respect to academic work.

HEE Domain 4 Supporting and Empowering Educators, HEE priority for 2019/20 reporting in this domain is:

MEDICAL TRAINING: Please provide details of the specific SPA time you allocate to individual trainers undertaking the roles of named Educational and Clinical Supervisor. Job planned 'one hour per week per trainee under named supervision' is the accepted standard and this is covered by the placement tariff sent with the LDA. Does your organization meet this standard; if not, what tariff do you apply?

PGME has surveyed all of the NLAG Consultants to explore how well supported they are in accomplishing the professional obligation of Educational Supervision in addition to examining attitudes towards educational supervision. The result of the survey has enabled the DME to recommend that the number of PAs allocated to each Educational Supervisor per trainee should be 0.25 with a limit of 2 Trainees per Educational Supervisors. On the recommendation of the Trust Board the DME has developed a Service Level Framework that defines the duties, scope and funding of all supervisory activities. This is awaiting the Trust Management Boards approval.

MULTIPROFESSIONAL TRAINING:

Please provide details of the protected annual time for continued development you allocate to those providing educational roles over and above the time required annually for their continuing clinical development. What in house courses/support do you provide; what external courses do you regularly use?

Medical

Educational and Clinical Supervisors utilise their Trust study leave along with allocated time in job plans for continued development within their educational roles. The educational training is largely provided by HEE or GMC as shown below

The following training has been encouraged for Educational Supervisors to complete

- GMC – Consent, Confidentiality - on line training packages
- HEE – Training the Trainers, Educational Supervisors Update Sessions
- PGME is reinstituting Face to face Educational Supervisor Training that would include problem areas such as exception reporting, work scheduling and professional wellbeing support.

Nursing and Midwifery
This is included within job plans and staffing uplifts. The Trust provides development days for different clinical groups: CNS, Clinical Sisters, Matrons, for example. The Trust offers a wide range of clinical, managerial and administrative courses in-house and utilizes a range of apprenticeship programmes such as the Operations/Department Manager Level 5 Apprenticeship. The Trust accesses HEI-provided courses via the SSPRD budget.

HEE Domain 5 Delivering Curricula and Assessments, HEE priority for 2019/20 reporting in this domain is:

With the introduction of new workforce roles (e.g. Physicians Associates) and increased numbers of Advanced Practitioners in training, together with an increased reliance on Locally Employed Doctors on service rotas, how do you ensure that doctors in training receive their required curricular opportunities and where necessary how are these needs prioritized?

Training opportunities are prioritized for Doctors in Training and are continually monitored via DME surveys, placement and exception reports.

The NHS People Plan identifies the need for increased placement numbers to accommodate the planned growth in student numbers to meet future workforce demand. What plans do you have in place to accommodate increased student placements? What impact do you envisage this will have on your ability to maintain the learning experience provided to current students and to clinical service provision?

Medical Students

NLAG currently has students on placement from Hull York Medical School and Sheffield Medical School with the vast majority from HYMS. Both medical schools were successful in their bids for additional student places. During the planning process the Trust was involved in discussions to ensure that we were able to consult with tutors and others involved regarding increases in student numbers to ensure we could maintain the excellent reputation we have amongst students. Due to this we have agreed only to take additional HYMS students. The numbers are increasing in a phased way so we have time to work with divisions and tutors to increase the capacity. We have enthusiastic tutors and over the next few years there are plans to recruit more and involve members of staff from all disciplines. We are developing the Clinical Teaching fellow role which is proving to be very successful and highly effective as we are able to deploy them to cover any temporary difficulties such as sickness and target areas of the curricula. We are increasingly able to recruit to these very valuable roles. As we move forward may need to look at increasing the number of these. The Trust Board recognises the importance of having medical students and supports the increased numbers and recognises the fact that if the student has a good experience they are more likely to return to the Trust to work. This will hopefully have a beneficial effect on recruitment in the future.

From a logistical point of view we will be reviewing the education centres to ensure they are adequate for the increased numbers and are hopeful that we will be able to made some modifications that will help. There have been meetings and plans regarding the development of new accommodation at Scunthorpe to meet the requirements as currently this is already under pressure. We will keep the administrative and clinical skills support structure under review as numbers increase. As simulation and virtual teaching expands we will also review our teaching methods, systems and kit to ensure we can continue to deliver teaching in a varied format

Nursing and Midwifery

The Trust has worked with HEE to fulfill and achieve an additional 35 Student Nurse/Midwife places for 2020/21. The Trust has also worked in partnership with Grimsby Institute to support their new BScRN programme in order to grow our own local workforce. This will be managed by the introduction of new placement models that will work in tandem with the new NMC curriculum.

Pharmacy

We have a number of student placements for pharmacists and pharmacy technicians including; Lincoln University students on placements, summer pharmacy student placements, pre-registration pharmacist posts (4 across the Trust) and Pre-registration pharmacy technicians (apprenticeships).

We don't have capacity to further increase the opportunities offered to students due to the small size of the Pharmacy department relative to student numbers.

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Domain 6 Developing a Sustainable Workforce, HEE priority for 2019/20 reporting in this domain is:

The People Plan identifies as a priority the need to tackle both 'The Nursing Challenge' (Chapter 3) and to create the workforce needed to deliver '21st Century Care' (Chapter 4). What plans for 2019-21 does your organisation have to meet these challenges from an educational and training perspective?

The Trust has worked in partnership with Grimsby Institute to support their new BScRN programme in order to grow our own local workforce. The Trust is in the process of appointing a Lead for overseas recruitment and OSCE preparation to manage the recruitment and training of overseas recruits. The Trust works in close partnership with HEI providers to ensure that we are in a position to support the delivery of their curricula – for example, the Future Nurse Standards. The Trust has performed a gap analysis with respect to the latter and is addressing areas of risk and educational provision accordingly

Organisation top three successes and top three challenges

Please use this section to summarise three high-level successes your organisation is most proud of achieving, and list any challenges or prominent issues that HEE should be aware of.

Description of success	Description of Challenge
PGME supervised the Risk Assessments and re-deployment for Doctors in Training during the current COVID Crisis.	At initial stages of the COVID crisis information was inconsistent resulting in challenges with rota management that we resolved with effective deployment planning.
We have seen a continual rise in the Trusts fill rate for Doctors in Training that currently stands at 94%.	Geographical isolation disadvantages recruitment.
The Trust has worked with HEE to fulfill & achieve an additional 35 Student Nurse/Midwife places for 2020/21. The Trust has also worked in partnership with Grimsby Institute to support their new BScRN programme in order to grow our own local workforce. This will be managed by the introduction of new placement models that will work in tandem with the new NMC curriculum.	Meeting placement capacity.

Please use this section to summarise three items of Best Practice your organisation is most proud of achieving, and the impact this has had within your organisation. Please Note: Best Practice will be shared with other organisations.

Description of Best Practice	Impact of Best Practice
Management of Trainees in Difficulty – We have introduced a Training Advisory Group that consists of Medical Directors Office, PGME, Trainers, Human Resources, Occupational Health, Safeguarding Adults, who meet to agree the most appropriate and timely actions required.	Satisfactory outcome to both Trainees and Trainers while keeping patients safe.
Responsiveness to Trainee concerns. – PGME has developed an Educational Risk Management Plan and Risk Register. 4 – 6 weekly Junior Doctor Huddles and forums ensure that PGME has mitigation and contingency plans ready.	PGME is always abreast of training issues before they escalate.
The Trust provides development days for different clinical groups: CNS, Clinical Sisters, Matrons, for example. The Trust offers a wide range of clinical, managerial and administrative courses in-house and utilizes a range of apprenticeship programmes such as the Operations/Department Manager Level 5 Apprenticeship. The Trust accesses HEE-provided courses via the SSPRD budget.	A skilled, developed and value workforce.

Nursing and Midwifery Students (NMC)

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met. Link to the ***HEE Quality Framework 2019-2020***

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

Not Applicable	*Y/N*
Applicable	*Yes*

Domain 1 Learning Environment and Culture,
please see ***HEE Quality Framework*** *page 9 & 10.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	☑	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviors.	☑	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	☑	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	☑	☐	☐
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	☑	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	☑	☐	☐

Domain 2 Educational governance and leadership,
*please see **HEE Quality Framework** page 11 & 12.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	☑	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☑	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☑	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	☑	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	☑	☐	☐

Domain 3 Supporting and empowering learners, *please see **HEE Quality Framework** page 13 & 14.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☑	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	☑	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	☑	☐	☐

3.4 Learners receive an appropriate and timely induction into the learning environment.	☑	☐	☐
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	☑	☐	☐

Domain 4 Supporting and empowering educators,
Please *see* ***HEE Quality Framework*** *page 15.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	☑	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	☑	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	☑	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	☑	☐	☐

Domain 5 Delivering curricula and assessments, *please see* ***HEE Quality Framework*** *page 16.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☑	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☑	☐	☐

5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	☑	☐	☐

Domain 6 developing a sustainable workforce, *please see HEE Quality Framework page 17.*

Please don't select more than 2 answer(s) per row.	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☑	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	☑	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviors to meet the changing needs of patients and service.	☑	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	☑	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

Please don't select more than 6 answer(s) per row.

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Adult Nursing	☐	☐	☐	☐	☐	☐
Child Nursing	☐	☐	☐	☐	☐	☐
Community Nursing	☐	☐	☐	☐	☐	☐
Health Visitors	☐	☐	☐	☐	☐	☐
Learning Disabilities Nursing	☐	☐	☐	☐	☐	☐
Mental Health Nursing	☐	☐	☐	☐	☐	☐
Midwifery	☐	☐	☐	☐	☐	☐
Nursing Associates	☐	☐	☐	☐	☐	☐

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met.
***HEE Quality Framework** 2019-2020.*

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

Not Applicable	*Y/N*
Applicable	*Yes*

Domain 1 Learning Environment and Culture,
*please see **HEE Quality Framework** page 9 & 10.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	☐	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviors.	☐	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	☐	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	☐	☐	☐
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	☐	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	☐	☐	☐

Domain 2 Educational governance and leadership,
please see ***HEE Quality Framework*** *page 11 & 12.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	☑	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☑	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☑	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	☑	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	☑	☐	☐

Domain 3 Supporting and empowering learners, p*lease see* ***HEE Quality Framework*** *page 13 & 14.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☑	☐	☐

3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	☐	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	☐	☐	☐
3.4 Learners receive an appropriate and timely induction into the learning environment.	☐	☐	☐
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	☐	☐	☐

Domain 4 Supporting and empowering educators, *please see* ***HEE Quality Framework*** *page 15.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	☐	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	☐	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	☐	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	☐	☐	☐

Domain 5 Delivering curricula and assessments, *please see* ***HEE Quality Framework*** *page 16.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☐	☐	☐

5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☐	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	☐	☐	☐

Domain 6 Developing a sustainable workforce, *please see* ***HEE Quality Framework*** *page 17.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☐	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	☐	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviors to meet the changing needs of patients and service.	☐	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	☐	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

Please don't select more than 6 answer(s) per row.

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Postgraduate	☐	☐	☐	☐	☐	☐
Undergraduate	☐	☐	☐	☐	☐	☐
Physicians Associates	☐	☐	☐	☐	☐	☐

Dental Training (General Dental Council)

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

Not Applicable *Y/N*

Applicable *No*

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

*In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met. Link to the **HEE Quality Framework** 2019-2020.*

Domain 1 Learning Environment and Culture,
please see HEE Quality Framework page 9 & 10.

Please don't select more than 2 answer(s) per row.	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	☐	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviors.	☐	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	☐	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	☐	☐	☐
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	☐	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	☐	☐	☐

Domain 2 Educational governance and leadership, *please see* ***HEE Quality Framework*** *page 11 & 12.*

Please don't select more than 2 answer(s) per row.	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	☐	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☐	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☐	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	☐	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	☐	☐	☐

Domain 3 Supporting and empowering learners, p*lease see* ***HEE Quality Framework*** *page 13 & 14.*

Please don't select more than 2 answer(s) per row.	Met	Not Met	Action Plan Available
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☐	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	☐	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	☐	☐	☐

3.4 Learners receive an appropriate and timely induction into the learning environment.	☐	☐	☐
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	☐	☐	☐

Domain 4 Supporting and empowering educators, *please see* ***HEE Quality Framework*** *page 15.*

Please don't select more than 2 answer(s) per row.	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	☐	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	☐	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	☐	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	☐	☐	☐

Domain 5 Delivering curricula and assessments, *please see* ***HEE Quality Framework*** *page 16.*

Please don't select more than 2 answer(s) per row.	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☐	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☐	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	☐	☐	☐

Domain 6 Developing a sustainable workforce, *please see HEE Quality Framework page 17.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☐	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	☐	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviors to meet the changing needs of patients and service.	☐	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	☐	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

Please don't select more than 6 answer(s) per row.

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Dentists	☐	☐	☐	☐	☐	☐
Dental Therapists	☐	☐	☐	☐	☐	☐
Dental Technicians	☐	☐	☐	☐	☐	☐
Dental Nurses	☐	☐	☐	☐	☐	☐
Dental Hygienists	☐	☐	☐	☐	☐	☐

Pharmacy Training (General Pharmaceutical Council)

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

Not Applicable	*Y/N*
Applicable	*Yes*

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met.

Domain 1 Learning Environment and Culture,
please see ***HEE Quality Framework*** *page 9 & 10.*

Please don't select more than 2 answer(s) per row.	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	☑	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviors.	☑	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	☑	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	☑	☐	☐
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	☑	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	☑	☐	☐

Domain 2 Educational governance and leadership,
please see ***HEE Quality Framework*** *page 11 & 12.*

Please don't select more than 2 answer(s) per row.	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	☐	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☐	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☐	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	☐	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	☐	☐	☐

Domain 3 Supporting and empowering learners, *please see* ***HEE Quality Framework*** *page 13 & 14.*

Please don't select more than 2 answer(s) per row.	Met	Not Met	Action Plan Available
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☐	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	☐	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	☐	☐	☐

3.4 Learners receive an appropriate and timely induction into the learning environment.	☑	☐	☐
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	☑	☐	☐

Domain 4 Supporting and empowering educators, *please see* ***HEE Quality Framework*** *page 15.*

Please don't select more than 2 answer(s) per row.	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	☑	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	☑	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	☑	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	☑	☐	☐

Domain 5 Delivering curricula and assessments, *please see* ***HEE Quality Framework*** *page 16.*

Please don't select more than 2 answer(s) per row.	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☑	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☑	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	☑	☐	☐

Domain 6 Developing a sustainable workforce, *please see* ***HEE Quality Framework*** *page 17.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☑	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	☑	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	☑	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	☑	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

Please don't select more than 6 answer(s) per row.

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Pharmacy Technicians	☐	☐	☐	☐	☐	☐
Pharmacists	☐	☐	☐	☐	☐	☐
Pharmaceutical Scientists	☐	☐	☐	☐	☐	☐

All Other Learners

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

Not Applicable	*N*
Applicable	*Y*

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met.

Domain 1 Learning Environment and Culture,
*please see **HEE Quality Framework** page 9 & 10.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	☐	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	☐	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	☐	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	☐	☐	☐
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	☐	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	☐	☐	☐

Domain 2 Educational governance and leadership,
please see ***HEE Quality Framework*** *page 11 & 12.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	☐	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☐	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☐	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	☐	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	☐	☐	☐

Domain 3 Supporting and empowering learners, *please see* ***HEE Quality Framework*** *page 13 & 14.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☐	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	☐	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	☐	☐	☐

3.4 Learners receive an appropriate and timely induction into the learning environment.	☐	☐	☐
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	☐	☐	☐

Domain 4 Supporting and empowering educators, *please see* ***HEE Quality Framework*** *page 15.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	☐	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	☐	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	☐	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	☐	☐	☐

Domain 5 Delivering curricula and assessments, *please see HEE Quality Framework page 16.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☐	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☐	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	☐	☐	☐

Domain 6 Developing a sustainable workforce, *please see* ***HEE Quality Framework*** *page 17.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☐	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	☐	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	☐	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	☐	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

Please don't select more than 6 answer(s) per row.

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Clinical Psychology	☐	☐	☐	☐	☐	☐
Dieticians	☐	☐	☐	☐	☐	☐
Estates (i.e. clinical engineers)	☐	☐	☐	☐	☐	☐
Healthcare Scientists: Life Sciences, Physiological Sciences, Physical Sciences, Clinical Bioinformatics	☐	☐	☐	☐	☐	☐
Occupational Therapy	☐	☐	☐	☐	☐	☐
ODP	☐	☐	☐	☐	☐	☐
Orthotists and Prosthetists	☐	☐	☐	☐	☐	☐
Ophthalmologists	☐	☐	☐	☐	☐	☐
Orthoptists	☐	☐	☐	☐	☐	☐
Other Apprentice	☐	☐	☐	☐	☐	☐
Other Therapist (art, drama, music etc.)	☐	☐	☐	☐	☐	☐
Paramedics	☐	☐	☐	☐	☐	☐
Physiotherapy	☐	☐	☐	☐	☐	☐
Podiatry	☐	☐	☐	☐	☐	☐
Radiography Diagnostic	☐	☐	☐	☐	☐	☐
Radiography Therapeutic	☐	☐	☐	☐	☐	☐
Sexual Health Advisors	☐	☐	☐	☐	☐	☐
Sonographers	☐	☐	☐	☐	☐	☐
Speech and Language Therapy	☐	☐	☐	☐	☐	☐

19/20 Financial Accountability Report

Details of LDA Funding

A separate copy of the LDA Financial Section (Schedule E) was included in the email sent with the SAR. In this section please describe how the trust has utilised the HEE funding received via LDA payments.

I can confirm that funding listed in the LDA (Schedule E) has been utilised for its intended purpose? (Yes)

Yes

If you selected No, please specify:

Insert Text

Additional in year funding already provided

Have you received any further funding not included in the LDA?

Yes

In this section please list any additional funding received from HEE, for example any regional or national funding received outside of the LDA payments. Please state the amount received, provide a high-level description of what this additional funding is for and please describe how the trust has utilised this funding.

Please state the amount received	Please describe what this additional funding was for?
£60,833	Fatigue and Rest Facilities for Junior Doctors

Medical Directors Office Structure. 1st .

Section 5: Simulation, Patient Safety and Human Factors

5.1. Patient safety

Please consider the following questions below.

Questions	Trust's response
1. Who is the Lead for Patient Safety in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	Dr Kate Wood, Medical director is executive lead for patient safety. Angie Legge, Associate Director for Quality Governance is the strategic lead for patient safety. The team are currently awaiting national training which is specifically in respect of the Patient Safety Specialist Initiative. There are monthly meetings in place with other Safety leads / Champions in the Trust
2. Please advise up to three areas relating to patient safety agenda that you have worked on in the last two years and you are most proud of? Could these be applied regionally and be shared with HEE?	The Associate Director of Quality and governance has been in post for the last 18months. 1. Improvement of quality in SI analysis 2. Development of SI annual report with themed analysis of causes 3. Introduction of Serious Incident Review Group to look at previous SI's and have we done enough
3. In which areas would you like support from HEE? E.g. educational events, funding, specific areas of training for example quality improvement?	Human factors training would be valuable as we would like to provide further training to all of our anaesthetic department.

5.2. Simulation

Prompt: We advise you to consult with your Simulation Manager or Lead when compiling your response.

Questions	Trust's response
1. Who is the Simulation lead in your organisation? Please advise on name, job title and email address. What support do they receive in delivering this role? E.g. job-planned time, resources etc. Are they linked in with the HEE Simulation Network in their locality?	The Simulation Team are placed within Training and Development under the Directorate of Human Resource & Organisational Development. Dr Alex Quayle, lead clinician for simulation, Consultant Anaesthetist (1 SPA) Nick Harrison, Clinical Simulation Lead (Full time) Rochelle McGuffie, Clinical Simulation Technician (FT) Yes we are linked in with the HEE Y&H network, and have also created a sub-network called SPARK (spark-neynl.org.uk). The team attend regional, national and international conferences too, presenting Trust work.
2. Who is responsible for keeping an inventory of the simulation equipment within the Trust including all task trainers and low fidelity mannequins?	Nick Harrison, Clinical Simulation Lead and the Clinical Simulation Technician, Rochelle McGuffie.
3. How many simulation specific trained faculty does the trust have?	We have approximately 35 trained faculty, mixture of consultants, trust grade/speciality grade doctors, nurses, midwives, and AHP's.

4. Which directorates or inter-professional groups are actively engaged with simulation based education within your organisation? How do you encourage equitable access to simulation for all staff?	Nursing, Medical Students, Post Grad Education, Paediatrics', Community, Midwifery, ODP's, ACP'S, Physio's, AHP's. All clinical areas are invited to participate in simulation.
5. Is there strategic engagement and representation in simulation activity in the organisation i.e. board level, clinical governance, patient safety, incident reviews?	Yes, the simulation lead runs a Clinical Simulation Group on a quarterly basis, which feeds into the quality and safety executive team meetings. Nick Harrison and Dr Alex Quayle also report to the Medical Education Committee on a quarterly basis. The simulation lead also receives RCA's, SI's and Never Events to identify if simulation is able to be utilised to learn lessons and identify latent errors.

5.3. Human Factors

Questions	Trust's response
1. Who is the Lead for Human Factors in your organisation? What support do they receive in delivering this role? Eg job-planned time, resources etc.	There is not a designated lead for Human Factors, we have a from a Consultant Anaesthetist who is the Medical Clinical Simulation lead and has job planned time , and Clinical Simulation Lead , human factors is integrated into clinical simulation training.
2. Please describe the extent to which your HF training covers the following domains: • People – the individual & teamwork • Environment – the physical aspects of a workspace • Equipment and technology • Tasks and processes • Organisation • Ergonomics and research methods	Clinical simulation is carried out both in the simulation lab and insitu. These cover all the domains.
3. For the training delivered in the reporting period please also consider and describe the following: • The audience to which HF training is being delivered, including details of multi-professional staff. • Frequency of training, or whether ad hoc events. • Who are the faculty that deliver the training? Please describe their "HF expertise", professional background, specialty, whether they have job-planned time to deliver HF training. • What is the wider Trust context within which HF training is delivered. Is there a link between patient safety incidents, SI investigations, root cause analysis? • To what extent is HF training seen as part of a wider patient quality and safety agenda or integrated into	HF training is delivered to the multidisciplinary team integrated into simulation. Dr Quayle our simulation lead, consultant anaesthetist has undertaken Human Factors training and has job planned time. HF is included in RCA training. Clinical simulation is used following SI/RCA where appropriate which integrates human factors and is incorporated into the report. Further work into HF training is required to

clinical governance structure/process?	integrate further across the Trust.

SAR 2020 Incidents and Coroner's Case Support

Supporting Learners at Coroners' Court and following Serious Incidents

To help HEE better understand how your organisation supports learners please complete the questions below.

Clinical Incidents

What system is used for reporting clinical incidents?

DATIX

How is feedback on an incident given to the reporter?

- Datix automated email from Datix when incident closed
- Reporter's manager
- Investigator of incident
- Freedom to Speak Up Guardian (if reported

What system is used for reporting Serious Untoward Incidents/ Never Events?

Datix and STEIS

Support for learners involved in a Serious Incident:

How does the Trust identify learners involved in a serious incident?	Those involved are identified on the Potential Serious Incident Proforma and names are followed up to ensure a list by the 72 hour report.
What is the target timescale for identifying learners involved in a serious incident?	72 hours although some may be identified at a later date as the investigation progresses On completion wider learning groups may be identified
Who in the education team is notified about a learner involved in a serious incident (e.g.DME,FPD, ES, names CS, Clinical Lead, etc...)?	PGME are notified via email who then notify the relevant Clinical Supervisors
Who offers support to a learner involved in a serious incident (e.g. DME, FPD, ES, Named CS, Clinical Lead, Manager, PALS, Trust Legal Team, etc...)?	Staff liaison nominated by the investigation team and also the Clinical Supervisor or a Clinical Lead and PGME. This depends on the incident as others will offer support as required eg. Head Of Legal.
Describe briefly how support to a learner involved in a serious incident is delivered?	1:1 Support, debrief, additional training, guidance and support from Educational Supervisor/Clinical Supervisor, PGME. Staff can contact a confidential care line, access to Occupational Health and other mental wellbeing mechanisms.

Describe briefly arrangements for debriefing/ support for other staff involved in a serious incident?

As above

Does your Trust hold Schwartz rounds of similar events

No we not currently hold Schwartz rounds
Debriefing sessions are delivered where emotional support is provided to staff involved in a Serious Incident

What guidance does the Trust offer about reflection on serious incidents?

PGME ensures that the trainees fulfil their responsibility by ensuring reflective practice is undertaken. .Nursing Staff reflect with their line manager.

Writing statements and giving evidence

Who advises and supports learners in the following:

Writing statements for an inquiry into a serious incident, root cause analysis, complaint, etc?	Supervisors/Managers/Clinical Supervisors/Clinical Leads/ Central Governance Team/Complaints Facilitators/ Staff Liaison/ Head of Legal issues
Giving evidence to an inquiry into a serious incident, root cause analysis, complaint, etc?	Head of Legal/Clinical Supervisor/Educational Supervisor

Coroner's statement and inquests

Support for learners involved in a Coroner's case:

How does the Trust identify learners involved in a Coroner's case?	Head of Legal will identify key staff involved in Coroner's inquests by reviewing patient medical records
What is the target timescale for identifying learners involved in a Coroner's case?	Within one week of receipt of letter from Coroner
Who in the education team is notified about a learner involved in a Coroner's case (e.g. DME, FPD, ES, names CS, Clinical Lead, etc...)?	Medical Education Manager; Medical Education Co-ordinator; DME
Who offers support to a learner involved in a Coroner's case (e.g. DME, FPD, ES, Named CS, Clinical Lead, Manager, PALS, Trust Legal Team, etc...)?	Clinical Supervisor; Educational Supervisor; Clinical Lead; Head of Legal
Describe briefly how support to a learner involved in a Coroner's case is delivered?	Advice and support is provided in relation to drafting a statement. Should the learner be called to give oral evidence at the inquest Head of Legal will support the learner through this, which will include a 1 to 1 meeting with the learner to discuss what to expect on the day of the inquest and types of questioning they may get.

Who offers advises and supports learners in writing statements for a Coroner's case (e.g. ES, DME, Trust Services, Legal Department, etc...)?	Clinical Supervisor; Educational Supervisor; Clinical Lead; Head of Legal
Who advises and supports learners in giving evidence to a Coroner's case?	Clinical Supervisor; Educational Supervisor; Clinical Lead; Head of Legal
How do the answers to the previous questions differ if the learner has moved to another Trust?	Head of Legal would assist learner via Skype or over telephone if required. We would link in with the legal services of the Trust where the learner is based.

Do you publicise the advice about Coroner's hearings on the HEE Website?

No

What training does your Trust offer on Duty of Candour?

Lead Investigator training; RCA training and other relevant risk management training. Support and guidance also provided by central team and Family Liaison Officers for Serious Incidents.
A new training package on supporting families and Duty of Candour is in development.

Page 2: 2020 Staff, Associate Specialist and Specialty Doctors (SAS) and Locally Employed Doctors (LEDs)

Use of funding to Support Staff, Associate Specialist and Specialty Doctors (SAS) and Locally Employed Doctors (LEDs) Faculty development

Please provide answers to the following questions. You may wish to include funding details, as required. For further information in relation to LEDs please review the following NACT document LEDs across the UK http://www.nact.org.uk/documents/national-documents/.

It is recommended that if the trust has a nominated lead for SAS doctors and/ or LEDs, they should complete this section.

1. Nominated leads for SAS doctors and LEDs

Name of nominated lead for SAS doctor development (*if there is no nominated lead, state "None"):*

Mr Khurram Barlass

Name of nominated lead for LED development (*if there is no nominated lead, state "None"*):

None

Number of SAS doctors and LEDs in the trust

	Answer
Number of Specialty Drs:	122
Number of Associate Specialists:	23
Number of Staff Grades:	8

TOTAL number of SAS doctors:	153
Number of LEDs (e.g. Trust Grade, Clinical Fellow):	50 Trust Grades = 45.5 WTE

Study leave budgets

	Amount (£)
Trust study leave funding allocation per SAS doctor (£):	£750.00 per year
Trust study leave funding allocation per LED (£):	£500.00 per year

How do these allocations compare to the study leave funding allocation for consultants?

Your answer should be no more than 3000 characters long.

Both Consultants and SAS doctors get 30 days every 3 years (10 days per year) Consultants get £1100.

Please outline any examples of good practice or challenges regarding study leave budget allocations:

Your answer should be no more than 3000 characters long.

The allocations were agreed at Joint Local Negotiating Committee (JLNC). The budget envelope and how it is used is always done in partnership with JLNC, the BMA and the Trust.

HEE SAS Development Funding received during the financial year 2018/19

	Amount £	Detais (if req)
SAS Development Fund – Individual courses (£):	£4,274.34	Postgraduate Orthopaedic FRCS Lower Limb & Paediatric FRCS CCISP Ultrasound Training FRCEM Final SAQ Course

SAS Development Fund – Trust-hosted courses (£):	None	
Funding for SAS tutor/ lead role (£):	£500.00 per month	Invoiced via Curriculum D
Funding for SAS administrator role (£):	Not aware of funding available for this	N/A
Any other funding received from SAS Development Fund (please give details):	None	N/A
TOTAL funding received from HEE (£):	£10,274.34	

2. Identification of SAS doctor development needs

	Development needs:
lease describe the process by which the development needs of SAS doctors within your organisation were individually and collectively identified:	All SAS Doctors are contacted on a regular basis through different modalities for identification o educational requirements that are generic to al In addition all ideas are considered for training events.
were priorities decided in regard to applications to the HEE SAS Development Fund?	Applications for SAS Study Leave from the development fund were for those areas of education that contributed to the Professional Development of the SAS Doctors. Knowledge and skills learned can be used for trust and better patient care can be achieved.

3. CESR

	Answer
Number of doctors currently being supported by the trust to work towards CESR application:	3
Number of doctors who completed a successful CESR application during the year April 2018 to March 2019:	

4. SAS doctors as Clinical and Educational Supervisors

	Answer
Number of SAS doctors who are GMC-approved Clinical Supervisors:	4
Number of SAS doctors who are GMC-approved Educational Supervisors:	4

4 more have completed their on-line Educational Supervisor Training and are awaiting to complete the course with the face to face session.

Who decides which trainees have a SAS doctor as their named Clinical or Educational Supervisor?

Your answer should be no more than 3000 characters long.

This decision is made between the relevant department and Postgraduate Medical Education

What governance arrangements are in place for SAS doctors who are Clinical and Educational Supervisors?

5. SAS doctors in leadership roles

	Answer
Annual appraisals take place which includes their roles as Educational/Clinical Supervisors.	
Number of SAS doctors who are in leadership roles:	5
Please give details of the roles being undertaken:	SAS Tutor Foundation Training Programme Director Clinical Dean, HYMS Participate as SAS representor in LNC Meeting

6. Has the SAS Charter been implemented in the trust?

The SAS Tutor has been involved in the implementation of the SAS Charter in the Trust most of which has been achieved, with only one area left which will be met in the very near future.

Please give details of any examples of good practice or challenges in implementing the SAS Charter:

	Good Practice	Challenge
1	SAS Doctors are part of interview panel for recruitment of Junior Doctors and Speciality Doctors	Recruitment Policy need further improvement. SAS Doctors needs to be involved in shortlisting of candidates.
2	We are running a CESR programme in A&E.	This CESR program can be more organised and formalised then what is at place now
3		

7. Please give details of any programmes or initiatives in place to support the development of LEDs:

Your answer should be no more than 3000 characters long.

We are running the training programme for CESR for A&E SAS doctors. We do conduct courses for the help in CESR application but due to COVID 19 situation it was not possible this year. I have personally guided and motivated many SAS colleagues to go for CESR route.

I was in a process to conduct a face to face course for writing the report after any complaints but again due to COVID 19 situation it has been postponed until further notice.

I convinced and encouraged the SAS doctors to show interest for Educational Supervisors Role. Many colleagues have shown written interest so I was arranging the course for preparation of this role with collaboration of Trust Medical Education Department but due to Covid 19 Pandemic it has slow down. I am sure once the situation will improve we will have a course.

Please outline any examples of good practice in developing SAS doctors or LEDs which you would like to highlight:

	Good Practice - Please outline any examples of good practice in developing SAS doctors or LEDs which you would like to highlight:	Challenges - Please outline any particular challenges in developing SAS doctors or LEDs:

1	SAS Doctors have started to take on Educational Supervisors roles.	We were not able to conduct the training courses for Education Supervisor because of COVID. Hopefully we will arrange them in near future.
2	The structure for autonomous practice protocol by SAS Doctors has been finalised This has agreement on principal by the Trust Management Board	Waiting for the ratification of this protocol
3		
4		
5		

Any other comments you would like to make regarding development of SAS doctors & LEDs:

Your answer should be no more than 3000 characters long.

Our Trust is going in right direction and have implemented SAS Charter nearly 100%. I think considering the location of our trust we can offer many other incentives for the development of our SAS doctors but NHS was put on emergency measures due to COVID. So many of our plans and targets were put on halt. Despite this, I have achieved many objectives.

SAR 2020 Library Quality Process

Page 1: Organisation Details

Trust Name:

Northern Lincolnshire & Goole NHS FT

Report signed off by (name):

Jo Thomas

Date signed off:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

21/02/2020
(dd/mm/yyyy)

Page 2: Library Quality Process

We recommend that you consult with your Library and Knowledge Services Manager or Lead to complete this section. Please provide narrative and evidence (for 1, 3 and 4) on the following 4 areas for your Library and Knowledge Service. Please also highlight any issues or concerns, including any areas which are not being met. If your Library and Knowledge Service is provided via a service level agreement, please consult with the providing Library and Knowledge Services Manager. Additional prompts have been added under each heading.

1. Describe how your Trust is implementing the ***HEE Library and Knowledge Services Policy*** (https://hee.nhs.uk/sites/default/files/documents/NHS%20Library%20and%20Knowledge%20Services%20in%20England%20Policy.pdf namely: To ensure the use in the health service of evidence obtained from research, Health Education England is committed to:

Enabling all NHS workforce members to freely access library and knowledge services so that they can use the right knowledge and evidence to achieve excellent healthcare and health improvement.	Access to library services is on a 24/7; 365 day per year basis. Our e-resources are well maintained and promoted for access anywhere and at any time. Current awareness services, including via Knowledgeshare are delivered to those who want them. Mediated literature searching is one of our service offers as is literature search training. **Trust Library Services Guide Grimsby attached as evidence.** Trust_Library_Services_guide_Grimsby.do
Developing NHS librarians and knowledge specialists to use their expertise to mobilise evidence obtained from research and organisational knowledge to underpin decision-making in the National Health Service in England.	Via HEE Library Leads plus via the NLaG Library Services Manager, the staff ensure they attend pertinent CPD events. **Reflective write up of undertaking Knowledgeshare training attached as evidence.** Reflective write up of undergoing Knowle A particular example of our library service mobilising knowledge is in relation to Workforce Planning, helping to provide the evidence to support new workplace roles and initiatives. **E-mail summary of a meeting with Workforce planning as evidence of steps taken to mobilise evidence.** Email summary of a meeting with Workfor

Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence from your Library and Knowledge Services' strategy or annual action/implementation/business/service improvement plan.

2. HEE's ***Library and Knowledge Services Policy is*** delivered primarily through local NHS Library and Knowledge Services.

Please identify the budget allocated to your Library and Knowledge Service in the current financial year.	£148,600 pay; £75,500 non-pay
If possible please identify the sources of this funding, differentiating for example between educational tariff funding and any contribution from your organisation.	Not possible

Prompt: Your Finance department and/or your Library and Knowledge Service Manager should be able to supply this information.

3. Please tell us about any areas of Library and Knowledge Services good practice that you would like to highlight.

Our service is particularly supportive of the cohorts of trainee Advanced Clinical Practitioners that are going through their training (3 cohorts at the time of writing). On carrying out an impact interview with some of the trainees, we discovered that the support we have given them has already resulted in the production of a new pathway for the Trust for lumbar puncture. **ACP impact interviews (summary) attached as evidence**

ACP impact interviews Dec 2019.

We are getting much more involved in supporting systematic reviews, and impact case studies are showing that this is beneficial for clinicians when delivering training to other doctors. There are also potential benefits, of course, for patients either currently, or in the future. **Impact case study Consultant Dr A attached as evidence.**

The Learning and Development Agreement that Health Education England has with your organisation states that for 2018- 19 the LKS should have achieved a minimum of 90% compliance with the national standards laid out in the NHS Library Quality Assurance Framework. **LKS that scored below 90% submitted an action plan to Health Education England in March 2019 describing their planned improvements. If you submitted an action plan, please describe the improvements you have made against the plan.**

N/A – 99% compliance

NLG(21)043

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	02 February 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Christine Brereton, Director of People
CONTACT OFFICER	Christine Brereton, Director of People
SUBJECT	Monthly Workforce Report
BACKGROUND DOCUMENT (if any)	
PURPOSE OF REPORT	The Workforce Report provides the Board with an overview of activity within the People Directorate within the month of December and highlights our activities to support Covid and wider workforce priorities.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	This report gives an update for the month of December 2020 highlighting main areas of activity for the People Directorate including COVID impact and activity. This report highlights the risks identified in month. This report should be read in conjunction with the Integrated Performance report. The Flu Self-Assessment paper is included as an Appendix in this report.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	The report relates to Objective 2 'To Be a Good Employer' and within the Board Assurance Framework.

TRUST BOARD ACTION REQUIRED	• The Board are asked to note the contents of the report and update on the areas of work within the People Directorate. • The Board as asked to approve that the decision to formally stand down the Flu campaign for 20/21 to support the roll out of the covid vaccination programme. • The Board are asked to approve the Flu Checklist for 20/21 as outlined in Appendix One which unfortunately should have been tabled in December 2020.

Northern Lincolnshire and Goole NHS Foundation Trust

Workforce Update – December 2020

Christine Brereton, Director of People

01 February 2021

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Appendix One 9

1. Executive Summary

The People and Organisational Directorate continue to focus their attention on responding to Covid-19 mainly through the roll out of the covid vaccination programme which launched on 4th January 2021 and the lateral flow testing which launched in November 2020. We have also closed down our Flu Campaign to concentrate all efforts on the Vaccine roll out. Directorate staff are heavily deployed in these major programmes of work which impact significantly on the delivery of business as usual.

Also to support Covid, focus has been on the development and roll out of our Health and Wellbeing offer for all of our staff. This has included ensuring that risk assessments for all staff, especially those that are high risk are completed. This is to ensure that we provide the right level of support and redeployment where necessary to protect staff. There is still concern about the numbers of risk assessments outstanding and we have taken a proactive approach this month including engaging directly with staff and joint communications with our trade union colleagues.

It is noted that sickness levels due to anxiety and depression continue to rise as we enter into wave 3 and our intention is to refresh our Health and Wellbeing offer and engage directly with staff across the Trust to remind them of the tools and support available for them during these challenging and difficult times. Caring for our staff is a priority area for the Trust and our Directorate.

In addition to providing Covid support, our attention on recruitment and retention continues, specifically for Healthcare Support Assistants (HCSA, also known as Healthcare Support Workers HSCW) as this is a national initiative with an ambition to have zero vacancies by 31st March 2020. We have a programme of work aimed at attracting HCSA given that our non-registered nursing vacancies continue to rise. Also our plans for international recruitment to attract oversees nurses will get back underway working closely with our system partners. This has been supported externally with funding being allocated to NLAG by NHSI for both HSCA and nurse recruitment.

Wherever possible, we continue to deliver our workforce projects aimed at improving our service to the Trust or enhancing the employee experience, were relevant these are detailed in the report.

The information contained within this report also supports/refers to the data contained within the IPR submitted separately to the Board and links with the Directorate objectives outlined in the Board Assurance Framework.

An new Director of People and Organisational Development commenced employment within the Trust on 1st January 2021 and will now work with the People Directorate senior team to shape key priorities for the Directorate for the remainder of the financial year and beyond in line with Trust priorities. This will be presented to the Board as part of its development day in March.

2. Strategic Objectives, Strategic Plan and Trust Priorities

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

3. Introduction / Background

3.1 The Workforce Report provides the Board with an overview of activity within the People Directorate within the month of December and highlights our activities to support Covid and wider workforce priorities.

4. Discussion / Issues

4.1 Lateral Flow

The Director of People has now taken on the role the Senior Responsible Officer for the lateral flow programme and is currently reviewing the first roll out for evaluation and improvements to help inform the second phase. This has resulted in 5233 kits being issued to staff. The second phase order has now been placed for 6315 kits for patient facing staff. We have also requested a further 1543 kits for other staff which we will receive if stock is available. The second order request figures are based on current 'staff in post' figures which will allow us to replenish at the 12 week renewal point and include new staff. A roll out plan is in place for when we receive the delivery. Improvements already identified are around ensuring that reporting on both negative and positive results is timely and information is updated by staff.

4.2 Covid Vaccination

The Director of People has now taken on the role of Senior Responsible Officer for the Covid vaccination programme which commenced on 4th January 2021. There are currently two vaccination hubs operating, one at SGH and one at DPOW. The Pfizer vaccination is being delivered at each site, dose 1 only with dose 2 scheduled in 12 weeks in line with national guidelines. The vaccinations are being offered to all our front line staff and the wider Health & Social Care community as outlined in the JCVI priority list. The programme has received positive feedback from staff. We are also planning for a one off pop up clinic to run from Goole, although a number of staff have already been vaccinated at SGH.

Reporting on data of vaccines is governed by national teams and we are currently working with the Chief Information Officer on completing a number of national and regional sitreps. Currently a large proportion of the people team are supporting the roll out and resources to the programme are being reviewed by the Senior Responsible Officer.

4.3 Health and Wellbeing (HWB)

ICS Health and Wellbeing funding – The Trust took part in a successful ICS-wide HWB bid from which £510k has been secured. Further work is required to scope the timeframes and workforce required to implement. Additional resources included:

- Launching additional ICS-wide mental health coaching support for all staff
- Desk based physical exercise programme for office/PC users and use at virtual meetings
- Locally the Trust has received £40k to procure Debriefing Support for Critical (Trauma) Incidents, Schwartz Rounds/Team Time licences, Money Advisory Service Financial Wellbeing programme and to fund Staff Wellbeing Retreats

Charities Together Funding Bid – Following the national outstanding achievement by Captain Tom the Trust has been invited to submit a bid to secure funding for HWB initiatives to run 2021/22 and 2022/23. The bid for £145k, which includes the ongoing costs for a Snr HWB Practitioner, support for the Insights staff development scheme and several HWB campaigns such as establishing internal football, cricket, netball inter-divisional leagues, art therapy etc. remains under review by Charities Together with feedback expected Q4 2020/21.

Mental Health – We have a full and extensive offering of mental health and wellbeing support and in the coming weeks POE will deliver a programme of reenergising the communications and engagement directly with staff to highlight what is available and what support can be accessed. This will also concentrate on the message of our 'Stay Well at Work' programme by continuing to encourage staff to take annual leave for rest and recuperation.

4.4 Risk Assessments

As reported to the Board in January, outstanding risk assessments for our staff remain an area of concern. As at 27th January we had a total of 674 risk assessments outstanding.

Our Deputy Director of People has personally contacted all of those staff and their line managers with an outstanding risk assessment via email, requesting them to either complete the risk assessment or to record refusal should they wish. It has been identified that a number of the outstanding risk assessments are new starters to the organisation so a process is now in place to review how the risk assessment can be included as part of the new starter/induction paperwork. For those staff that still remain high risk with an outstanding risk assessment this will be escalated to Senior Line Managers via our Deputy Director.

We have identified that 63% of the outstanding risk assessments are bank staff and 8.4% are BAME so potentially high risk.

Joint communications with our trade union colleagues has also been sent out to all staff to remind them of the risk assessment process and the support available.

Given the large number of outstanding risk assessments for bank staff a personal letter has been sent to all identified bank staffs targeting those that are currently working. This will help us identify those that may present a higher risk. This letter also offer bank staff the opportunity to call the helpline to assist with booking a vaccine directly for them. We are also going to focus our priority for this work on high risk and BAME staff.

4.5 Recruitment and Retention

International Nurse Recruitment
The recruitment team are working closely with the Chief Nurse Directorate on international nurse recruitment. Bids for additional funding to help support the sourcing and on-boarding of nurses from overseas have been successful. The team have sourced candidates through our Talent Acquisition Team and have had a number start already. 20 nurses started in December, with further cohorts arriving in February and March. Further cohorts of 20 are planned to arrive in 2021 in May, August, and October.

Funding has been sourced to increase the capacity of the Continuous Professional Development (CPD) team to train and prepare new nurses from overseas in OSCE preparation and local induction.

Healthcare Assistants (HCA)
The HCA vacancy rate has been increasing steadily over the last few months and budgeted establishment has fluctuated but with a general increase. We have a large number of candidates in the pipeline who we have recruited who are currently going through the care camp induction process. A bid for additional funding for the sourcing of HCAs has been successful; this is tied into sourcing candidates without a background in healthcare to start in these roles before the end of March 2021. The recruitment team have been working with ***Indeed***, and held a webinar last week in conjunction with Chief Nurse Directorate to encourage candidates without a healthcare background to apply. The advert closes at the end of this week and so far the Trust has received 110 applicants, interviews are being held 11th February. The funding for this programme is based upon achieving a zero vacancy rate for HCAs by the end of March 2021 as part of wider national programme.

A joint review is underway with Finance, Nursing and People directorate to audit the reported vacancy figures to ensure the parameters of reporting are correct. This will provide assurance and help to inform future activity in relation to the Trust vacancy position.

Medical Staff
We are continuing to appoint medical staff through usual sourcing methods, mainly using Trac and NHS Jobs. We are also now utilising the Talent Acquisition Team to source candidates via social media, headhunting, and Google Ads etc. We have a pipeline of circa 53 candidates appointed awaiting start between now and March/April.

February trainee intake work is ongoing, with 78.57% of training posts that rotate in February filled by HEE, and we are working with operational groups on backfill for their vacancies.

Medical Support Workers
These are new roles which we have funding for, they are designed for individuals who have a medical degree but are not registered – this could be retired doctors or doctors who haven't worked in the UK. The role is to assist medics, procedures, discharges etc. as a junior doctor would but without prescribing or initiating treatments. We have been working with Lincolnshire Refugee Doctor Project

(LRDP) and we have sourced 8 refugee doctors so far, and are arranging educational supervision, rotas, etc with a view to them starting in February if possible.
In addition work continues with the Bring Back Staff campaign, various ad-hoc bank staff vaccinators, and other organisations were appropriate.

Patient Liaison Assistants
The Redeployment hub have been arranging staff to cover administration duties on wards as patient liaison assistants to redeploy corporate staff to support, and have been covering other shifts with bank staff where possible.
Agreements to recruit to 10 WTE for these have been received, it has been advertised, and interviews taking place 5th February.

4.6 Sickness Absence

Trust wide sickness rates have been rising monthly since June 2020 and is currently outside of the Trust control limits as per the Integrated Performance Report (IPR) for the first time in a 12 month period. The last data point recorded in December 2020 showed a sickness rate of 6.54% which was the first reduction in the monthly sickness rate since June.

Covid related sickness levels correlates with the overall sickness rates peaking in November for the six month reference period previous and has subsequently reduced in-line with the overall sickness figures in December indicating that the main driver for increased sickness levels overall is Coivd-19 as expected.

In December 2020 the highest reasons for sickness following covid19 were Gastrointestinal and then Anxiety/ Stress/ Depression. Both of these levels of sickness are higher when compared with the same reference period in the previous year (2019). The Trust is currently taking a considered and supportive approach in relation to standard sickness monitoring processes, and is working closely with individuals affected either directly or indirectly by Covid.

4.7 Mandatory Training and PADR

Compliance figures as at 30th December 2020 are as follows:

- Trust wide PADR – 80%
- Core Mandatory Training – 89%
- Role specific Mandatory Training – 78%

Full reports are issued monthly and are available on the HUB site for all divisions and authorised managers. These reports breakdown compliance by topic, area and individuals and further work continues with the HRBP's and their areas to review any poor uptake masked by the overall trust rates.

4.8 Flu

The Flu campaign has now ended reporting a final uptake of 71.4%. This figure is reported regionally using parameter/guidance ass set by NHSE/I (other reporting mechanisms use other parameters). The programme has ended earlier than usual to enable the Trust to full mobilise the Vaccination programme. Further we are required by NHSI/E to complete a self-assessment checklist to provide the Board with assurances that we have organised and delivered a flu campaign. This is attached to the report for Board sign off and assurance.

5. Risks

- Covid 19 restrictions in relation to international recruitment could create delays in recruitment processes.
- Increased sickness rates as a result of Covid 19 pressures will increase the strain on remaining staff.
- All staff across all teams within POE are heavily involved in the delivery of Covid vaccinations and lateral flow roll out and therefore core activities are running with a minimal staff.
- Assurance and control activities identified within the BAF are at risk and Director of People is currently assessing the alignment of resources within the directorate against priorities.

6. Outcomes

6.1 The IPR report submitted separately to this report outline Workforce performance against a number of KPIs. Further work to support the delivery of the agreed People Strategy and NHS People Plan will be developed and discussed at Workforce Committee. Any measures developed will demonstrate achievement against our key Workforce priorities determined for 2021 and beyond.

7. Conclusion

7.1 The Workforce report outlines risks and current activity combined with the impact of COVID. The Board are asked to read the report in conjunction with the IPR as the two reports complement each other. Further work is now underway to review how the two reports will work together in the future.

8. Recommendations

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

8.2 Board as asked to approve that the decision to formally stand down the Flu campaign for 20/21 to support the roll out of the covid vaccination programme.

8.3 Board are asked to approve the Flu Checklist outlined in Appendix One which unfortunately should have been tabled in December 2020.

Compiled By: Christine Brereton, Director of People
Date: 27th January 2021

Appendix 1 - Healthcare worker flu vaccination best practice management checklist

For public assurance via trust boards

A	Committed leadership Trust	Trust Self-Assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	√
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	√
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	√
A4	Agree on a board champion for flu campaign	√
A5	All board members receive flu vaccination and publicise this	√
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	√
A7	Flu team to meet regularly from September 2020	√
B	Communications Plan	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	√
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	√
B3	Board and senior managers having their vaccinations to be publicised	√
B4	Flu vaccination programme and access to vaccination on induction programmes	√
B5	Programme to be publicised on screensavers, posters and social media	√

B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	√
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	√
C2	Schedule for easy access drop in clinics agreed	√
C3	Schedule for 24 hour mobile vaccinations to be agreed	Not Possible due to COVID
D	Incentives	
D1	Board to agree on incentives and how to publicise this	√
D2	Success to be celebrated weekly	√

NLG(21)045

DATE	02 February 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 2020-21				
BACKGROUND DOCUMENT (if any)	N/A				
PURPOSE OF REPORT	For Trust Board assurance and consideration				
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A				
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The FTSU Guardian Q2 Report for 2020-21 gives an update from the last Trust Board report, an overview of the number of concerns raised, national and regional updates and the proactive work undertaken by the Trust's FTSU Guardian.				
ACTION REQUIRED					
Approval	**Information**	**Discussion**	**Assurance**	**Review**	
LINK TO STRATEGIC OBJECTIVES					
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**	
TRUST PRIORITIES					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**
BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	To be a good employer				
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: • Note the report and offer assurance • For consideration how the Trust implements the NGO national training for staff				

Freedom to Speak Up Guardian Report Q2 2020-21 (July – September)

1.0 Executive Summary

1.1 This paper provides an update regarding NLaG activity for Q2 2020-21. Due to the timings of Board Meetings Quarter 3 data will be presented to the April 2021 Board. Within the paper the results of the National Guardians Office publications are presented alongside NLaG information to provide national and regional comparison and context.

1.2 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.

1.3 A board development session is provisionally planned for March 2020 along supported by NHSI; work is in progress to discuss the outline of the training and to gain formal agreement for the session.

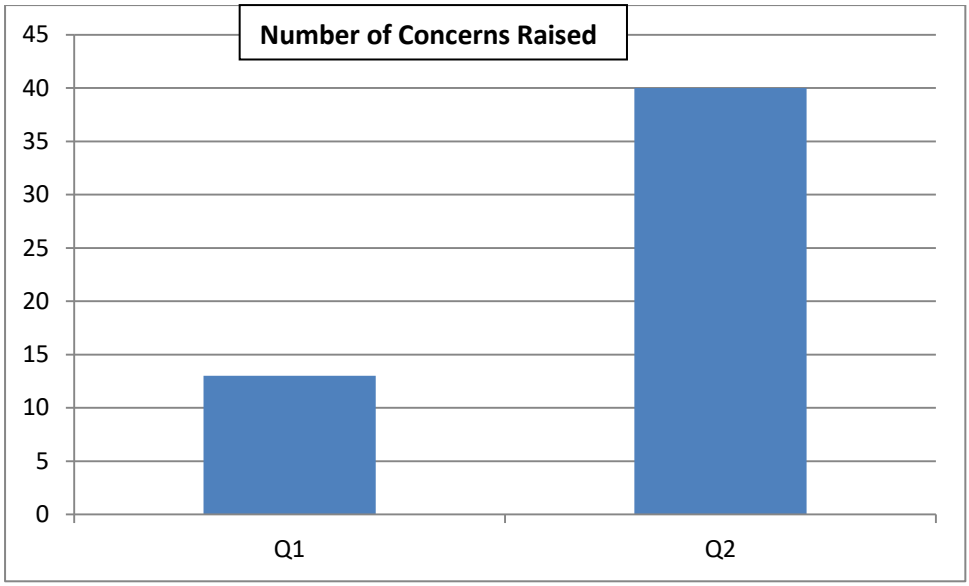
2.0 Assessment of FTSU Concerns Raised

2.1 In Q2 2020-21 the number of concerns received were 40. One concern was raised anonymously.

2.2 This was a significant increase compared to Q1 when concerns were particularly low due to the pandemic and staff finding other avenues to speak up. The high number of concerns is felt that it is a combination of people reflecting after the first wave of the pandemic and the fact that services and people were starting to do more business as usual work, so back in own teams. Q1 was very low due to the pandemic and the fact that people were getting information from other sources i.e. daily briefings etc.

2.3 The main themes raised were around Behaviours, Bullying & Harassment, Process, Staff and Patient Safety. This remains the same as in Q1.

2.4 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 CEO for awareness and support if required.



Q1. 2020-21 (April-June 2020)			Q2. 2020-2021 (July-September 2020)
Concerns	**13**		**40**
Themes	Behaviour / relationships	7	16
	Bullying & Harassment	4	11
	Culture	2	2
	Leadership	0	0
	Patient Safety	3	11
	Process/Systems	2	14
	Personal Grievance	0	0
	Staff Safety	2	11
How Raised	Openly	3	9
	Confidentially	10	30
	Anonymously	1	1
Perceived detriment		0	0

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

Q1 Report Breakdown by Division and Role.

Q1. 2020-2021 (April-June 2020)			Q2. 2020-2021 (July-September 2020)		
Role	**Division**	**Number**	**Role**	**Division**	**Number**
Doctor	SCC Medicine	2	Doctor	Medicine x 2 SCC x 2 Med Director	5
Nurse	CSS Chief Nurse	2	Nurse	Chief Nurse x 2 Surgery x1 CSS x 2 W&C x 1 Medicine x 2	8
HCA	CSS C&T	2	HCA	CSS	2
Admin	CSS SCC POE	3	Admin		6
AHP	Medicine x2 C&T	3	AHP	CSS x 2 SCC x 7	9
Other	POE	1	Other		9
			Cleaning/Catering/Facilities	Facilities	1

2.5 FTSUG Feedback /Evaluations received:

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback that has been provided by staff and learners who have spoken up has been predominantly positive summarised with national comparators.

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

Within the feedback received, the following are extracts of qualitative feedback that has been received:

I feel the FTSU team is a great way to talk about a problem when you feel like no one else is listening or taking you seriously. I felt like I had the guardian's trust that they wanted to help solve my problem. It made me feel like someone cared how I felt and how upset situations were making me feel. They were like a friend when I needed someone to have my back.

I would feel comfortable to speak up again if a situation happens again because, they provide the advice on how to deal with the situation and also be able to help through the situation and having regular updates. The regular communication has helped with knowing what has been happening and also updating the guardian if anything happens during that time too. The situation has settled for the time being however the main thing of respect if anything happens again in the situation I have been through I would highly speak up to the guardian again to gain more advice and how to approach the problem.

I would definitely speak up again. I was very hesitant to speak up but Liz eased my worries and went above and beyond to ensure that my concerns were voiced. I probably wouldn't have spoken out if it wasn't for this amazing service. It has helped to make positive changes in my department. Thank you sooo much.

The culture of an organisation is something that all individuals contribute to, and are responsible for. The direction of travel is set by the leaders and as ever some are better than others…. If we are saying that we are kind, have courage and are respectful then we all should have the opportunity to safely confirm and challenge. Otherwise we remain in a cycle of acceptance of poor behaviour that remains and is perpetuated, and maybe even validated. To be courageous and challenge and learn from experiences shows true integrity and authenticates the vision and values …. the FTSUG is the conduit by which information is shared in confidence ….we have a responsibility to support each other through good times and bad without fear but unless the voices are heard we can change nothing-honest, open caring communication is the key to success.

3.0 Regional and National Information and Data

3.1 National update:

The National Guardians Office (NGO) has now released its e-learning package for healthcare workers. This has been developed in partnership with Health Education England. Titled 'Speak Up, Listen Up, Follow Up'. The first module 'Speak Up' was released during October's national 'Speaking Up' campaign and is the core training for all staff. The 'Core' training is for all staff with the second level being aimed at managers only. Careful consideration is needed for implementation at NLAG.

Across the region, there is a mixed approach; some Trusts are making it mandatory others are asking staff to complete it as part of induction. The NGO would like it to be on parity with mandatory training and to be repeated regularly, but have not specified guidance around frequency.

The NGO plans to review national guidelines around training in 2021.
Staffs from the NGO are working remotely; therefore all Foundation Training has been postponed for new Guardians. There is an expectation that once the Foundation Training is resumed, all newly appointed Guardians will attend.
The national figures for 2019/20 has been released by the NGO and 16199 concerns were raised in 2019/2020
Data collection for Q1 and Q2 data for 2020-21 has been submitted to the NGO by the Guardian

NGO have now asked for staff to be identified not only by profession but into professional level of 'worker', 'manager' or 'senior leader'. The Guardian has provided this additional information.

3.2 Regional update:

The FTSU Guardian continues to attend virtual regional meetings. The regional update reflected the experience of the Guardian – in the first few months of the pandemic, concerns to Guardians dropped but have since increased. Concerns are back to pre-pandemic levels both regionally and within the Trust.

There is going to be a new Regional Chair as the current Chair has been promoted in her organisation.

It has been agreed that regional meetings will be bi-monthly.

4.0 Proactive Work of the FTSUG during Q2

- Finalised the Trust Vision and Strategy for FTSU following Trust Board Approval
- Worked with Communications and developed the plan for launching the Strategy for FTSU and further awareness of FTSU
- Completion of NGO introductory Foundation Training
- Worked with Communications for 'Speaking Up' campaign in October
- Monthly 1 to 1's with CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- FTSU information now included in the Trust's Learning Strategy
- Continued input into Leadership Training development to ensure that leaders at all levels are given the skills to be able to have supportive, honest conversations incorporating FTSU messages

5.0 Future Plans

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

- Revamp FTSU information on staff app – to include the ability for staff to report concerns directly from app to nlg-tr.ftsuguardian@nhs.net
- Use social media to raise awareness of FTSUG and the role.
- FTSUG to have input into all virtual Trust inductions (ie Doctor, Overseas Doctors and Nurses as well as Trust Corporate Induction).

Liz Houchin

Freedom to Speak Up Guardian

NLG(21)046

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	2nd February 2021
REPORT FOR	**Trust Board of Directors – Public**
REPORT FROM	Andrew Smith, Chair of Audit, Risk and Governance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**Audit, Risk and Governance Committee Highlight Report – January 2021**
BACKGROUND DOCUMENT (if any)	Audit, Risk & Governance Committee Agenda Papers 21st January 2021
PURPOSE OF REPORT	For Noting and Assurance
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Not Applicable
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The attached highlight report summarises the key issues presented to, and discussed by the Audit, Risk & Governance Committee at its meeting on the 21st January 2021: **1.** **External Audit – Year End Issues**: Revised audited accounts submission date, and associated re-scheduled ARG Committee date for June 2021. New national approach to reporting of Trust's VFM arrangements and the impact on year-end audit work. **For Board Attention.** **2.** **Internal Audit Progress with 2020/21 Plan**: The Critical importance of delivering the 2020/21 Internal Audit Plan to ensure a meaningful Head of Internal Audit Opinion can be achieved at year-end. **For Board Attention.** **3.** **Overdue Controlled Documents**: Ongoing concerns regarding out of date documents from as far back as 2006. **For continued monitoring by the Committee and referral to Q&S Committee**. **4.** **Board Assurance Framework**: Ownership of external threats' risks and where these should sit. **For Board discussion.**

	5. **Cyber Security**: Annual update received, and a further update with timescales to be brought back to the Committee during 2021. **For future review by the Committee.** **6.** **Conflicts of Interest**: New electronic system for the management of staff conflict of interest declarations being developed by the Trust's IT team and expected to be operational from April 2021. **For future oversight by the Committee.** **7.** **Annual Review of Policy for Engagement of External auditors for Non-audit Work**: Policy updated to reflect latest NAO guidance. **Attached for Board's information.**

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

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	2nd February 2021
Report From:	Audit, Risk and Governance Committee held on 21st January 2021.

Highlight Report:

1. **External Audit – Year End Audit Issues** – NHSE/I have confirmed the submission dates for the year end accounts - draft accounts by 27th April 2021 and audited accounts by 15th June 2021. As a result, the provisional date for the audited accounts being received by the Audit, Risk and Governance Committee has been adjusted accordingly, and is now scheduled for Thursday 3rd June 2021.

   The Trust's External Auditor, Mazars, discussed the scope of work for the 2020/21 year-end audit. They advised of a number of changes to the approach to be taken to the VFM Conclusion this year, as a result of a new Code of Practice issued by the National Audit Office.

   The new Code changes the way in which the External Auditor will report their findings in relation to the Trust's VFM arrangements. The Auditor must still be satisfied there are proper arrangements in place, and report any significant weaknesses, however their output will now require them to provide a commentary on the Trust's arrangements which will form part of the Auditor's Annual Report. Previously it has only been presented as a conclusion. This new approach will require the Auditor to gather sufficient evidence to be able to report under three specific reporting criteria:

   - Financial sustainability: how the body plans and manages its resources to ensure that it can continue to deliver its services.
   - Governance: how the body ensures that it makes informed decisions and properly manages its risks.
   - Improving VFM: how the body uses information about its costs and performance to improve the way it manages and delivers its services.

   The Board is asked to be aware that as a result of these new requirements that the Trust and its External Auditor will need to plan time and resources very carefully for addressing these important reporting requirements in the available year-end audit window.

2. **Internal Audit Progress with 2020/21 Plan** – Audit Yorkshire updated the Committee on the position with the agreed plan for 2020/21, which has been impacted by Covid-19 and as a result of which a number of deferral requests had been received. In order to ensure that Audit Yorkshire is able to produce a meaningful Head of Internal Audit Opinion at the end of the financial year, the plan has been considered in terms of 'must do' and 'should do' audits. All 2020/21 audits are however expected to be completed.

   <u>The Board</u> needs to be very alert to the critical importance of delivering the remainder of the revised 202/21 audit plan and that there is no scope for slippage without risking the verdict in the annual Head of Internal Audit Opinion; which is in turn critical to signing off this year's annual report and accounts. The Board should also note that the changes to the current year plan will reduce Board comfort provided by internal audit in the key Board Risk Appetite area of quality and safety; there will be a need to consider this in order to compensate in next year's audit plan.

3. **Overdue Controlled Documents -** The Committee remain concerned that there is little movement with some very aged controlled documents: i.e. there are overdue documents dating back to 2006 (x2), 2009 (x1), 2013 (x12), 2014 (x5), etc. The Committee queried whether in particular any of these could cause patient harm as a result of not being reviewed and either updated or a decision taken that they are no longer required.

   The overdue documents report is to be discussed with the Chair of the Quality and Safety Committee with a view to having it feature in the Q&SC agenda also.

4. **Board Assurance Framework –** Strategic Risk 3 relating to external threats, and the Committee having nominated ownership of this as an assurance sub-committee, was discussed.

   The Committee agreed that this needed further discussion at the Trust Board in February 2021 as to where the external threats' risk issues should best sit.

5. **Cyber Security –** In line with the Committee's workplan, the annual update on the position with the Trust's approach to cyber security was received. The Committee heard from the new Chief Information Officer, who advised that lots of things need to come together to achieve a good digital organisation. The Committee discussed how the NHS had been slow to wake up to the benefits of digital services but was now wanting to rely heavily on it.

   The Committee also discussed the timescales for certain key actions and it was agreed that a further update would be provided during the first half of 2021/22 which would focus more fully on risks, required actions and deadlines for resolution.

6. **Conflicts of Interest –** The Trust Secretary informed the Committee that a system is being developed by the Trust's IT team to make the process for staff making declarations of interest electronic, and prompting them to review and make declarations periodically thereafter. It is expected that this system will be up and running from April 2021.

   The Committee agreed that it should be updated on progress at its October 2021 meeting and also to the suggestion of this being an audit area in its 2022/23 internal audit plan.

7. **Annual Review of Policy for Engagement of External Auditors for Non-Audit Work –** the Policy has been substantially updated to reflect the latest National Audit Office guidance issued in May 2020 which further limits the scope for such engagement.

   The Board's attention is specifically drawn to the policy which is included with the Highlight Report for information only.

Confirm or Challenge of the Board Assurance Framework:

The Committee did not discuss the detail of the latest (December 2020) version of the BAF, as the Trust Secretary advised it was going to the Trust Board on the 2nd February 2021 and would be discussed in greater detail there.

The Committee did however raise the question of external threats' risks again, as detailed in the section above.

Action Required by the Trust Board:

The Trust Board is asked to note the key points raised by the Committee, and consider any further action needed.

Prepared by: Tony Bramley
Non-Executive Director and Chair of Audit, Risk and Governance Committee until 31.1.2021.

Signed-Off by: Andrew Smith
Non-Executive Director and Chair of Audit, Risk and Governance Committee with effect from 1.2.2021.

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Finance

POLICY FOR THE ENGAGEMENT OF EXTERNAL AUDITORS FOR NON-AUDIT SERVICES

Reference:	DCP106
Version:	??
This version issued:	??
Result of last review:	
Date approved by owner (if applicable):	N/A
Date approved:	21st January 2021
Approving body:	Audit, Risk and Governance Committee
Date for review:	January, 2022
Owner:	Lee Bond, Chief Financial Officer
Document type:	Policy
Number of pages:	(including front sheet)
Author / Contact:	Sally Stevenson, Assistant Director of Finance – Compliance & Counter Fraud

Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

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1.0 Introduction and Purpose

1.1 It is important that the independence of our External Auditors in reporting to Governors, Non-Executive Directors and Northern Lincolnshire and Goole NHS Foundation Trust (the Trust) is not, or does not appear to be, compromised in terms of the objectivity of their opinion on the financial statements of the Trust. Equally the Trust should not be deprived of expertise where it is needed, should the External Auditors be able to demonstrate higher quality and more cost effective service than other providers.

1.2 Auditors are required to comply with relevant ethical standards and guidance issued or adopted by their professional accountancy bodies. This includes the Ethical Standards issued by the Financial Reporting Council (FRC). The ethical standards and guidance require that a member of a professional accountancy body should behave with integrity in all professional, business and financial relationships. Integrity implies not merely honesty but fair dealing and truthfulness.

1.3 Auditors must carry out their work to enable a soundly based opinion on the Trust's financial statements to be expressed, with independence and objectivity. The Auditors' opinions, conclusions and recommendations should both be, and be seen to be, impartial. Auditors and their staff should exercise their professional judgement and act independently of the NHS Foundation Trust. They should ensure they maintain an objective attitude at all times and that they do not act in any way that might give rise to, or be perceived to give rise to, a conflict of interest.

1.4 This policy therefore seeks to set out what threats to audit independence theoretically exist and thus provides a definition of non-audit services which can be shared by the Trust and its External Auditor. It then seeks to establish transparent approval processes and corporate reporting mechanisms that will be put in place for any non-audit services that the Trust's External Auditor is asked to perform.

1.5 Guidance issued by NHS England and NHS Improvement (NHSE/I) (formerly Monitor), the Independent Regulator of NHS Foundation Trust recommends (in both the Foundation Trust Code of Governance and its publication 'Audit and assurance: a guide to governance for providers and commissioners' that Foundation Trusts implement a policy for approving any non-audit services that are to be provided by their External Auditor. The guidance publication states:

'The auditor must be able to carry out their work with integrity, objectivity and independence, and in accordance with the ethical framework applicable to auditors.'

'The audit committee should review and monitor the external auditor's independence and objectivity.'

'The audit committee should develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance. The organisation's policy should also extend to non-audit services provided by the organisation's external auditor to any entities it controls ie a subsidiary, regardless of whether the subsidiary has appointed the same external auditor as the parent organisation.'

'The Council of Governors should receive a report at least annually of non-audit services that have been approved for the auditors to provide under the policy (on the

basis of services approved, regardless of whether they have started or finished) and the expected fee for each service.'

1.6 The Institute of Chartered Accountants in England and Wales (ICAEW) sets out threats to independence as the following:

- Self-interest – the threat that a financial or other interest will inappropriately influence the auditors judgement or behaviour
- Self-review – where the auditors may be checking their own colleagues work and might feel constrained from identifying risks and shortcomings
- Advocacy – the auditors will promote a client's or employing organisation's position to the point that the their objectivity is compromised
- Familiarity or trust – where the level of constructive challenge provided by the auditor is diminished as a result of assumed knowledge or relationships that exist due to a long or close relationship with the client
- Intimidation – the auditor will be deterred from acting objectively because of actual or perceived pressures, including attempts to exercise undue influence over the auditor

1.7 The National Audit Office (NAO) issued an auditor guidance note (AGN) in December 2016 (last updated 29 May 2020) outlining new requirements in relation to non-audit services provided by the External Auditor which were effective from 17th June 2017. The new requirements placed a cap on the value of non-audit services that can be provided to the public body. From 17th June 2017 the total fees for non-audit services cannot exceed 70% of the total fee for all audit work carried out under the Code in any one year. There are however some exclusions for the purposes of applying the cap (see Appendix A, paragraph 51).

1.8 The relevant extracts from the NAO AGN 1 issued in May 2020 are attached at Appendix A for ease of reference.

1.9 AGN's are periodically updated by the NAO and the latest version can be accessed at the following link: https://www.nao.org.uk/code-audit-practice/guidance-and-information-for-auditors/

2.0 Area

This policy applies to all employees working for the Trust.

3.0 Duties

3.1 **Audit, Risk and Governance Committee** is responsible for approving this policy and monitoring its effectiveness.

3.2 **The Chief Executive** is ultimately responsible for the effective implementation of this policy.

3.3 **The Chief Financial Officer** has responsibility for ensuring this policy is adhered to and for ensuring that the policy remains up to date and appropriate.

3.4 **All Directors/Managers** are responsible for ensuring the implementation of and compliance with this policy within their respective areas.

3.5 **All Staff** who have delegated authority to make such an appointment must adhere to this policy.

3.6 **External Auditor** has a responsibility to ensure that all relevant ethical standards are met for any audit-related or non-audit services performed on behalf of the Trust.

4.0 Defining Types of Audit Related and Non-Audit Services and the Associated Approval Process

4.1 In order to provide a transparent mechanism by which non-audit services can be reviewed and progressed, the following categories of work are agreed as professional services available from the Trust's External Auditors, or prohibited, in line with Auditor Guidance Note 1 issued by the NAO (December 2016 – last updated May 2020).

4.1.1 Statutory and Audit related services:

- Statutory audit work is as mandated, in order for the External Auditor to provide a sound opinion on the Trust's financial statements. Such work will form part of the engagement letter between the External Auditor and Trust.

- Audit related services are those non-audit services specified in the FRC's Ethical Standard that are largely carried out by members of the audit engagement team, and where the work involved is closely related to the work performed in the audit and the threats to auditor independence are clearly insignificant and as a consequence, safeguards need not be applied.

- Audit related services (as referred to, but not listed, at paragraph 52 of Appendix A) are:

  • Reporting required by law or regulation to be provided by an auditor;
  • Reviews of interim financial information;
  • Reporting on regulatory returns;
  • Reporting to a regulator on client assets:
  • Reporting on government grants;
  • Reporting on internal financial controls when required by law or regulation;
  • Extended audit work that is authorised by those charged with governance performed on financial information (not including accounting services) and/or financial controls where this work is integrated with the audit work and is performed on the same principal terms and conditions.

- All audit related service engagements require the approval of the Audit, Risk and Governance Committee regardless of value.

4.1.2 Other non-audit services that may be provided:

- These are non-audit services which the External Auditor may be an appropriate provider of, but where the threats to independence arising from such services are not necessarily clearly insignificant. The External Auditor must consider whether such services give rise to threats to independence, and where appropriate, the need to apply safeguards.

- These are services which do not fall within 4.1.1 above.
- The approval of the Audit, Risk and Governance Committee will be sought in advance of such work commencing regardless of value.
- See Appendix A (paragraphs 50 and 51) for details.

4.1.4 Non-Audit Services that are not permitted

- There are some non-audit services that are not to be performed by the External Auditors. These services represent a real threat to the independence of the audit team such as where the External Auditors would be in a position where paragraph 1.6 might apply, such as auditing their own work (for example, systems implementation).
- See Appendix A (paragraph 54 for details).

4.2 The Audit, Risk and Governance Committee is responsible for approving all non-audit services undertaken by the External Auditors in line with section 4.1.

4.3 For the avoidance of doubt, the Audit, Risk and Governance Committee requires the business sponsor of the proposed work to obtain a proposed scope and fee estimate before the work commences. The business sponsor must also seek written confirmation that the Auditor will be able to safeguard their independence, through compliance with all relevant ethical standards, in relation to the proposed non-audit service.

4.4 Details of the scope of the non-audit service, fee proposal and written confirmation of compliance with all relevant ethical standards should be submitted to the Audit, Risk and Governance Committee Chair and Chief Financial Officer for consideration and approval. If approved the non-audit work should be logged by the Audit, Risk and Governance Committee secretary to be raised at the next Audit, Risk and Governance Committee meeting.

4.5 The Audit, Risk and Governance Committee shall report to the Council of Governors at least annually details of non-audit services that have been approved under this policy.

4.6 In cases where it is undecided which category services fall into they will default to the category that requires Audit, Risk and Governance Committee approval and be expected to take that route until such time as a this policy is reviewed and updated by the Audit, Risk and Governance Committee.

5.0 Monitoring Compliance and Effectiveness

The arrangements for monitoring compliance with and effectiveness of this policy/procedure will be as follows:

- The Audit, Risk and Governance Committee will formally agree on an annual basis that it is content with the structure, content and operation of this policy
- The Audit, Risk and Governance Committee will include within their Annual Report to the Trust Board and the Council of Governors all additional services performed by the Trust's External Auditors

- The External Auditors will include within their annual ISA 260 (report to those charged with governance) an appendix that summarises any additional non-audit services that they have performed for the Trust and a review of the effectiveness of this policy

- Such engagements will also be reported in the Trust's Annual Report in line with guidance issued by NHSE/I

6.0 Associated Documents

6.1 Audit and assurance: a guide to governance for providers and commissioners (NHSE/I, December 2019).

6.2 NHS Foundation Trust Code of Governance (Monitor, July 2014).

6.3 NHS Foundation Trust Annual Reporting Manual (NHSE/I).

6.4 Ethical Standard for Reporting Accountants (FRC, December 2019).

6.5 Auditor Guidance Note 1 (National Audit Office, May 2020).

6.6 Code of Ethics (ICAEW, January 2020)

7.0 References

There are no references.

8.0 Definitions

There are no definitions.

9.0 Consultation

Audit, Risk and Governance Committee.

10.0 Equality Act (2010)

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

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

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

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

11.0 Freedom to Speak Up

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this policy, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to the Trust's 'Speaking Out Policy' (Freedom to Speak Up Policy and Procedure (DCP126)) or by contacting the Human Resources Department. Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact the Trust's Freedom to Speak Up Guardian in confidence by email to nlg.tr.ftsuguardian@nhs.net. More details about how to raise concerns with the Trust's Freedom to Speak Up Guardian can be found on the Trust's intranet site.

Appendix A

Extract from the latest NAO Guidance Note (May 2020) relating to the application of the 70% cap on non-audit services

ANNEX TO AGN 01 – SUPPLEMENTARY GUIDANCE ON ETHICAL REQUIREMENTS

44. ***This Annex forms part of AGN 01 and sets out explanatory and supplementary guidance on the provisions of the Code relating to safeguarding integrity, objectivity and independence.*** *The Code requires auditors to comply with the Financial Reporting Council's (FRC's) Revised Ethical Standard (December 2019), referred to in this Annex as the 'FRC Ethical Standard', at all audits of local public bodies.*

45. Auditors of any local public bodies that are 'public interest entities' or 'other entities of public interest' (as defined in the FRC Ethical Standard) comply with the requirements of the standard applicable to auditors of 'public interest entities' or 'other entities of public interest'. Auditors of local public bodies that are not 'public interest entities' or 'other entities of public interest' should have regard to the guidance set out below in addition to complying with the FRC Ethical Standard.

46. The FRC Ethical Standard permits the provision of some non-audit and audit-related services, applying a cap to the value of services as a proportion of the audit fee in specified circumstances. This Annex to AGN 01 is consistent with the FRC Ethical Standard, but also applies the cap as follows.

47. Local public audit is wider in scope than the financial statements and includes other responsibilities such as the need to consider arrangements to secure value for money or to consider the exercise of the auditor's additional powers and duties under the Act. Therefore, audit work is defined as all work carried out under the Code.

48. When the auditor provides to the audited local public body, or its controlled undertakings, non-audit services (other than the services listed below), the total fees for such services to the audited entity and its controlled entities in any one year should not exceed 70% of the total fee for all audit work carried out in respect of the audited entity and its controlled entities for that year.

49. Although the 70% cap is similar to the limit applicable to public interest entities at paragraph 4.15 of the FRC Ethical Standard, the definition used in this AGN is the one applicable to local public bodies which are not public interest entities or 'other entities of public interest'. For the avoidance of doubt, this AGN has been tailored to the specific circumstances of local public bodies where it is helpful to clarify how the descriptions in the FRC Ethical Standard relate to the work of local auditors at relevant authorities.

Non-audit and audit-related services

50. The FRC Ethical Standard sets out (Paragraphs 5.40 and 5.41 of the FRC Ethical Standard) non-audit services which may be provided but which may still count against the cap where this is

applicable. This AGN does not apply the FRC Ethical Standard's list of permitted services to all local public bodies subject to audit under the Code, but does apply the 70% cap to non-audit or audit-related services provided, except in the circumstances set out below.

51. For the avoidance of doubt, ***the following non-audit services are explicitly excluded for the purposes of applying the 70% cap****, in accordance with this Annex to AGN 01, at local public bodies:*

• Reporting required by a competent authority or regulator under law or regulation, for example: o other assurance (such as work on the quality accounts of local health bodies or work on grant claims and returns at local authorities) where such assurance is mandated by legislation or by a relevant national body or regulator.

• Reporting on internal financial controls when required by law or regulation.

• Reports, required by or supplied to competent authorities/regulators supervising the audited entity, where the authority/regulator has either specified the auditor to provide the service or identified to the entity that the auditor would be an appropriate choice for service provider.

• Services which support the entity in fulfilling an obligation required by UK law or regulation, including listing requirements where: the provision of such services is time critical; the subject matter of the engagement is price sensitive; and an it is probable that an objective, reasonable and informed third party would conclude that the understanding of the entity obtained by the auditor for the audit of the financial statements is relevant to the service, and where the nature of the service would not compromise independence.

• Audits or examinations of controlled entities, including charities, consolidated into the accounts of local public bodies.

• Assurance or attest work requested by the auditor of another public body (or on their behalf by a regulator or the NAO), for example assurance procedures carried out by the auditor of a pension fund to support the audit of a scheme employer.

• Services to the parent undertaking of a local public body where the parent undertaking is a government department (for example the Department of Health) or a relevant national body (for example NHS England) and where such services are inconsequential to, and remote from, the decision-making of the local audited body.

• Any other services required by national legislation to be performed by the auditor.

52. The FRC Ethical Standard also permits certain audit-related services to be provided. Any such permitted audit-related services provided to local public bodies are subject to the 70% cap that is applicable under this Annex to AGN 01.

53. Note that for both non-audit services and audit-related services, where the work is being undertaken for a pension fund, the 70% cap should be calculated in the context of the combined fee for the pension fund audit and the audit of the administering authority.

Prohibited services

54. Under this Annex to AGN 01, ***the following non-audit services cannot be provided to an audited local public body while the firm is, or is proposed to be, the auditor*** *(Note that a "clean year" is required for e) and h), consistent with the requirements in the 2019 FRC Ethical Standard (Appendix B)):.*

a) tax services relating to:

i. preparation of tax forms;

ii. payroll tax;
iii. customs duties;
iv. identification of public subsidies and tax incentives unless support from the auditor in respect of such services is required by law;
v. support regarding tax inspections by tax authorities unless support from the auditor in respect of such inspections is required by law;
vi. calculation of direct and indirect tax and deferred tax; or
vii. provision of tax advice,

b) services that involve playing any part in the management or decision-making of the audited body,
c) bookkeeping and preparing accounting records and financial statements,
d) payroll services,
e) designing and implementing internal control or risk management procedures related to the preparation and/or control of financial information or designing and implementing financial information technology systems,
f) valuation services, including valuations performed in connection with actuarial services or litigation support services,
g) legal services, with respect to:
i. the provision of general counsel;
ii. negotiating on behalf of the audited body; or
iii. acting in an advocacy role in the resolution of litigation,
h) services relating to the audited body's internal audit function,
i) services linked to the financing, capital structure and allocation, and investment strategy of the audited body, except providing assurance services in relation to the financial statements, such as the issuing of comfort letters in connection with prospectuses issued by the audited body,
j) promoting, dealing in, or underwriting shares in an entity controlled by the audited body,
k) human resources services, with respect to:
i. management in a position to exert significant influence over the preparation of the accounting records or financial statements which are the subject of the statutory audit where such services involve searching for or seeking out candidates for such positions, or undertaking reference checks for such positions;
ii. structuring the organisation design; and
iii. cost control.

NLG(21)047

DATE	2nd February 2021
REPORT FOR	**Trust Board of Directors – Public**
REPORT FROM	Andrew Smith, Chair of Audit, Risk and Governance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**Audit, Risk and Governance Committee Membership and Terms of Reference**
BACKGROUND DOCUMENT (if any)	Audit, Risk & Governance Committee Agenda Papers 21st January 2021
PURPOSE OF REPORT	For Approval
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	ARG Committee – 21 January 2021
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	In line with its agreed annual work plan, the Audit, Risk and Governance Committee performed its annual review of its formal Membership and Terms of Reference at its meeting on 21st January 2021. The Committee discussed and approved a limited number of changes, including: • Changing Director of Finance references to Chief Financial Officer; • Addition of the Health Tree Foundation Committee and Ethics Committee to section 7.9.3. Changes are tracked on the attached paper for ease of reference.

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

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

TRUST PRIORITIES - which Trust Priority does this link to? Highlight the box this refers to					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**
BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)		N/A			
TRUST BOARD ACTION REQUIRED		The Trust Board is asked to approve the revisions to the Audit, Risk and Governance Committee's Membership and Terms of Reference.			

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Finance

AUDIT, RISK AND GOVERNANCE COMMITTEE

Membership and Terms of Reference

Reference:	DCT122
Version:	1.6
This version issued:	28/10/20
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	04/08/20 / 22/10/20
Approving body:	Trust Board / Audit , Risk & Governance
Date for review:	August, 2021
Owner:	~~Director of Finance~~Chief Financial Officer
Document type:	Terms of Reference
Number of pages:	17 (including front sheet)
Author / Contact:	~~Director of Finance~~Chief Financial Officer / Sally Stevenson, Assistant Director of Finance – Compliance & Counter Fraud

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1.0 Constitution

1.1 The Audit, Risk and Governance Committee (the Committee) is a standing committee formally established by the Trust Board (the Board).

1.2 The Committee is a non-executive assurance committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

1.3 These terms of reference have been produced in line with the guidance contained within the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2018).

2.0 Membership and Quorum

2.1 The Committee shall be appointed by the Board from among the Non-Executive Directors of the Trust and shall consist of not less than three members. One of the members shall have recent relevant financial experience.

2.2 A quorum shall be two of the three members.

2.3 One of the members will be appointed Chair of the Committee by the Board.

2.4 The Chair of the Trust shall not be a member of the Committee.

2.5 The Trust Board may appoint such Associate Non-Executive Directors as it deems beneficial to add expertise to the Committee and these will be non-voting positions not forming part of the quorum.

3.0 Attendance at Meetings

3.1 The ~~Director of Finance~~Chief Financial Officer and internal and external audit representatives shall normally attend meetings.

3.2 The Trust Secretary shall normally attend meetings.

3.3 The Chair of the Trust and the Chief Executive should be invited to attend and should discuss at least annually with the Audit, Risk and Governance Committee the process for assurance that supports the Annual Governance Statement. The Chief Executive should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

3.4 Other Executive Directors/managers should be invited to attend, normally for their items(s) only, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director/manager.

3.5 The Local Counter Fraud Specialist will attend to report upon and discuss counter fraud matters.

3.6 Representatives from other organisations (e.g. NHS Counter Fraud Authority (NHS CFA)) and other individuals (e.g. Local Security Management Specialist) may be invited to attend on occasion.

3.7 The Secretary to the Committee shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.8 At least once a year, usually at its May meeting, members of the Committee shall meet privately with the External and Internal Auditors. Other meetings will take place at the request of members or auditors.

4.0 Access

The Head of Internal Audit, representatives of External Audit and the Local Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

5.0 Frequency of Meetings

5.1 The Committee should meet at least five times per year at appropriate times in the audit cycle to allow it to discharge all of its responsibilities in line with its annual workplan. Additional meetings, including any focus working group, may be called as required. The Committee will review this annually.

5.2 The Accountable Officer, External Auditors and/or Head of Internal Audit may request a meeting if they consider that one is necessary.

6.0 Authority

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6.3 The Provisions in the attached Annex to these Terms of Reference will only come into force at the explicit discretion of the Trust Board; and then only for those periods of time such as it determines to be appropriate in order for the Trust to discharge its functions under its business continuity plans during periods of potentially significant disruption to service delivery.

7.0 Responsibilities

7.1 The Committee supports the Board by:

- Assessing the Trust's overarching framework of governance, risk and control
- Obtaining assurances about the design and operation of internal controls
- Seeking assurances about the underlying data (upon which assurances are based) to assess their reliability, security and accuracy
- Challenging poor and/or unreliable sources of assurance

- Challenging relevant managers when controls are not working or data are unreliable

The duties / responsibilities of the Committee are categorised as the follows:

7.2 Integrated Governance, Risk Management and Internal Control

7.2.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

7.2.2 In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications
- The policies and procedures for all work related to counter fraud and corruption as required by the NHS Counter Fraud Authority

7.2.3 In carrying out this work the Committee use the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers.

7.2.4 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

7.2.5 As part of its integrated approach, the Committee will have effective relationships with other Trust Board Sub Committees (which may include reciprocal membership) to provide an understanding of processes and linkages and particularly to enable review and oversight of the other Sub Committee's governance of risk. This will include the exchange of their chair's action logs and highlight reports to the Trust Board.

7.3 Internal Audit

The Committee shall assure itself that there is an effective internal audit function that meets Public Sector Internal Audit Standards (PSIAS) and provides independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Reviewing and approving the internal audit strategy, the annual internal audit plan and more detailed programme of work, that is consistent with the audit needs of the Trust as identified in the Assurance Framework

- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources

- Monitoring the implementation of agreed internal audit recommendations in line with agreed timescales, and where concerns exist in relation to the lack of implementation in a particular area the Committee can request the relevant operational manager to attend a meeting and give explanation

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation

- Reviewing the Internal Auditor's annual report before its submission to the Board

- Monitoring the effectiveness of internal audit and carrying out an annual review and obtaining independent assurance that Internal Audit complies with PSIAS

7.4 External Audit

The Committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Assisting and advising the Council of Governors in their appointment of the External Auditors (and make recommendations to the Board when appropriate)

- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan

- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee

- Reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

- Establishing a clear policy for the engagement of external auditors to supply non-audit services; and for scrutinising and where appropriate approving uses of, or exceptions to, this policy.

7.5 Financial Reporting

7.5.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

7.5.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

7.5.3 The Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances

7.6 Risk Management

7.6.1 The Committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks the Committee considers it is appropriate to do so. This will include:

- Reviewing the Trust's information governance and cyber security arrangements, in order to provide assurance to the Board that the organisation is properly managing its information and cyber risks and has appropriate risk mitigation strategies
- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks
- Overseeing actions plans relating to regulatory requirements in terms of the Single Oversight Framework and Use of Resources
- Providing the Board with assurance over developing partnership arrangements (e.g. accountable care organisations) and mitigation of risks which may arise at the borders between such organisations

7.6.2 The Board will however retain the responsibility for routinely reviewing specific risks.

7.7 Counter Fraud and Security

7.7.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud that meet the NHS CFA's standards and shall review the outcomes of work in these areas. The Committee shall receive the annual report and annual work plan from the Local Counter Fraud Specialist, and shall also receive regular progress reports on counter fraud activities.

7.7.2 The Committee shall also receive and review the annual report and the annual work plan from the Local Security Management Specialist. It shall receive other security activity reports as appropriate.

7.8 Management

7.8.1 The Committee shall request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

7.8.2 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit).

7.9 Other Assurance Functions

7.9.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

7.9.2 These will include, but not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g. the Care Quality Commission, NHS E/I~~Improvement~~, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

7.9.3 In addition, the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular this will include any clinical governance, risk management or quality committees that are established. The Committee shall receive the action logs and highlight reports to the Trust Board of the following Board sub-committees for information:

- Finance and Performance Committee
- Quality and Safety Committee
- Remuneration & Terms of Service Committee
- Workforce Committee
- HealthTree Foundation Committee
- Ethics Committee

7.9.4 In reviewing the work of the Quality & Safety Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

7.9.5 The Committee will review Standing Financial Instructions, Scheme of Delegation and those elements of the Trust Constitution (Standing Orders) that provide assurances on the internal management of procurement and financial matters. It will also review the Trust's Standards of Business Conduct Policy.

8.0 Reporting

8.1 Minutes of each meeting shall be submitted to the next meeting for formal approval and signature by the Chair as a true record of that meeting. ~~A Chair's log and t~~The approved minutes will be submitted to the next meeting of the Board for information.

8.2 The Chair shall draw to the attention of the Board (via a highlight report) any issues that require disclosure to the Board, or require executive action.

8.3 The Committee shall report to the Board annually on its work in support of the Annual Governance Statement specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence that shows the organisations is fulfilling regulatory requirements relating to its existence as a functioning business and the robustness of the processes behind the quality accounts.

8.4 The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The report will also outline its workplan for the coming year.

8.5 The Committee's annual report and workplan will also be submitted to the Council of Governors for information.

9.0 Whistleblowing / Freedom to Speak Up Guardian

9.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensures that any such concerns are investigated proportionately and independently.

9.2 The Trust's Freedom to Speak Up Guardian, or his or her nominated deputy, shall attend the Committee at least annually to provide assurance on the design and operation of the function.

10.0 Administrative Support

10.1 The agenda for the Committee shall be approved by the Chair of the Cc~~c~~ommittee (or his or her nominated deputy).

10.2 Secretarial support (including distribution of agenda and papers to the Committee and noting of apologies) will be arranged by the ~~Director of Finance~~Chief Financial Officer (or his or her nominated deputy).

10.3 Agenda papers will be circulated to all members of the Committee no less than five working days prior to each meeting. Late papers may only be circulated, or tabled at the meeting, with the prior approval of the Chair.

11.0 Review

11.1 The Committee will review its Terms of Reference annually, or as necessary in the intervening period, to ensure that they remain fit for purpose and best facilitate the discharge of its duties. It shall recommend any changes to the Trust Board for approval.

11.2 The Committee will carry out an annual self-assessment (Appendix A) that is based on the good practice guide found in the HFMA's NHS Audit Committee Handbook.

12.0 Equality Act (2010)

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

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

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

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

ANNEX

Additional Provisions under Terms of Reference Paragraph 6.3

Under the provisions of paragraph 6.3 of the Committee's Terms of Reference:

(a) The application of the provisions in this Annex is subject to the explicit written prior approval and review of the Trust Board;

(b) References to *"The Period"* in this Annex mean to such period(s) of time as the Trust Board may specify, and;

(c) The provisions in this Annex are additions to the Committee's Terms of Reference and therefore should in no way be interpreted as diminishing the overall remit of the Committee.

"3.0 Attendance at Meetings":

Additional paragraph **3.9** added:

(a) "*During The Period meetings of the Committee may be held on such basis – physical; teleconference and/or videoconference – as may be decided by the Chair of the Committee in consultation with the ~~Director of Finance~~Chief Financial Officer.*

(b) *Subject to adhering to the requirements for quorum (section 2.0) then it will be a matter for the Chair of the Committee in consultation with the ~~Director of Finance~~Chief Financial Officer to determine who should be a participant in any Committee meeting during The Period.*

(c) *Notes are to be made of both the attendance at the meeting and of the decisions taken on the items discussed at the meeting for subsequent formal written presentation to the Trust Board monthly.*

(d) *The Chair in consultation with the ~~Director of Finance~~Chief Financial Officer will maintain a log of those agenda items tabled but not discussed at the meetings during The Period; this will be presented to the Trust Board monthly in writing for information with a statement on the intended action."*

"5.0 Frequency of Meetings":

Additional paragraph **5.3** added:

"During The Period the Committee shall meet with such frequency as may be determined by the Chair in consultation with the ~~Director of Finance~~Chief Financial Officer and also in order to comply with any revised year-end or other reporting procedures required of it by NHSE/I."

"7.0 Responsibilities":

Additional bullet point added to paragraph **7.1**:

- *"Reviewing the adequacy of the Trust Board's revised arrangements for governance and assurance during The Period; including any proposal to suspend Standing Orders; and making recommendations to the Trust Board in these matters."*

"7.2 Integrated Governance, Risk Management and Internal Control":

The following text added to the final bullet point to paragraph **7.2.2**:

- *"…with a particular focus on the heightened risk for fraud and criminal activity during The Period."*

The following text added to paragraph **7.2.5**:

- *In the absence of the operation of any of the other Trust Board Sub-Committees during The Period it will fall to the Chair of the Committee to maintain regular liaison with those Sub-Committee Chairs in order to remain briefed on any issues that may be of interest to the Committee."*

"7.3 Internal Audit":

The following text added to the end of this section:

"During The Period to agree such revised arrangements with the Internal Auditors (such as the conduct of the work programme for internal audits and follow-ups; and the obtaining of audit opinions, etc.) as may be deemed necessary in the circumstances."

"7.4 External Audit":

The following text added to the end of this section:

"During The Period to agree such revised arrangements with the External Auditors (such as the conduct of annual audit plan; and the annual audit opinion, etc.) as may be deemed necessary in the circumstances."

"7.6 Risk Management":

The following text added as an additional bullet point to **paragraph 7.6.1**:

- *"During The Period any such other matters as the Committee may consider to be relevant in the prevailing circumstances, but in particular in the absence of the operation of any of the other Trust Board Sub-Committees the Committee will assume general oversight of the Sub-Committee-level of the Trust's Board Assurance Framework and report any issues or concerns to the Trust Board*

"7.7 Counter Fraud & Security":

The following text added to paragraph **7.7.2**

"…with a focus on the particular nature of the heightened risk for fraud and criminal activity during The Period."

"7.9 Other Assurance Functions":

The following text added as a new paragraph **7.9.6**:

- *"During The Period and in the absence of the operation of any of the other Trust Board Sub-Committees the Committee may, if considered relevant in the prevailing circumstances, consider such assurance reports as the other Sub-Committees may otherwise have considered and propose a course of action on each."*

The electronic master copy of this document is held by Document Control, Office of the Trust Secretary, NL&G NHS Foundation Trust.

Appendix A

HFMA NHS Audit Committee Handbook, 2018 – Extract

This checklist is designed to elicit a simple yes or no answer to each question. Where 'no' answers have been given, the issues should be debated to determine if any further action is needed.

Area/Question	Yes	No	Comments/Action
Composition, establishment and duties			
Does the audit committee have written terms of reference and have they been approved by the governing body?			
Are the terms of reference reviewed annually?			
Has the committee formally considered how it integrates with other committees that are reviewing risk?			
Are committee members independent of the management team?			
Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?			
Does the committee prepare an annual report on its work and performance for the governing body?			
Has the committee established a plan of matters to be dealt with across the year?			
Are committee papers distributed in sufficient time for members to give them due consideration?			
Has the committee been quorate for each meeting this year?			
Internal control and risk management			
Has the committee reviewed the effectiveness of the organisation's assurance framework?			

Area/Question	Yes	No	Comments/Action
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?			
Has the committee reviewed the accuracy of the draft annual governance statement?			
Has the committee reviewed key data against the data quality dimensions?			
Annual report and accounts and disclosure statements			
Does the committee receive and review a draft of the organisation's annual report and accounts?			
Does the committee specifically review: • The going concern assessment • Changes in accounting policies • Changes in accounting practice due to changes in accounting standards • Changes in estimation techniques • Significant judgements made in preparing the accounts • Significant adjustments resulting from the audit • Explanations for any significant variances?			
Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?			
Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?			
Internal audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?			
Does the committee review and approve the internal audit plan, and any changes to the plan?			

Area/Question	Yes	No	Comments/Action
Is the committee confident that the audit plan is derived from a clear risk assessment process?			
Does the committee receive periodic progress reports from the head of internal audit?			
Does the committee effectively monitor the implementation of management actions arising from internal audit reports?			
Does the head of internal audit have a right of access to the committee and its chair at any time?			
Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?			
Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*?			
Does the committee receive and review the head of internal audit's annual opinion?			
External audit			
Do the external auditors present their audit plan to the committee for agreement and approval?			
Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?			
Does the committee review the external auditor's value for money conclusion?			
Does the committee review the external auditor's opinion on the quality account when necessary? **[Note: this question is not relevant for CCGs]**			

Area/Question	Yes	No	Comments/Action
Does the committee hold periodic private discussions with the external auditors?			
Does the committee assess the performance of external audit?			
Does the committee require assurance from external audit about its policies for ensuring independence?			
Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?			
Clinical audit **[Note: this section is only relevant for providers]**			
If the committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?			
If the committee is responsible for monitoring clinical audit has it: • Reviewed an annual clinical audit plan? • Received regular progress reports? • Monitored the implementation of management actions? • Received a report over the quality assurance processes covered by clinical audit activity?			
Counter fraud			
Does the committee review and approve the counter fraud work plans, and any changes to the plans?			
Is the committee satisfied that the work plan is derived an appropriate risk assessment and that coverage is adequate?			
Does the audit committee receive periodic reports about counter fraud activity?			

Area/Question	Yes	No	Comments/Action
Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?			
Do those working on counter fraud activity have a right of direct access to the committee and its chair?			
Does the committee receive and review an annual report on counter fraud activity?			
Does the committee receive and discuss reports arising from quality inspections by NHSCFA?			

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)049

DATE	2 February 2021
REPORT FOR	**Trust Board of Directors**
REPORT FROM	Neil Gammon, NED / Chair of Health Tree Foundation Trustees' Committee
CONTACT OFFICER	Ellie Monkhouse – Chief Nurse Dr Kate Wood – Medical Director
SUBJECT	HTF Trustees' Committee Highlight Report – November 2020
BACKGROUND DOCUMENT (if any)	-
PURPOSE OF THE REPORT	Issues from the Health Tree Foundation Trustees' Committee meeting requiring escalation by exception to the Trust Board
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The attached highlight report summarises two key issues presented to, and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 5th November 2020 and worthy of highlighting to the Trust Board.

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

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

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

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

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	2 February 2021
Report From:	Health Tree Foundation Trustees' Committee held on 5 November 2020

Highlight Report:

NHS Charities Together Grants

- In response to invitation, HTF Charity Manager submitted application for further grant from NHS Charities Together Wave 2 Covid-19 monies.
- Application for £50k was successful and will be used to benefit staff and patients during Wave 2 Covid-19 infections.

Fundraising in 2021 and Beyond

- A brief discussion took place to consider how fund raising in a Covid-19 pandemic and post pandemic climate might best be managed
- Agreed that Charity Manager HTF would produce paper on subject for next HTF Trustees' Committee Meeting.

Confirm or Challenge of the Board Assurance Framework:

Not Applicable

Action Required by the Trust Board:

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

Neil Gammon
Non-Executive Director / Chair of Health Tree Foundation Trustees' Committee

NLG(20)050

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	2 February 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Helen Harris, Trust Secretary
CONTACT OFFICER	As above
SUBJECT	Annual Review of Non-Executive Director (NED) Statutory & Other Lead Roles
BACKGROUND DOCUMENT (if any)	None
PURPOSE OF REPORT	To provide information of NED Roles and Responsibilities
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The Report provides the current roles and responsibilities assigned to NEDs

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Risk to strategic objective: 11) Risk of insufficient investment and development of the Trust's leadership (including clinical leadership) - capacity and capability.
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report

Non-Executive Director Statutory & Other Lead Roles & Responsibilities

NED	NED Chair of Trust Meetings & Board Sub-Committees	Deputy Chair and / or Attendee	NED Statutory / Assurance Roles	Non-Executive Director Linkages through CoG Working Groups
Terry Moran **Trust Chair**	• Council of Governors • Trust Board • RATS Committee		• Oversight of CoG Development • Oversight of Trust Board & Trust Leadership Development	• Appointment & Remuneration Committee for Non-Executive Directors
Linda Jackson **Vice Chair** ***Attached to Clinical Support Services Division***		• Trustee of Health Tree Foundation (HTF) • Rotational attendance at Q&SC, F&PC and Workforce Committee meetings • Member of the RATS committee	• Freedom to Speak Up Guardian Champion and NED oversight and assurance role • CQC response -NED oversight and assurance • NED Champion for Leadership Development for Board and Senior Staff (Part of NHSE/I recommendations on the Trust Board Improvement Plan)	• Governor Assurance Group • Appointment & Remuneration Committee for Non-Executive Directors
Mike Proctor ***Attached to Family Services Division***	• Quality and Safety Committee	• Deputy Chair of Workforce Committee • Trustee of Health Tree Foundation (HTF)	• Safeguarding / Mental Health Act / Mental Capacity Act (MCA) -NED oversight and assurance • End of Life- NED oversight and assurance	• Governor Assurance Group

NED	NED Chair of Trust Meetings & Board Sub-Committees	Deputy Chair and / or Attendee	NED Statutory / Assurance Roles	Non-Executive Director Linkages through CoG Working Groups
		• Member of the RATS committee	• Maternity & Children's Champion- NED oversight and assurance • NED Champion for Quality Improvement Strategy (Part of NHSE/I recommendations on the Trust Board Improvement Plan) • Mortality and Morbidity NED oversight and Assurance (did sit with Tony)	
Andrew Smith – Associate NED **will take over on 25.01.2021** ***Attached to Community and Therapies Services***	• Audit, Risk & Governance Committee	• Member of the RATS committee • Deputy Chair of Finance & Performance Committee • Member of Quality and Safety Committee	Security -NED oversight and assurance • NED Champion for Internal and External Communications (Part of NHSE/I recommendations on the Trust Board Improvement Plan)	• Governor Assurance group
Neil Gammon NED until 31.03.2021 (will flex to fit around the appointment of successor)	• Chair of Finance and Performance Committee	• Member of Audit, Risk and Governance Committee	• Equality & Diversity - NED oversight and assurance • Dementia & Learning Disability - NED oversight and assurance	• Governor Assurance Committee

NED	NED Chair of Trust Meetings & Board Sub-Committees	Deputy Chair and / or Attendee	NED Statutory / Assurance Roles	Non-Executive Director Linkages through CoG Working Groups
Attached to Surgery and Critical Care Division	• Independent Chair of Health Tree Foundation	• Member of the RATS committee	• NED Champion for the Integrated Performance report (Part of NHSE/I recommendations on the on the Trust Board Improvement Plan)	
Michael Whitworth NED ***Attached to the Medicine Division***	• Chair of the Workforce Committee	• Deputy Chair of Audit, Risk and Governance Committee • Deputy Chair of the Quality and Safety Committee • Member of the RATS committee • Trustee of Health Tree Foundation (HTF)	• NED Champion for Strategic Development – including Trust Vision and Strategic objectives (Part of NHSE/I recommendations on the Trust Board Improvement Plan) • NED Champion for the workforce Strategy (Part of NHSE/I recommendations on the development of the board)	• Governor Assurance Group

Stuart Hall Associate NED		• Member of the Finance and Performance Committee • Member of the Audit, Risk and Governance Committee • Member of RATS committee		

NLG(20)051

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	2 February 2021				
REPORT FOR	Trust Board of Directors – Public				
REPORT FROM	Terry Moran, Chair				
CONTACT OFFICER	As above				
SUBJECT	Board Feedback – January 2021 Meeting				
BACKGROUND DOCUMENT (if any)	None				
PURPOSE OF REPORT	To provide feedback to Trust Board members of the meeting held on the 5 January 2021				
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None				
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The Report provides overall feedback from the meeting held on the 5 January 2021				
ACTION REQUIRED					
Approval	**Information**	**Discussion**	**Assurance**	**Review**	
LINK TO STRATEGIC OBJECTIVES					
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**	
TRUST PRIORITIES					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**
BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	To provide strong leadership (Strategic Objective 5)				
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report				

TRUST BOARD – REVIEW OF MEETING

(ratings 1 to 4: 1 = low/poor, 4 high/good)

Date of Meeting: Tuesday, 5 January 2021

Business Conduct		Rating (1-4)				Comments
		1	2	3	4	
1	Did the Board focus on the appropriate agenda items?		3	2	5	• The timing of the meeting had to be prescriptive, but due to the time constraints faced by Executive members this was appropriately so. • No operational performance given the risks it needs to be done. • There was much to cover and the Chair allowed the meeting to overrun, in my view quite appropriately in order not to constrain debate on most important items. • My observation is that the Board agenda is too weighted on operational details. Boards and Execs that I have been on 80% of the agenda/time is focused on the actions that will impact future facing activity. • We ended up talking in depth about performance, yet there was no specific paper about performance. Minimal focus on 'quality'.
2	Where appropriate, were relevant items debated at the relevant Board Assurance Sub-Committee prior to being submitted to the Trust Board?		6	2	2	• Particularly important in terms of the BAF, changes to which should be informed by Committees.

						• Need to establish these to ensure assurance provided. • In part, as evidenced by the minutes of those relevant assurance committees. The difficulty was that with the temporary C-19 suspension of the F & P Committee, no prior debate over current performance, including risk stratification, had taken place before TB. • I wonder if we might continue and increase the focus on reporting by exception, summary/highlight reports from board sub committees on the key items that require us to review. • The absence of F&P sub-committees led to performance discussions dominating Q&S agenda item. • Much longer discussions on operational matters due to Board Sub-Committees being stood down. • No – performance was not discussed pre TB in detail – otherwise we would not have had the length of discussion at Board. It would be helpful if the people paper covered education in more detail.
3	Were you satisfied with the quality of papers: a) Is the purpose and content clear? b) Are papers clear on the Board action required? c) Did the papers meet your expectations to provide the necessary assurance? Please provide any additional comments.	a)	**1**	**3**	**5**	• Failed to provide this in a number of areas. • Further evidence was required in respect of performance issues. Under these extremely difficult times for staff, TB does need to have an accurate picture of current performance across the board. • The papers are well written. Some
		b)	**1**	**3**	**5**	
		c)	**2**	**4**	**3**	

						coming to the Board have information that should be decided by operational directors. More Graphs, less narrative would be more impactful. Ex. Report on our People some of that info should be decisions points for Exec. Board could receive a graph of current staffing levels against expected standard; vacancy rate graph against average/ average for region. Key staffing – nursing and doctors. It has not been my experience that the establishment budget is at a Board meeting. Board should pick up Finance issues from the Finance committee of Board – highlight report. I expect managers/directors to manage their budgets. • The improved brevity of papers helps enormously. We must continue to avoid copious appendices. Less was more in this case. • MI, clarity and tie into risk management frameworks could improve. • Agreed with the feeling of some more information in various areas would have been helpful. • The patient impact paper was a paper produced as previously agreed to cover quality issues. Yet the focus of the discussion was on performance. So there needs to be a decision as to whether there will be a paper for performance, or whether the patient

						impact paper needs to focus on this area too, and this needs to be communicated to the exec and the team developing the paper. OR a separate paper is provided.
4	Did any one item / paper stand out for you as a model to adopt for all items? Provide rating of paper and then be specific about why by providing a comment.				**2**	• Found the paper on the IT strategy particularly informative and what could be a very technical style was couched in a format which could be understood by lay readers. • NLG(21)012, Digital Strategy, was commendable in its clarity, comprehensive coverage of a complex subject and engendering of confidence in the digital future. • As noted the papers are well written. I question what is appropriate. Are they narrative or graph or tables? At times some repeat information that is in another report. • Patient Impact which brought together MD and CN perspectives was helpful. • Patient impact – focussed on quality issues with clear risks and mitigations.
Meeting conduct & timing		**1**	**2**	**3**	**4**	**Comments**
5	Did the tone and conduct of the meeting feel that you were able to contribute constructively?		**1**	**2**	**7**	• Most certainly. • The agenda is quite full. The tone is very comfortable and encourages contribution however it might help to have a discussion on the appropriate items for senior executive / board decisions.
6	How effective was the chairing of the meeting? Please include a comment if required.			**5**	**5**	• Chair does an excellent job keeping on track and encouraging the input. The Chair invites discussions that are open

						and encourages all views to be heard. Chair makes you feel you can contribute. • We went well over time but this was absolutely necessary. When discussions get more difficult the more the short-comings of video meetings are exposed.
7	Was the length of the meeting appropriate?	**1**	**3**	**1**	**5**	• The additional time allowed was quite necessary. • The original time was 9.00 am – 10.30 am public, then 10.30 am – 11.00 am private. We ended at noon. I am pragmatic and we likely need to rethink what is on the agenda or extend the meeting time. I personally think to do the work well – it needs more time. • Yes, but only because the Chair exercised flexibility. • More time should have been allocated to strategy discussions eg Digital Strategy.
8	Any Other Comments: • I would be particular keen to see included in the Finance papers over the next 2 Boards how the Trust has performed against the criteria detailed by Regional office to facilitate exit from financial special measures. • Please could we ensure to have a paper covering C19 update. • Please could we ensure to discuss performance as per quality and finance. It is important that we are all informed. • As noted in point 1 above - My observation is the board appears to have too much of the agenda time on operational information. An observation - previous digital /organisational strategies presented at Boards – were generally 30 min to 1 hour on agenda. As they are forward /future facing directions of travel. In this meeting it was less than 10 min. The digital strategy is a future looking piece of work, with implications for running the organisation. I would expect healthcare boards spend a fair bit of time discussing the digital/business transformation, out of hospital care, and reviewing how business benefits are being achieved for investments being made & the identified priorities to meet the business strategy. Discussion on the ICS work, HASR, and major projects. Daily operational items should be within the accountability of the COO, senior Directors, not at the Board. My observation is that NLaG has very experienced and knowledgeable senior people involved in all aspects of running					

	things. This is not sustainable and will not enable us to develop leadership & accountability at the appropriate levels in the organisation. I would expect coming into Feb/March there will be more time on the estate's strategy and how the business planning is linked to the 2020-2025 NLaG strategy. In my experience at this time, TMB/Sr. Execs would be approving priorities for fiscal 2021/22 with the plan for it to be presented at March board for approval in readiness for new fiscal year. It might be helpful if the agenda had a section that included the key NLaG strategic priorities and what has been achieved to advance those priorities. We did have some discussion on priorities however, to run a complex business everyone needs to be cited on what the key priorities are for the organisation. This guides how decisions are made. We have had Covid since March 2020 and it is an ongoing issue, however that should not pull Exec away from Board level / senior leadership work indefinitely. It may be useful to have an open discussion about bringing the board and board sub-committees back to do the Board level work. There are very competent senior people in the Trust that report to Shaun, Ellie, Kate, that run the operations on a daily basis. Once they have their decision-making parameters, they are/should be capable of doing their job. They know how to escalate. The executive team and Board have a wealth of knowledge and experience, and this needs to be leveraged at the strategic level while enabling others in the organisation to make day to day operational decisions. The board is the place to have interesting discussions that take us to the future. Overall the organisation, running of the board, input and engagement is excellent. Apologies if I included too much information. Thank you for the opportunity to provide feedback. • This meeting covered key issues and the Chair appropriately let the discussion run but quality of data and MI presented was at times short of where it might be.

NLG(21)052

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	2 February 2021
REPORT FOR	**Trust Board of Directors (Public)**
REPORT FROM	Neil Gammon, Non-Executive Director / Chair of Finance & Performance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**Finance & Performance Committee – Minutes of meetings held on 27 August & 30 September 2020**
BACKGROUND DOCUMENT (if any)	-
PURPOSE OF REPORT	For Information
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee 30 September & 28 October 2020
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	Minutes of the Finance & Performance Committee held on 27 August and 30 September 2020 and approved at its meetings on 30 September and 28 October 2020 respectively.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Risks 1, 6, 7, 8, 9
TRUST BOARD ACTION REQUIRED	The Board is asked to note the report.

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **27 August 2020 – via GoToMeeting**

PRESENT:	Neil Gammon	Non-Executive Director / Chair of F&P Committee
	Tony Bramley	Non-Executive Director
	Stuart Hall	Associate NED, NLAG / Vice Chair HUTH
	Linda Jackson	Trust Vice Chair
	Jim Hayburn	Interim Director of Finance
	Jug Johal	Director of Estates & Facilities
	Shaun Stacey	Chief Operating Officer
	Ivan McConnell	Director of Strategic Performance
	Kathryn Helley	Associate Director of Business Planning & Performance Management
IN ATTENDANCE:	Matt Clements	Assistant Director of Finance – Financial Management
	Lucy Kent	Improvement Delivery Manager (for Item 5.1)
	Anne Barker	Finance Admin Manager (Minutes)

Item 1 08/20 **Apologies for Absence**

Apologies for absence were received from: Terry Moran; Peter Reading; and Brian Page

It was noted that Jim Hayburn had to attend another meeting and would be joining the Finance & Performance Committee late; therefore Matt Clements attended until Jim Hayburn could join.

It was also noted that Shaun Stacey would have to leave the meeting by 3.00pm to attend a retirement presentation on behalf of Peter Reading.

Neil Gammon advised that all papers presented at the meeting today would be taken as read and only changes and/or updates would need to be highlighted.

Item 2 08/20 **Declarations of Interest**

There were no Declarations of Interest.

Item 3 08/20 **Minutes of the previous meeting held on 29 July 2020 – Public**

The public minutes from the previous meeting held on 29 July 2020 were reviewed and agreed as an accurate record.

Item 4 08/20 **Matters Arising**

Page 1 - Neil Gammon referred to the *Use of Resources and Timetable which highlighted the need for the Committee to be briefed on a summary of where the Trust is an outlier, either good or bad; and the process for resolution* and asked for the Committee to bear these two issues in mind when discussing that item.

Page 5 – Neil Gammon referred to *IT / Digital Risks and the potential duplication with the ARG Committee and an action for Neil Gammon and Tony Bramley to discuss outside of the meeting.* He advised that it had been agreed with Tony Bramley that this best fitted with the ARG Committee.

Minutes of the previous meeting held on 29 July 2020 – Private

The private minutes from the previous meeting held on 29 July 2020 were reviewed and agreed as an accurate record.

Matters Arising

Tender – Pathology Sexual Health & HIV – Briefing Paper – Neil Gammon asked what next and asked if an update would be provided on lessons learned and the outcome of the concerns raised on the whole process. Ivan McConnell advised that no response had been received so far but agreed with the suggestion of looking at lessons learnt. **Add to Action Log**

Kathryn Helley joined the meeting.

In response to the suggestion of an update on lessons learned, Jug Johal highlighted that this would be a routine action as part of the follow up of all tenders. Neil Gammon asked which assurance committee would receive this from a governance point of view. Jug Johal suggested that as Mick Chomyn brought the paper to the Finance & Performance Committee then the update should come back to this Committee. Neil Gammon agreed to ensure that it appears on the agenda for the next meeting.

4.1 Action Log

The action log was reviewed as follows:

- 4.2 – Additional KPIs to be added to the IPR document – Kathryn Helley updated the Committee and referred to the "Plot the Dots" development session held in August which resulted in redesigning the whole of the IPR. Alex Bell had taken, to that session, a template of the document which was subsequently signed-off by Peter Reading; a mock-up of the new look IPR would be available by the end of September as a test. Kathryn Helley noted that this timescale significantly bettered the original 6 month estimate.

Stuart Hall commented that he had found the August development session invaluable and had subsequently recommended to Terry Moran to weave similar into HUTH's quality development programme. He commended any work that is done at pace.

Neil Gammon asked Kathryn Helley to ensure that the Trust 2020/21 priorities were reflected in the report that is taken to Trust Board.

Following review the Action Log was noted.

4.2 Contracting Risks

Neil Gammon referred to the minutes from September 2019 of the F&P Committee in respect of the contracting update. At that time the Committee heard from Zoe Plant on the risks and specifically the impact on clinical income from the contracting process. It was acknowledged that the current Covid-19 situation had resulted in commissioner block payments being made and therefore it was agreed that it was not necessary to pursue a further update on this at the current time and that it would be considered in the ARG workplan given the potential risks. Shaun Stacey highlighted that at the end of year the Trust would likely see a different contract with different risks. If NLAG were not able to deliver on this income could potentially be blocked. It was agreed this situation would need to be reviewed by the ARG Committee before being brought back to F&P Committee.

It was agreed that any potential risks during the latter part of the current year would be highlighted and reviewed through the BAF.

Kathryn Helley referred to recent NHSE/I instructions concerning activity recovery. She explained that the Trust were currently planning Phase 3 delivery as part of the post Covid-19 recovery. This involved considering the wider ICS picture; working with partners, particularly within Humber Acute Services and more locally; making place considerations; planning within Covid-19 regulations clinically and socially on site and in the community; balancing planned financial performance incentives with safe, sustainable care as required by CQC and ensuring staff are managed and treated appropriately. This involved careful management of several options with competing and overlapping risks.

Neil Gammon also commented that within the CIP paper there were a number of warning notes of contracts due to expire.

Item 5 08/20 Presentations for Assurance / Transformation Project Briefing

5.1 CQC Progress Report

Lucy Kent attended to present the report which was taken as read and she was invited to update on any additional points to note.

Lucy Kent advised that her team were now up to full capacity with two additional members of staff. She pointed out that the paper received by the Committee is identical to the one that is taken to two of the other assurance committees i.e. Quality & Safety and Workforce Committees and is also discussed at PRIMs.

She noted the progress made including the external oversight of progress which would commence through the Patient Safety Group in early September and advised of continued monthly relationship meetings with CQC as well as continued close working with NHSE/I.

Lucy Kent drew the Committee's attention to the number of actions (141) with 43 (30%) of those being rated as Red and advised that these would not have the completion dates changed to avoid losing pace with what has been achieved. Some of the Red Rated actions need to be linked with the BAF which Jeremy Daws would do.

Following discussions with Shaun Stacey and NHSI, three or four questions would be developed to ask Divisions at each meeting for them to give assurance on patients not coming to any harm, and to give a clear narrative evidence of performance achieved, which, she noted was currently not clearly evident. The next report would have information generated through Power BI and information on those actions.

Linda Jackson commented that the report was better and acknowledged that it would evolve. She said that the responsibility of the Finance & Performance Committee was to assure the Trust Board and, referring to page 6 within the report, asked how the Committee obtain that level of assurance if the evidence was not in plain sight. The Committee could not just regurgitate information. She stated that whilst she accepted that not all actions were contained within the plan, since it tended to cover the transactional ones, how could the Committee be assured on progress when much of what was happening to transform progress was not reflected in the report?

Lucy Kent explained that similar information and reports were being presented to several assurance committees and therefore this was an attempt to provide a key summary.

Tony Bramley referred to the report's section on risk (page 5) and suggested that the risks on that list appeared to be entirely within the Trust's control and ownership which, he suggested may not be entirely accurate. He said that the risks shown were mainly procedure or process related, apart from the capacity and cost ones. Was it therefore a benign analysis of the risks and he queried if the Trust is being brutally honest with themselves.

Neil Gammon acknowledged that the report concentrated on the process risks and working with Divisions but asked if wider risks could also be included, adding that to get an accurate picture on the executive summary it needs to reflect the totality of the situation.

Stuart Hall concurred with the comments made by Tony Bramley and stated that he understood the requirement not to change the date of some of the actions in Red. However, he was concerned that if the due date was passed this could result in the eye being taken off the ball and he would need to be assured that the risks were still being monitored appropriately, including for any interdependencies. In terms of risk generally, he noted that the first challenge was always collation of evidence. He felt strongly that it was crucial that a suitable process was created once and reused many times with the support of robust management information systems.

Shaun Stacey explained that it was intended to link the CQC report to BI reports already in use rather than creating something new. He suggested that a level of assurance could be gained by looking at these linked BI reports. He commended the CQC report but acknowledged it could be open to differing interpretations. For example, a Red alert does not necessarily mean the action was not happening but that perhaps a trajectory was not where it should be. He further highlighted that the new IPR, under development, would give much broader assurance than just RTT, 62 day and such like. The development work continued and he advised Lucy Kent should continue with the current report for the time being.

Stuart Hall agreed that the RAG rating is not always a true reflection and was comfortable with the response.

Jug Johal suggested that once the new IPR is in place the NEDs could be given a log-in to the BI reports to see more detail, which the NEDs agreed would be useful and prevent a lot of questions being raised in Committee. Jug Johal also agreed to arrange a PowerBI user session for the NEDs.

Action: Jug Johal

Linda Jackson agreed that an extraordinary amount of work had gone into the production of the report but was still not sure that it gave the Committee the necessary assurance to report back positively to Trust Board.

Neil Gammon suggested waiting for the CQC briefing session involving the Divisional Triumvirates the following week to see if all three assurance Committees need to receive duplicate reports. Linda Jackson wondered whether the Divisions have entirely the right approach at present. Shaun Stacey supported this question and explained that whilst trying to ensure that everyone was informed, acknowledged it was more about assurance and probably needed a different approach. He agreed to wait until the 1 September briefing the following week and then bring a proposal back to the Committee. This was agreed.

Action: Shaun Stacey

2.20pm There were no further questions or updates and Lucy Kent left the meeting.

5.3 OPD Transformation / Reduction of follow-up waiting list position

The paper was taken as read and Shaun Stacey drew the Committee's attention to the additional paper, Adapt and Adopt, that had also been circulated.

Shaun Stacey explained that Adapt and Adopt is a new programme that NHSI/E are promoting across the UK which outlines best practice to adopt but can be adapted to local requirements. It is a rapid improvement programme rather than a long term one and he highlighted that the Trust is leading the way with a Community MDT model at system level.

Tony Bramley, referring to the Outpatient Transformation Paper 5.3, mentioned the governance structure for Outpatient Transformation Board (page 2) and Risks and Escalations (page 7). He noted that the risks listed were all rated at 20 with only one at 15 and therefore very high risks and asked whether the mitigation outlined had taken account of adapt and adopt or if that had to still come into the equation. OPD1 referred to resource issues and Tony Bramley asked if it was an expectation on the F & P Committee to highlight this matter. He wished to understand the role of F&P in this.

Shaun Stacey stated that it is important to understand the risks associated with Outpatients, given the Covid-19 situation. Despite mitigation it was necessary to look at what more can be done to get nearer to the end of year plan as reported previously in terms of waiting lists.

Shaun Stacey continued that the challenge with this programme is the need to convince clinical colleagues to work differently and to equip primary care to put the patient in the centre of all that we do and not the doctor. In order to do that we would need the support of primary care network resources. Shaun Stacey has raised the resource issue at Trust Board and also with NHSI/E and commissioners but this has stalled as the instruction was to work within current resources. He explained that current staff have been mobilised as far as possible but running out of resource without further investment, so need influence to release external resource to work at least a couple of days within the organisation.

Linda Jackson noted that clinical service redesign was still identifying a resource requirement and questioned if this was a clinical need, which Shaun Stacey confirmed.

Stuart Hall noted that similar activity had been rolled out at HUTH in November with two key strands, namely clinical engagement and resources. Resources include patient initiated follow up and patients taking responsibility for their own health. This initiative needs to be moved forward.

5.3.1 Shaun Stacey reminded the committee that there was a continuing need to educate GPs to prevent unnecessary referrals to the Trust. He explained that using a new community MDT model and holding monthly events with GPs with one speciality at a time was underway with a pilot programme. This encompasses elements of primary care to manage patients on follow up waiting lists. It was essential not to lose momentum with this initiative but additional resource would be required. He felt it was key to transforming outpatient performance and reducing the backlog waiting list, with potential to be more beneficial than other waiting list initiatives.

2.40pm Jim Hayburn arrived

It was agreed to raise the resource issue for outpatient transformation in the highlight report.

Item 6 08/20 **Integrated Performance Report**

Shaun Stacey presented the reported for discussion.

Deterioration in performance continues although cancer performance is still showing limited improvement but this will deteriorate later in the year unless improved and sustained access to diagnostics is obtained. In addition, more work is underway with HUTH for complex cancer cases.

A&E – ambulance handovers appeared more optimistic in the narrative than the reality of the figures. The 15-30 mins delays were highest for 12 months with 30-60 mins delays third highest in the year.

Shaun Stacey highlighted a 25% increase in ambulance arrivals since last year which is of concern. The difficulty is their arrival in one block with 6-9 at a time for 15-20min period and the Trust does not have capacity for that volume. The COO at EMAS had been asked to look at the patient data, particularly minor ailments transported by ambulance and the high patient numbers brought in with no clinical intervention required.

Tony Bramley noted the IPR should be the source of performance reporting data and information but Covid-19 had distorted previous norms. Figures now regularly exceeded the upper and lower control limits, therefore what should we be looking for and questioning?

Jim Hayburn stated that focus should be on trajectories rather than overall performance. Ivan McConnell added that it is about getting the right data set, manipulating and correlating that data set and displaying it to maximum information advantage.

Stuart Hall commented on A&E performance, same day emergency care (SDEC) and rostering. He enquired about the rostering review and what the SDEC target was. Shaun Stacey responded that the SDEC national target is 20%, which NLAG exceeds. Contributing to this success was the rostering of acute medicine consultants for 12 hours per day now, potentially with more to come. Stuart Hall congratulated Shaun Stacey on that good result.

3.00pm Shaun Stacey left the meeting

5.2 NLAG Clinical Strategy 2020-24

Ivan McConnell presented the report which outlined the process and next steps following on from the presentation of the draft Clinical Strategy at the July F&P Committee.

Ivan McConnell described the strategy as a compelling narrative as part of a dynamic system and outlined the changes in the preparation timescales in response to Humber Acute Service alterations, capital investment adjustments and divisional reviews for CQC. He is now working towards a submission date to Trust Board of 1 December 2020.

Tony Bramley referred to the approval process (page 5) including to TMB and F&P for review and comment and asked if, as a matter of principle, that it should also be taken to Q&S for appropriate scrutiny which Ivan McConnell agreed.

Linda Jackson asked what would happen if the CQC arrived on 1 December. Ivan McConnell noted that if the CQC arrived the following day then a document would be available, but he would want to get to the point where multiple system stakeholders had had an opportunity to see and comment on the strategy. Thus, a document was available now but with gaps that needed closing. The Trust and wider system were also developing

the financial strategy. Jim Hayburn reiterated previous comments that a financial strategy cannot be created in isolation and the current difficulty was not having confirmation of income streams and values for the latter part of the year.

It was agreed to highlight to the Trust Board the difficulty of aligning the financial strategy with the Clinical Strategy.

6.3 BAF Risk Review

An increase in follow ups was noted as well as the good news on radiographer numbers resulting in a risk rating reduction. Ivan McConnell highlighted that radiographers are currently being trained on their new equipment which will go live at the end of the year.

Neil Gammon referred to the heat map for Strategic Objective 1 and noted that the Trust were currently unable to deliver four performance targets due to demand and capacity constraints. The report stated that a trajectory had been agreed for each and he asked who had made that agreement. Kathryn Helley stated that this probably referred to the phase 3 planning process and initial agreement with the Divisions, which was a continuing work in progress.

Tony Bramley commented on the scrutiny of the BAF and noted that links had been made with agenda item 5.3, specifically To Give Great Care with priorities of *improve performance; reduce waiting times; and improve patient flow.* It was therefore appropriate to note that the Committee had discussed this earlier in some detail, thereby covering the commitment to review those risks.

3.30pm Matt Clements left the meeting

Item 7 08/20 Finance Report – M04

Jim Hayburn presented the report and highlighted a £600k underspend with a Covid-19 top up of £1m received this month compared with £800k last month which is due to an increase in activity numbers in almost all areas. Conversations have taken place with Divisions on the likelihood of the £100k underspend continuing to the end of the year and what additional capacity could be achieved in that time. Jim Hayburn noted a number of potential penalties later in the year if activity numbers are not achieved so the finance team are also examining the implications of that with Divisions.

Jim Hayburn highlighted that the Trust's better payment practice code performance had once again improved with the value of within 30 day payments of non-NHS invoices paid from 48% to 79% and the number of invoices paid of non-NHS invoices from 24% to 75%. Trade Creditors have also reduced by £6.9m since 31 March 2020.

He reiterated the lack of guidance for the financial arrangements for the latter part of the year and was slightly concerned that allocations would be going to STP then to CCGs. Potentially, there may be no income for contracts valued of less than £500k. The point has been made to NHSI about block payments at the beginning of the year of £7m and the shortfall against that and the only reason performance has increased is because of increased activity.

Tony Bramley referred to the staffing costs which showed an increase in agency and locum spend and asked to what extent these increases were attributable to Covid-19 against business as usual. Jim Hayburn said that it was total costs including Covid-19 expenditure and explained that the difficulty was stripping out the Covid-19 costs, but agreed to take the action away to see if a high level split could be made. Linda Jackson supported the challenge on staffing costs.

Action: Jim Hayburn

Linda Jackson was aware that various submissions of activity planning were due to be submitted to the ICS and regional teams over the coming weeks and enquired whether the activity figures and associated trajectories could be shared with the Committee.

Jim Hayburn commented that the role of this Committee is to provide assurance on what was being said and presented and not to assess returns themselves. He added that there would be various iterations of this work culminating in the final submission, leading to the risk of differing profiles being presented, potentially causing confusion.

Linda Jackson acknowledged what had been said and was aware that a lot of work was being undertaken but it had not been seen at all by the NEDs. Kathryn Helley agreed with the DoF's comments but she thought that the Committee need to have had sight of it. It was agreed that Jim Hayburn and Kathryn Helley would discuss how best to present the information to the Committee.

Action; Jim Hayburn / Kathryn Helley

Jim Hayburn referred to the recent letter providing national financial guidance. It called for a formal trust finance submission the following week with instructions not to include any impact of the potential penalties. Further agreement is required between NHSI and the Treasury to enable more definitive instructions. There is no clear sense of direction on efficiencies only the certainty of no Covid-19 top up. Allocations will go to the ICS rather than individual organisations, thereby adding another level of risk.

Jim Hayburn referred to CIP impact and the fact that the Board agreed to continue with CIP development with a savings target of £13m to Divisions. In addition there was a shortfall of £7m at the start of the year. By chance, the budget allocations to divisions are in line with block payments and income but without CIP included. As we move further through the year it will be more of a challenge on general managers to achieve balance. . General Medicine and Family Services, have been asked for specific plans for review in September. If necessary supportive oversight will be put in place. Kathryn Helley commented that until the funding envelope is known the figure of £13m is being used to develop plans.

7.2 BAF Risk 6

Tony Bramley suggested that the risk against Strategic Objective 3 within the BAF had been covered in the previous item. Neil Gammon asked in light of the letter mentioned above whether the current risk rating of 12 should be reviewed.

Tony Bramley suggested that following the conversation in the previous item and the uncertainty it could be flagged that the risk remains at 12 for now but will need to be reviewed. Jim Hayburn agreed the level of uncertainty had not decreased over the last month so agreed it needed to be.

Action: Jim Hayburn

Item 8 08/20 Savings Programme 2020/21

The CIP situation had already been discussed through other items and Neil Gammon invited questions from the Committee.

Tony Bramley referred to the Nursing and Midwifery section and noted a step change between August and September and wondered why there had been a swing from Red to Green and asked if it is linked to the recruitment rounds with new nurses. Kathryn Helley agreed that recruitment could be part of it but also annual leave during August would

cause an increase in bank and agency spend resulting in less savings. Tony Bramley asked how that would sit with previous discussions in the Finance section on bank and agency. Neil Gammon also referred to the financial performance cumulative bar charts and noted that May was missing on several of them. Kathryn Helley agreed to review.

Action: Kathryn Helley

Stuart Hall queried the recurrent CIP delivery and Kathryn Helley, expressing disappointment at the low levels of recurrence, suggested that Covid-19 might have affected some of the plans that Divisions had in place and many savings that had been gained had been non-recurrent. Work continues with the divisions through financial improvement meetings to increase the proportion of recurrent savings initiatives and some deep dives had been undertaken where support was needed. Jim Hayburn added that some divisions have high CIP requirements due to non-delivery the previous year. Kathryn Helley agreed to share the principles underpinning savings delivery.

Action: Kathryn Helley

Neil Gammon referred to the Contracts savings shortfall situation under the Procurement KPIs (page 23) and Kathryn Helley explained that a number of contracts had expired and were due to be reviewed. However, given the capacity issues within Procurement, particularly during the Covid-19 PPE situation, they had insufficient spare capacity to pursue and challenge the Divisions to renegotiate at less cost.

Item 9 08/20 **Strategic Development**

Ivan McConnell gave a brief verbal update on the current position of the capital programme. He explained the three main phases of the capital programme, what proposals should materialise and an update on the two items on the agenda i.e. Outline Business Case – AAU (9.2); and Full Business Case – SGH MRI (9.3).

Ivan McConnell explained that the work was led by the ICS and that he is on the board for major capital funding allocations.

It was noted that £30m had been allocated for redevelopment of both SGH & DPOW EDs but no formal confirmation had been received to date. Jug Johal advised that he had spoken with the Local Authority Planning team at North Lincolnshire Council on the designs and he was working with clinical and capital colleagues on those. It had been agreed to proceed at risk on the design following discussions with NHSI/E but without formal confirmation of the capital allocation can do no more at this stage.

Ivan McConnell outlined additional schemes including Energy (£10m) and Digital accelerator (£5m) that had received confirmation of funding. Following discussions with Peter Reading and Terry Moran it had been agreed to establish a Trust Capital Board with programme boards reporting to it, namely aDigital Programme Board and a Core Capital Board. Ivan McConnell advised that he was the overall SRO and would follow cabinet office review process.

In terms of other schemes Ivan McConnell explained that as a result of a tender going out to market SGH MRI had to be delayed a month due to request for an extension. Briefing for contractors would take place later that day.

Jug Johal highlighted the strict timelines with some of the capital requiring to be spent by 31 March 2021 with the remainder by December 2021 but this does have risks.

Jim Hayburn highlighted that part of the capital spend does not have formal approval therefore he proposed that a paper was brought to the next F&P Committee in October 2020 outlining the level of risk. Whilst he supported Ivan McConnell and Jug Johal there needed to be a formal paper.

Action: Ivan McConnell / Jug Johal

BAF Risk Review – Risks 8 & 9

The risk review had been discussed in the previous item and it was agreed that no change was required.

Item 10 08/20 Business Planning & Performance

10.1 Clinical Support Services Use of Resources

10.2 Corporate Use of Resources

The above two papers were discussed jointly. Neil Gammon referred to the suggestion made the previous month by Jim Hayburn on the two areas that the Committee needed to be briefed on i.e. where the Trust is an outlier, either good or bad; and the process for resolution.

Kathryn Helley presented the reports and asked if the Committee were content with the level of detail provided.

Tony Bramley suggested that the both reports were too detailed for this Committee and he would have expected to see a summary of the work being undertaken, risk assessment and evaluation.

Linda Jackson supported these comments and asked if the report indicated that the Trust were in a better position. She went on to say that she would want to have a feel for the risk areas and whilst the general position had improved it would be useful if this could be summarised more clearly.

Kathryn Helley agreed to work with her team on this to be better focussed.

Action: Kathryn Helley

Item 11 08/20 Estates & Facilities

11.1 BAF Risk Deep Dive – Ventilation

Jug Johal presented the report which outlines the status of the risks associated with the safe management of the Heating and Ventilation and Air-Conditioning systems, which basically refers to theatre plant. An action plan was embedded within the paper and he advised that the majority of the actions were up to date.

There were no questions raised.

11.2 BAF Risk Deep Dive – BLM

Jug Johal presented the paper and highlighted that it was out of date and based on last year's information as the paper had previously been due to be brought to the Committee in April 2020.

Tony Bramley asked if the BLM gets solved through any other funding streams. Jug Johal explained that it is included within the Estates Strategy and referred to the six facet survey which had recently been refreshed and was now circa £91m. He went on to explain that when investment is made so much is taken up with design costs. leaving a smaller spend for BLM. A paper would be presented to Trust Board in December 2020 and will include the work done over the last 5 years; this will be brought to the Finance & Performance Committee in November 2020.

Action: Jug Johal

11.3 BAF Risk Review – Risk 7

A new item was noted i.e. Equipment risk – Ophthalmology Pentacam and Tony Bramley noted that this had been discussed at Q&S Committee in terms of replacement.

Stuart Hall referred to the energy centres at SGH and Goole (under Strategic Objective 4) and asked what was driving the risks. Was it because the contracts had expired or replacement boilers were required. In the BAF the risk at GDH was rated Red whereas at SGH it was Amber and he asked why not Red. Jug Johal explained that boiler servicing is on a rolling programme at SGH so provision is in place. This was not the case at GDH. He added that the SGH boiler was 29yrs old and is the main heat source into the main site so will need to be replaced prior to any potential new build.

Item 12 08/20 **Items for Information**

12.1 The workplan (v5) in the new rolling programme format was provided for information and noted.

Item 13 08/20 **Matters to Highlight to other Trust Board Assurance Committees**

There were no items to highlight to other Trust Board Assurance Committees.

Item 14 08/20 **Matters for Escalation to the Trust Board**

The following issues were agreed to add to the highlight report:

- CQC Progress Report
- Outpatient Transformation
- Integrated Performance Report
- NLAG Clinical Strategy 2020-24
- Strategic Development

Item 15 08/20 **Any Other Urgent Business**

There were no issues raised.

The meeting closed at 4.45pm

Item 15 08/20 **Date, Time and Venue of next meeting**

Wednesday, 30 September 2020 – 9.00am-12.30pm – Virtual Meeting

Attendance Record 2020/21

Name	*Apr 20	May 20	June 20	July 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	March 21
Neil Gammon		✓	✓	✓	✓							
Linda Jackson		✓	Apols	✓	✓							
Tony Bramley		✓	✓	✓	✓							
Stuart Hall		✓	✓	✓	✓							
Jim Hayburn		✓	✓	✓	✓							
Peter Reading		-	-	-	Apols							
Shaun Stacey		✓	✓	✓	✓							
Jug Johal		Apols	✓	✓	✓							
Ivan McConnell		✓	✓	Apols	✓							
Marcus Hassall		-	-	-	-							
Kathryn Helley		✓	✓	✓	✓							
Helen Harris			✓	-	-							
Brian Page		Apols	Apols	✓	Apols							
TOTAL ATTENDEES		**8**	**9**	**9**	**9**							

* Meeting Cancelled

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **30 September 2020 – via GoToMeeting**

PRESENT:	Neil Gammon	Non-Executive Director / Chair of F&P Committee
	Tony Bramley	Non-Executive Director
	Andrew Smith	Associate Non-Executive Director
	Jim Hayburn	Interim Director of Finance
	Jug Johal	Director of Estates & Facilities
	Ivan McConnell	Director of Strategic Development
	Kathryn Helley	Associate Director of Business Planning & Performance Management
IN ATTENDANCE:	Claire Hansen	Deputy Director of Operations
	Lucy Kent	Improvement Delivery Manager (for Item 5.1)
	Mike Simpson	Associate Director – Strategic Development (for items 5.3 & 5.4)
	Anne Barker	Finance Admin Manager (Minutes)

Item 1 09/20 **Apologies for Absence**

Apologies for absence were received from: Stuart Hall; Shaun Stacey (rep Claire Hansen); Linda Jackson; and Helen Harris

Neil Gammon welcomed Andrew Smith to the meeting who is a new Non-Executive Director and will be the Chair of the Finance & Performance Committee following Neil Gammon's departure at the end of November 2020.

Neil Gammon advised that all papers presented at the meeting today would be taken as read and in order to allow maximum time for discussion only changes and/or updates would need to be highlighted by presenters.

Item 2 09/20 **Declarations of Interest**

There were no Declarations of Interest.

Item 3 09/20 **Minutes of the previous meeting held on 27 August 2020 – Public**

The public minutes from the previous meeting held on 27 August 2020 were reviewed and agreed as an accurate record.

Item 4 09/20 **Matters Arising**

All actions were noted as included within the Agenda and there were no matters arising.

4.1 Action Log

The Action Log was reviewed as follows:

- 4.2 – *Additional KPIs to be added to IPR document.* Kathryn Helley advised that the Executive Team have agreed the new format and work is continuing to populate and determine indicators within it. It will include a single framework as well as the Trust priorities. There had been a slight delay due to a lack of capacity within the Information team and additional resource was being sought.

Tony Bramley asked for approximate timescales for completion of the revised IPR and if the trajectories would be recast to take account of Covid-19 impacts. This was confirmed. Kathryn Helley advised that the original timescale was 6 months but it was hoped that it could be reduced but until the changes were made then the current IPR would continue to be in place; noting that national guidance would have to be followed.

Ivan McConnell explained that a work plan sets out what would need to be done and by when and the team were looking at how data could be included in multiple formats where colleagues would be able to test what that would look like. He added that the challenge for Operations was feeding in the trajectories and scenarios.

Tony Bramley referred to the resource issue, in particular Alex Bell in the Information Team, and would fully support increasing that resource. Ivan McConnell explained that there are young analysts available across the system. Such skilled resources need to be harnessed to be shared across the system, and this was currently being considered.

Neil Gammon noted that a full update would be brought to the October F&P meeting.

- 4 – *Tender – Pathology Sexual Health & HIV*. Jim Hayburn advised that ongoing discussions are taking place with DOFs from both NLAG and ULH and the outcome would be brought to the October meeting.
- 5 – *Power BI log-ins to NEDs*. Jug Johal advised that these have all been issued. Training is to be rescheduled. **COMPLETE**
- 7- *Finance Report* – Agency and Locum costs to be split into Covid-19 expenditure v business as usual. Jim Hayburn advised that this is currently being undertaken but it had to be done retrospectively and should be available for the October meeting.
- 7 – *Finance Report – Finance Risks* – Whilst the financial envelope has now been received, conversations are taking place at ICS level. Deferred until the October 2020 F&P meeting for further update.
- 8 – CIP principles underpinning CIP savings. The methodology had been shared by Kathryn Helley with Stuart Hall. **COMPLETE**

Jim Hayburn advised that delivery of CIP plans by Divisions was discussed at the latest Performance Management Meetings (PRIMs). Medicine Division had been unable to deliver their plan for remainder of the year, citing current operational pressures. He suggested that the F&P Committee should undertake a deep dive. Tony Bramley and Neil Gammon were nervous about adding pressure on the Division. Jim Hayburn understood their concern but suggested that the workload would increase even more with the onset of winter and therefore it would be an opportunity missed if not taken now.

Kathryn Helley added that a plan is in place for FY20/21 CIP savings of £13m with a plan to achieve £10.4m, which currently is £500k short so she was asking Medicine Division to work up a plan noting that other areas are compensating for their shortfall.

9.30am Mike Simpson joined the meeting for Items 5.3 & 5.4

Kathryn Helley advised that work continues to identify the remaining gap, which will be difficult to bridge given winter and Covid-19 pressures.

Jim Hayburn highlighted that the CIP savings plan is in a relatively good position but it is not just about this year. The reason Medicine have huge savings to be made is that they did not deliver sufficiently on a recurrent basis last year and again this year. If progress is not made now, next year's (FY21/22) Medicine CIP will be an unachievable task.

Claire Hanson advised that the Medicine Division are expecting to attend F&P Committee in October and also agreed that this is the best time particularly with a new Interim DOF in post. Claire Hansen made a plea to the Committee that attendance at the meeting is not just a challenge for Medicine but is seen as working through the problems together. Neil Gammon agreed that Medicine Division should attend the Committee meeting in October and confirmed that it would be in an entirely supportive manner and asked Claire Hansen to brief the Division accordingly.

11.1 – *BAF Risk Deep Dive – BLM* – A paper would be presented to the Committee in November 2020 and Jug Johal asked that the title of this item should be Trust Estates Strategy. **Action**: Anne Barker

Following review and discussion the Action Log was noted.

Item 5 09/20 **Presentations for Assurance / Transformation Project Briefing**

5.2 Reference Cost Process and submission / SLR Utilisation

Jim Hayburn advised that whilst the Reference Cost Process is progressing there are considerable information gaps, with one of the issues being the ownership by Divisions of the costing process. Jim Hayburn explained that a steering group for costing would be established with representatives from across the divisions to ensure gaps are identified. He stated that as the Trust moves into a new finance regime costing, understanding the cost base is critical, potentially more important now than the contracting side.

Jim Hayburn explained that the deadline for Reference Cost submission is 16th October 2020 however that will inevitably include gaps. Tony Bramley stated that the issue in the past has been one of timescales. He felt it was essential for F & P Committee to see the full report prior to submission and quarterly updates were included in the workplan for that reason. Jim Hayburn advised that Zoe Plant is preparing a paper for TMB in October which will identify the process. That report would be brought to F & P Committee in November; It was agreed to add this to the Action Log and amend the workplan accordingly.

Action: Anne Barker

9.45am Lucy Kent joined the meeting for Item 5.1

5.1 CQC Progress Report

The report was taken as read and Lucy Kent was invited to update the Committee on any changes.

Lucy Kent advised that she had two main points to highlight. Firstly that progress during August was slower than desired, largely due to annual leave and the Divisions preparing for the CQC Board Development session on 1 September 2020. It is anticipated that improvement will be seen by November as reporting requirements are streamlined and workload reduced. Secondly, Lucy Kent highlighted discrepancies in that some actions had been enthusiastically signed-off by Divisions without going through the full process. Additional guidance is being provided to obviate this problem.

Tony Bramley referred to the F&P section (page 19) and suggested a sense of progress would be helpful on the front page.

He noted a general concern (page 2) regarding PADRs where pockets of non-compliance were noted at workforce committee and felt that reference was needed to that.

In terms of Number 2 on page 20, new to follow-ups, reference is made to recovery plans and CQC actual plan and he wanted to ensure that the two correlate but it is not clear how the two are aligned.

Lucy Kent acknowledged this is a major challenge and advised that she had linked with Vicki Quinn to ensure this plan mirrors the recovery plan and was reporting the same data through to the CQC plan. Lucy Kent highlighted the difficulty in accessing a single version of the truth and Tony Bramley raised his concern that given previous comments from CQC he would have expected this to be critical.

Kathryn Helley stated that it is important to put the Committee members' minds at rest that the single version of the truth is the IPR, noting that Power BI is a daily report so will obviously give a different figure from the IPR. A Phase 3 planning meeting would be taking place later in the week on how to monitor the plan and each Division would be able to see their progress.

Claire Hansen commented that NHSI/E colleagues are supporting Vicki Quinn and a task and finish group, including Divisional General Managers, was in place to monitor and improve the recovery position.

Jim Hayburn added that CQC costs would be discussed at a system meeting on how to take that forward and then a further meeting to confirm the right actions are being taken. Once agreement is reached then money will be identified to cover CQC costs. It was unclear at this time how much of those costs would be for the Trust to fund and how much for the system and this would be part of those discussions. Lucy Kent added that CCGs are to feed back to NHSI before finalising their budgets.

Neil Gammon asked that given the Trust had already incurred or planned to incur CQC costs and if CCGs and other system stakeholders do not agree to the funding, where does that leave the Trust? Lucy Kent referred to a meeting the previous week where this was discussed and an acceptance of the gaps and risk to be agreed.

Jim Hayburn had a slight concern on the discussions held the previous week and asked Lucy Kent to confirm that the discussion covered whether actions being taken are correct. Lucy Kent confirmed that the meeting focussed on quality aspects and whether they agreed with the Trust prioritisations, which would then feed in to the Finance colleagues at NHSI.

It was suggested that this particular aspect should be raised within the highlight report, noting that Q&S had a leading role in this.

Neil Gammon referred to the list of transactional changes needing to be made and embedded into the organisation and asked about the approach being taken. Lucy Kent advised that evidence would be collated on the work that had been done but was still a challenge to embed across all areas. She explained that this would be as rigorous as possible and whilst some changes had been adopted, getting appropriate evidence was problematic. Some Divisions had found it difficult to articulate the evidence clearly. The presentations to Trust Board, whilst helpful, were also a challenge for them, noting that the next session was due to take place on 3 November 2020.

10.05am Following review and discussion Lucy Kent left the meeting.

5.3 SGH MRI Full Business Case for Approval

Mike Simpson attended the meeting to present the paper, which was taken as read and there were no changes to highlight to those presented in the paper.

Tony Bramley asked for clarification on the information at the top of Page 5 of the report, specifically the Trust funding of £4.8m which included £59k already approved and asked if this left the Trust exposed on the gap; and also the fee line in the table that followed which he could not equate.

Mike Simpson explained that funding of £4.1m only is available from the centre and the tenders came in higher than originally thought leaving a gap at risk. Mike Simpson advised that all fees both professional and internal were against the actual budget and agreed to change for clarity before taking to Trust Board.

Jim Hayburn noted the £400k more than allocated but would expect the cost to come in at £4.1m and would then cover fees.

Jug Johal noted that based on the current infrastructure needs it was anticipated that contingency would be used to balance the figures, recommending that it would be the first call on core capital next year. That is what is recommended in the paper, which Ivan McConnell also agreed.

Tony Bramley noted that if there is a further call on capital expenditure this would be at the displacement of something else and asked what that would be. Jim Hayburn added that would support but was slightly concerned that removing core capital on a regular basis has a huge impact on the Trust that has high BLM requirements and equipment depreciation and there is a fundamental need to ensure expenditure is aligned to business cases.

Neil Gammon noted that one of the risks is the shortfall for £480k and should be included within the key risks listed in the paper.

Following the review, challenge and recommendations made by the Committee, the business case was approved as per the recommendations within the report i.e.

- Approval of a named principle contractor and named MRI scanner supplier subject to TMB, Trust Board and NHSE/I approvals
- Approval to commit to funding £421,020 from the Trusts Core Capital programme of 2021/22 to bridge the gap between pre-tender estimate and total funding envelope
- Acknowledge the timescales of submission of the FBC by 6 October 2020.

It was agreed that this item should be included within the highlight report.

5.4 AAU/ED Business Case

Ivan McConnell gave a brief update on the background and Mike Simpson highlighted the latest developments specifically the extremely tight timelines and requirements for external approvals; a requirement to spend £8m of the funding by the end of the financial year as well as capacity issues arising from the tight deadlines.

Tony Bramley questioned how the Trust is expected to deliver projects in this manner, with different timescales and constant changes. He likened it to “Alice in Wonderland”.

10.30am Lee Bond, Interim Director of Finance joined the meeting

Tony Bramley made reference to the difference in strength of business cases for the two sites but was taken aback by the proposed bed savings as the bed base is quite significant and asked for clarification on these two points.

Ivan McConnell advised that the ED scheme on-site costs are being revisited at the request of NHSI and he will report back to the Committee once that had been done.

In terms of the bed base Claire Hansen advised that the national data has been taken into account and deemed to be a robust model, noting that this is based on the AAU element.

Claire Hansen said that the bed base had been clinically challenged and a methodology agreed which is wrapped around the patient's needs, the same as emergency care principles which are nationally driven. The risk is the staff being able to work in that model but it is expected that by the time the new build is in place the hard work of changing behaviours and work modelling would have been done.

Tony Bramley added that it sounds like a really big challenge and would rely on that assurance.

Following discussion and review the Committee approved the OBC for AAU (within Annex 1); and approved the ED Business Proforma (within Annex 2), acknowledging the pace of the programme required verbal updates to the Committee on the document provided. This item was to be included in the Trust Board Highlight Report.

5.5 Trust Capital Programme 2020/21

Jim Hayburn presented the report and highlighted an error on page 1 (first bullet point) *…. Schemes with a value of just over £1m …..* should read £1bn.

Jim Hayburn explained that the risk of a shortfall of funding is being discussed with NHSI for additional resource, noting that the costs would have to come out of funding approvals and not core capital programme.

Tony Bramley referred to the £1.8m shortfall noting the reduction in BLM, which is already inadequate for what is required. Jim Hayburn advised that further discussions with the relevant Trust leads to determine how best to manage the position are underway and they would be reviewing risks against that.

Lee Bond queried the energy schemes that were awaiting approval and Jug Johal explained that NLAG is looking for funding of £10m through the NHSI decarbonisation fund, and currently waiting for confirmation.

The Committee noted the report, in particular the risks around the capital programme and additional staffing resource requirements to manage the programme.

5.6 Required Bed Base up to 31 March 2021

Claire Hansen presented the report which provided an explanation of the impact the recent pressures (including Covid) have had on the Trust's bed stock and the mitigation plans in place as part of winter planning.

Claire Hansen highlighted the key points including the reduction of the bed stock from 744 to 615 and the need to understand the bed plans through winter, how many beds in the community for support and what the shortfall might be.

Tony Bramley referred to the expectation of 40 community beds in both North East Lincolnshire and North Lincolnshire and asked if 80 would be enough or if more were expected and how realistic is the achievement of this figure.

Claire Hansen advised that confirmation had been received from NEL CCG with delivery group and Care Plus Winter Plan; discussions were ongoing with NL and the A&E Delivery Board were aware. The figure of 615 is back up to 660 due to red zones and opening of ward 29 and additional staff being brought back from shielding so the gap is not so big.

Jim Hayburn stated that the bed availability is critical to delivery of elective activity and part of the Phase 3 plan already submitted and asked Claire Hansen to explain the process of monitoring throughout the rest of the year. Claire Hansen explained that it would be discussed at NEL Covid-19 weekly meetings and NL monthly meetings and also reported to the Delivery Board.

Lee Bond asked if the bed numbers could be split down by the various Divisions to be able to determine where the risks are in each Division. Claire Hansen explained that the risks are mainly across Surgery and Medicine divisions equally, with paediatrics the concern in Women and Childrens.

Kathryn Helley advised that NL CCG had confirmed their support for 40 beds as part of the Phase 3 planning process, although the issue is their location.

Lee Bond asked if the beds provided in the community are the right kind of beds and are we able to use them. Claire Hansen confirmed that the NL beds are run by our own community teams and are the correct beds for short term placement before going elsewhere.

Following these discussions the paper was noted.

Item 6 09/20 **Integrated Performance Report**

Claire Hansen presented the report for discussion.

Tony Bramley referred back to discussions at last month's meeting regarding the source of reporting data in particular trajectories and timescales and what they mean in a Covid-19 setting and asked how the Committee can provide meaningful questions and comments.

Andrew Smith concurred with these remarks and acknowledged that trending may not be what it has been in terms of tracking and asked if this could be addressed by looking at other organisations. Kathryn Helley explained that information is shared across the ICS that highlights issues and ensures transparency, but agreed the need to look forward. Kathryn Helley further explained that different approaches have had to be made with Covid-19 and its impact, noting that this Trust is one of the few that have continued with cancer work and when comparing with other organisations this can be demonstrated. She agreed to raise this with the Information Team.

Neil Gammon noted that the report did not appear to have been updated since the previous month in some of the narrative under "To Do for next month" e.g. orthopaedic work already taken place and refers to 14 day isolation and he questioned if that was still the requirement.

Action: Kathryn Helley

Claire Hansen highlighted the outpatient stratification work that is in progress, with In-patients completed and outpatient ongoing. This will help patient follow up and identify which patients can go back to primary care and access secondary care when necessary. Support from NHSI is in place to take the initiative forward at pace.

Neil Gammon noted that ambulance handover does not seem to be improving and Claire Hansen agreed that it had been challenging for both EDs particularly in waiting areas and cubicles but ameliorative action is included within winter plans.

Jim Hayburn noted previous discussions on the increase in number of ambulances arriving with not the most appropriate patients and asked if this was still the case. Claire Hansen advised that this was being addressed through EMAS and A&E Delivery Board. Neil Gammon asked if this will be helped with "Talk before you Walk". Claire Hansen highlighted that minor benefits have been gained from the pilot sites around the country and it will depend very much on how the messages are given to the public.

Following review and discussion the report was noted.

6.3 BAF Risk Review – Risk 1

Tony Bramley referred to the risk stratification work on RTT performance still to be established and asked if timings could be advised.

Tony Bramley also raised cancer performance and in particular colorectal which was reported at Q&S Committee as a patient safety issue in theatres, noting the challenge faced during Covid-19 and asked if there is confidence that new arrangements will help. Claire Hansen advised that in terms of risk stratification the numbers are reviewed each week at the Deputy Managers meeting but unfortunately Surgery have struggled to make significant progress. Their increasing elective activity has taken them away from the risk stratification work that they were able to undertake during Covid-19. Stratification processes have been written and will be taken through Q&S Committee. Colorectal is challenging due to the large volumes and reduced access to endoscopy and consultants. Our own colorectal team has carried out much pathway work but there is still more to do around decision making of removing patients from waiting lists.

Lee Bond queried the strategic risk number 1 rating of 20 which he suggested was very high and would assume a catastrophic risk. Neil Gammon explained that the rating had been discussed previously by the F&P Committee and agreed that 20 was appropriate but suggested to Claire Hansen that given the reduction in the Trust's SHMI position this could be reviewed.

Tony Bramley acknowledged that the SHMI score had improved over the last few months but thought this rating was partly due to the potential patient harm issue where thousands of patients had to be reviewed. Given the reality was the actual levels of harm were very small and therefore probability of harm seemed to be low, although noting that Dr Kate Wood was still concerned about the unknown.

Jug Johal commented that the Trust SHMI score was now in the mid-range, although this had only happened over the last few months and the data quality issue and the thousands of clinical harm reviews had just been completed so agreed a good challenge and worth a review of the risk rating.

Andrew Smith asked if the waiting times and waiting lists had also been a driver for the high score. Claire Hansen advised that it was a combination of all risks, clinical harm, waiting lists, staffing fragility of some services but agreed with the Committee's view that it was worth a review of the risk rating.

Neil Gammon asked Claire Hansen to look at the risk rating and it was agreed that Dr Kate Wood and Ellie Monkhouse should be consulted through Q&S Committee.

Jim Hayburn suggested that it was not just about this one risk rating but whether consistency across the organisation was being applied, suggesting that the organisation is probably quite cautious about risk rating.

Neil Gammon proposed to raise within the highlight report and also contact the Trust Secretary to suggest that she may wish to undertake a review, which was agreed.

Action: Neil Gammon

Tony Bramley to speak with new chair of Q&S.

Action: Tony Bramley

Item 7 09/20 **Finance Report – M05**

Jim Hayburn presented the report, which was similar to previous reports of a balanced financial position for August 2020 with additional top up funding of £800k. The Trust incurred £1.5m additional expenditure relating to Covid-19 in-month with £700k underspend. Jim Hayburn noted that, worryingly, activity had decreased considerably during August but plans are in place to improve on that position. Better payment practice code performance continues to improve with NHS invoices paid within 30 days improving from 83% to 88% and non-NHS from 79% to 81% in August 2020 compared with July 2020.

Jim Hayburn also noted that divisional performance information is not included in the finance update as this is now completed quarterly. More in depth information will be presented at the November 2020 F&P Committee.

Tony Bramley queried the status with the SoD/SFIs and Jim Hayburn confirmed that this had been implemented on 7 September 2020 when all budget holders were written to; there had been no obvious adverse impact.

Neil Gammon referred to the pay expenditure trends in nursing (page 14) and noted that the figures for August were the worst for 2 years. Jim Hayburn explained that when Covid-19 costs are excluded this brings it back in line. However, overall staffing costs are an issue with recruitment plans unable to be fulfilled, whilst a reduction in beds does not necessarily result in a reduction in nurses.

Claire Hansen highlighted that BAME risk assessments are being undertaken and have reduced some of the work that particular staff can undertake. Additionally, August has been the first month that staff have been taking significant leave which may also be a factor. Jim Hayburn stated that budgets do allow for annual leave so there must be other reasons contributing to the overspend.

Lee Bond asked Jim Hayburn if the Covid-19 expenditure table could be split month by month to get a profile for the first five months. Jim Hayburn advised that this has already been done and he would ask Matt Clements to forward it to him.

Action: Jim Hayburn

Following review and discussion the report was noted.

7.2 BAF Risk 6

Jim Hayburn advised that the risk rating was currently 12 and this will be reviewed once the financial rules, instructions and information on the latter part of the year is confirmed. Jim Hayburn advised that conversations are underway with the ICS finance team with a plan to be agreed in October. Following that a risk assessment will be conducted on the potential to achieve the financial plan.

Item 8 09/20 **Savings Programme 2020/21**

The Savings Programme paper was taken as read and questions sought.

Neil Gammon referred to the CIP Development Summary (page 4), which states that the Trust CIP would be reviewed when guidance is received and Kathryn Helley confirmed that discussions had been held on the financial plan for the remainder of FY 20/21. She intended to discuss this with Lee Bond as soon as possible.

Neil Gammon also referred to the summarised Risk Register and Issues Log (page 7), in particular non-pay procurement opportunity risk and Kathryn Helley explained to the Committee that a decision needs to be made as to whether this should be pursued.

Tony Bramley referred to the summary CIP position by workstream (page 5) and the under delivery in areas including medical staff and clinical productivity and the CIP run rate position (page 6) which states that the under delivery is mainly due to the unidentified CIP. He asked whether his assumption that this relates to unidentified schemes rather than under delivery of plan was correct. Kathryn Helley confirmed that the majority of the shortfall is due to lack of a plan to achieve a £13m saving with some under delivery of schemes as well.

Following review and discussion the CIP savings programme position and development of 2020/21 plan was noted.

Item 9 09/20 **Strategic Development**

9.1 System Capital Programme and Governance

Ivan McConnell presented the report which outlined the Trust Capital Programme and Governance and the current scale and status of the projects/schemes. Ivan McConnell gave a brief summary of the schemes.

The report also included the major capital timelines and a proposed capital governance structure, which was noted, was in draft form awaiting approval.

Terms of Reference were currently being drawn up with the Trust Secretary.

Tony Bramley referred to the proposed membership and quorum of the revised Capital Investment Board and noted that it states that *the Chair of the Trust shall not be a member of the Board* (4th bullet); this should also include the Chair of ARG Committee being excluded as a member of the Capital Investment Board.

Tony Bramley referred to the proposed Capital Governance Structure chart and the Trust Capital Board chaired by a NED or CEO; this should be a NED and should report to F&P in the first instance therefore the Chair of the Capital Board should be the Chair of F&P. Mike Simpson acknowledged the governance structure is work in progress and welcomed this input.

Neil Gammon referred to the proposed membership of the Capital Investment Board (page 2) and questioned if there was enough clinical input. Mike Simpson advised that the Medical Director would be included on the Board.

Following discussion and review the committee noted the report.

9.2 BAF Risk Review – Risks 8 & 9

Ivan McConnell advised that the draft Trust Clinical Strategy is currently going through consultation process both internally and externally and was content on the risks' mitigation activities.

Neil Gammon asked for an update on the progress of the Finance Strategy. Jim Hayburn advised a small working group has been formed, led by Brian Shipley, to take this forward. The clinical model is now in place thus meetings are taking place with Divisions to discuss plans; it is anticipated that a draft financial strategy will be available by December 2020. Jim Hayburn added that a workforce plan would also need to be included.

12.05 pm Lee Bond left the meeting.

Item 10 09/20 Business Planning & Performance

10.1 Phase 3 Planning Submission

10.2 Plan Commentary – Humber Partnership

Kathryn Helley presented the reports which included the Trust's Phase 3 Planning submission including the Trust Recovery key risks and assumptions, final template detailing activity, workforce and performance against national targets.

Kathryn Helley explained that the second document, the Plan Commentary – Humber Partnership had been included to provide context and additional detail.

The Committee reviewed and discussed the reports and Ivan McConnell and Kathryn Helley provided detailed responses to queries.

It was agreed to add to the highlight report that the papers had been received.

Item 11 09/20 Estates & Facilities

11.1 BAF Risk Deep Dive – Fire

Jug Johal presented the report and advised that the Fire Safety report had been presented at both ARG Committee and Trust Board.

Noteworthy progress was being made on the fire action plan with significant investment being made over recent years. Jug Johal highlighted that £3.6m Critical Infrastructure Risk (CIR) funding had been secured and £2m would be allocated to upgrade the fire alarm systems.

Andrew Smith referred to section 3.0 Fire Systems surveys which identified a potential risk of a fire on the ground floor spreading to other levels including theatres and asked if Jug Johal was comfortable with the timescales to progress this work. Jug Johal advised that the Theatres in the Coronation Block in SGH are not used as these and the orthopaedic wards were decanted from there about 18 months ago.

Following review the report was noted.

11.3 BAF Risk Review – Risk 7

There were no issues raised within this risk.

Item 12 09/20 **Items for Information**

12.1 F&P Workplan 2020/21

Tony Bramley highlighted that IT and Information (page 3) items a) IT/Digital Strategy; and b) Cyber Security would now be included within the ARG Committee and therefore should be removed from the workplan.

Action: Anne Barker

Subject to this amendment the workplan was noted.

Item 13 09/20 **Matters to Highlight to other Trust Board Assurance Committees**

There were no items to highlight to other Trust Board Assurance Committees.

Item 14 09/20 **Matters for Escalation to the Trust Board**

The following issues were agreed to add to the highlight report:

- Development of IPR
- CQC Progress Report
- SGH MRI and AAU & ED Business Cases
- Phase 3 Planning Submission

Item 15 09/20 **Any Other Urgent Business**

Neil Gammon noted that this was Jim Hayburn's last working day for the Trust and wished to place on record on behalf of the Committee, thanks for his sterling support over the past year and to wish him the very best in his future moves. It was agreed it had been a pleasure and a privilege to work with Jim Hayburn.

The meeting closed at 12.30pm

Item 15 09/20 **Date, Time and Venue of next meeting**

Wednesday, 28 October 2020 – 9.00am-12.30pm – Virtual Meeting

Attendance Record 2020/21

Name	*Apr 20	May 20	June 20	July 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	March 21
Neil Gammon		✓	✓	✓	✓	✓						
Linda Jackson		✓	Apols	✓	✓	Apols						
Tony Bramley		✓	✓	✓	✓	✓						
Stuart Hall		✓	✓	✓	✓	Apols						
Jim Hayburn		✓	✓	✓	✓	✓						
Lee Bond						✓						
Peter Reading		-	-	-	Apols	-						
Shaun Stacey		✓	✓	✓	✓	Apols						
Jug Johal		Apols	✓	✓	✓	✓						
Ivan McConnell		✓	✓	Apols	✓	✓						
Marcus Hassall		-	-	-	-	-						
Kathryn Helley		✓	✓	✓	✓	✓						
Helen Harris			✓	-	-	Apols						
Brian Page		Apols	Apols	✓	Apols	-						
TOTAL ATTENDEES		**8**	**9**	**9**	**9**	**7**						

* Meeting Cancelled

MINUTES

MEETING: Northern Lincolnshire and Goole NHS Foundation Trust
Audit, Risk and Governance Committee

DATE: **22 October 2020 –** via GoTo Meeting

PRESENT:	Tony Bramley	Chair of ARG Committee / Non-Executive Director
	Michael Whitworth	Non-Executive Director
IN ATTENDANCE:	Andrew Smith	Associate NED
	Stuart Hall	Associate NED, NLAG / Vice Chair HUTH
	Brian Shipley	Deputy Director of Finance
	Helen Harris	Trust Secretary
	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)
	Jon Machej	External Audit - Manager (Mazars)
	Sue Meakin	Data Protection Officer & Lead for Information Governance (For Items 6.3 and 6.4)
	Alison Hurley	Membership Manager (For Item 6.2)
	Ivan Pannell	Head of Procurement (For Items 6,4; 6.5; and 6.6)
	Liz Houchin	Freedom to Speak Up Guardian (For item 6.10)
	Becky Southall	NISI/E Governance Lead (Observer)
	Lynn Arefi	Executive Personal Assistant/Administrator (for the minutes)

The Chair opened up the meeting and welcomed Andrew Smith, new Associate NED and Becky Southall from NHSI/E observing the meeting.

Item 1 10/20 **Apologies for Absence**

Apologies of absence were noted from Neil Gammon, NED, and Lee Bond, Chief Financial Officer.

Item 2 10/20 **Declarations of Interests**

There were no declarations of interest made.

Item 3 10/20 **Minutes of the previous meeting**

The minutes from the meeting held on 23 July 2020 were reviewed and accepted as a true record. The Highlight report which was presented to the Trust Board was noted.

Item 4 10/20 **Matters Arising / Review of the Action Log**

4.1 Action Log

The Action Log was reviewed as follows:

Page 2 – 5.5 PO and non PO data: Brian Shipley confirmed that this would be discussed at the PRIMs meetings with Trust wide comms being drafted to circulate with the wider Scheme of Delegation. It was agreed that this could now be removed from the action log.

Page 3 – 7.1 A&E 4hr Wait Performance: This referred to recording of data. Tom Watson confirmed that the follow up review had commenced but they were experiencing delays in receipt of data to allow for checks of the quality of the data due to COVID19; once the audit work is finalised the report will be brought back to the ARG Committee in January 2021. The Chair acknowledged the delays and asked Tom Watson to liaise with Sally Stevenson should he have further difficulty in obtaining the information to enable escalation as appropriate.

ACTION: Tom Watson

Page 4 – 5.1 Contracting Income: This is now not relevant for this financial year. The Finance & Performance Committee have agreed to keep it under review. It was agreed that this item could be removed from the action log.

Page 4 – 6.1 Risk Management Strategy Annual Review: Helen Harris confirmed that this is an ongoing process with target dates being added. It was agreed that this could be removed from the action log.

Page 4 – 5.3 Annual Security Report: The Workforce Committee takes place week commencing 26 October 2020. It will be left on the action log and await update from the Workforce Committee at the next ARG Committee meeting.

Page 5 – 8 Losses & Comp Report: Update received regarding Pharmacy fridge deviation losses. Agreed to remove from action log and restart action if required.

Page 6 - 11.1 Internal Audit Progress Report – Establishment Control: It will be left on the action log and await update from the Workforce Committee at the next ARG meeting.

Following review the Action Log was noted.

Helen Kemp-Taylor joined the meeting.

Item 5 10/20 **Management Reports for Assurance – Items for Approval**

5.1 There were no Management Reports for approval.

Item 6 10/20 **Management Reports for Assurance – Items for Discussion**

6.1 Annual Review of Trust's Cyber Security Arrangements

The Chair advised that this item was deferred until the new CIO had started in post in November 2020.

6.2 Quarterly Document Control Report

The Chair welcomed Alison Hurley, Deputy Trust Secretary to the meeting and invited her to outline the Quarterly Document Control report. Alison Hurley went on to note that since the report was submitted the position has slightly improved achieving 91% against a target of 90%. In terms of progress since the last meeting Alison Hurley advised that they continue to address the backlog and meet with divisions; policies will be updated within 3 months with patient leaflets and other clinical documents updated within 3 to 6 months; these have also been added to the document control register to ensure a more robust position. Alison Hurley drew the Committee's attention to the current position with Surgery and Critical Care (S&CC); this will take slightly longer to address than the other divisions due to the volume, but they have agreed to do as soon as possible.

Andrew Smith thanked Alison Hurley for the superbly formatted report and posed the question should the analysis be risk-weighted rather than a generic assessment, i.e. overdue documents by virtue of importance linked to the activity of the Trust. Alison Hurley advised that Jonathan Darley, Trust Document Controller was responsible for the format of the report, and confirmed that they do go through the areas one by one to address priorities and would escalate with each division and agree timescales. Andrew Smith added that it would be useful to highlight particular concerns.

Stuart Hall noted that there were 30 documents still overdue from 2015; and also queried how many of those coming up for review in 3 months related to S&CC. Stuart Hall went on to add that many people responsible for these in 2015 may not even be with the Trust anymore and it needs to be addressed carefully. Alison Hurley acknowledged Stuart Hall's comments, adding that she did not have the available data with her, but confirmed these are being addressed one by one. A brief overview will be included within the next report to highlight any significant overdue documents.

ACTION: Alison Hurley

Michael Whitworth added that the position had improved since he started with the Trust, but because of the volume still overdue he queried which were the critical ones that the Trust should be focussing on; and also that this was a factor within the last CQC report and also included within the CQC action plan.

The Chair suggested that this be included within the Highlight report to the Trust Board, as there were the same areas with problems, it was a CQC action, there is the potential for the issue to impact on both patient safety and patient experience and we are unable to tell which ones are a priority for addressing. Divisions need to *"get a grip and with pace"* in completing.

ACTION: To include on Trust Board Highlight Report

9.55am Alison Hurley left the meeting.
9.55am Sue Meakin and Mark Surridge joined the meeting.

6.3 IG Steering Group Highlight Report including Status of Annual IG Toolkit Return Submission

The Chair welcomed Sue Meakin to the meeting. Sue Meakin highlighted the key points of the report; submission of the Data Security & Protection Toolkit (DSPT), an improvement plan had been issued with dates agreed with IT Services. Sue Meakin advised that there was movement on the penetration testing which would see lots of actions completed. Training is not included in the improvement plan as 95.4% compliance had been reached; this was a huge achievement and hopefully the momentum would continue until the new toolkit is released. The new toolkit was expected imminently. Next year's submission date has been extended to June 2021 with a baseline assessment due in February 2021. The improvement plan will be closely monitored by the IG Steering Group and Digital Services Risk and Governance Group. Caretower, who are the external Management Security Services with whom the Trust has a contract, has been approached to review a number of the responses to assertions within the plan to assist in achieving compliance, they have been appointed also to undertake the penetration test.

Sue Meakin then moved on to advise that the Trust had been notified of quite a number of IG incidents this year although none has required reporting to the ICO. However the Trust had received a response from the ICO regarding the RTT incident which was submitted in February 2019. Sue Meakin added that she wanted to draw this to the Committee's attention as the Trust very nearly received a substantial financial penalty due to the number of incidents the Trust had submitted linked to clinical system failures; the Trust need to improve and be very careful going forward in ensuring it has things in place for clinical systems.

Sue Meakin noted that data flows are under constant review throughout the organisation.

Sue Meakin then went on to update the Committee on *"Axe a Fax"*. There are three remaining fax machines within the Trust and she is working with the relevant departments to see if they can be removed by providing an alternative.

Sue Meakin advised that the new IG reporting had been added to the report; a lot of work has gone into this and Sue Meakin extended her thanks to Linda DaCosta for her time and effort on this. The next stage would be to identify the key offenders, directorates and areas that they could work with.

The Chair noted a big credit was due for the efforts made by all divisions and departments for the achievement of the 95% mandatory training compliance rate.

Andrew Smith thanked Sue Meakin for a good report and congratulated Sue Meakin for dealing with the ICO. It was commented that the ICO were exercising a degree of tolerance due to Covid-19. The Trust has had a few near misses with the ICO and if they were to take any action in the future the impact on the Trust could be substantial both in terms of financial and reputational damage. Andrew Smith posed the question of whether the current position (DSPT not compliant status) was something that the Trust Board are comfortable with and should the ARG Committee be looking to the Trust Board for more support, adding that this gave him cause for concern as a risk practitioner. Sue Meakin completely agreed with Andrew Smith's comment, stating that the ICO would look at the DPST if there were further issues, and added

ultimately it is a resource issue. The more awareness the organisation has about the gaps the better prepared the Trust will be. Sue Meakin stated that NHS Digital approve the action plan, however there is a bigger picture and this is something that the new CIO will be looking at when they start in post in November 2020.

Stuart Hall went on to note that the IG problems the Trust faced need to be re-emphasised; the consequences for the Trust in relation to financial penalties could have been significant which was a real concern. Sue Meakin advised that upon receipt of the ICO outcome, she had contacted the ICO to ask for further understanding of what the outcome could have meant and they had advised of the potential for a fine, etc. Andrew Smith commended Sue Meakin for going back to the ICO to gain a better understanding, which he said was the right thing to do.

Stuart Hall also commented that there was a need to axe the remaining faxes as soon as possible, and the Chair echoed this.

The Chair thanked Sue Meakin for the report. The Committee advised that it would not expect to see any fax machines in operation within the Trust the next time the Committee meets in January 2021.

The Chair acknowledged how close the Trust had "sailed to the wind" in respect of the ICO; this will be highlighted to the Trust Board and flagged as a concern.

ACTION: To include on Trust Board Highlight Report

10.05am Ivan Pannell joined the meeting.

6.4 Data Breach Issue Outcome

Sue Meakin advised that this was in relation to the investigation of the inappropriate access of WebV. HR concluded their investigation and 198 sanctions will be issued to staff, on the basis that they had not been able to justify their access, their justification was not considered appropriate, or they had left the PC logged on. A number of actions have been put into place linked to the technical side with mitigating actions in place and they will continue to work with staff and issue warnings that, if staff are found to be abusing their access rights to clinical information, there will be serious consequences. Sue Meakin added that she was comfortable, as a Data Protection Office (DPO), that the Trust had done what they could. CCGs have been made fully aware of the outcome.

The Chair added that this was an area of interest to the Trust Board and would be included within the Highlight report. The Chair noted that this was a serious incident for the Trust and was comfortable in how it had been handled and the outcome, adding that there has been lots of comms to staff from the CEO. Andrew Smith asked if the sanctions were known throughout the Trust and had there been any comms. Sue Meakin confirmed that comms had been sent through the CEO to all staff. Andrew Smith commented that it was also good that the IG training was on a positive trajectory. Helen Harris asked if additional training for those staff involved had been identified. Sue Meakin thought that a breach automatically flags up the need to repeat IG training but she would confirm with Human Resources.

In relation to the conclusion part of the report the Chair asked for an IG update to be presented to the next meeting.

ACTION: To include on Trust Board Highlight Report

10.15am Sue Meakin left the meeting.

6.5 Waiving of Standing Orders Report

The Chair welcomed Ivan Pannell to the meeting and invited him to outline the Waiving of Standing Orders report. Ivan Pannell took the report as read noting that there was a reduction in this quarter compared with the last report which had been exceptional due to the impact of Covid-19. Stuart Hall queried four waivers which related to clinical coding, and whether there was any specific reason for this and why waivers had been raised and the proper process not followed. Ivan Pannell confirmed these were connected to the continuity of some Grant Thornton work around the SHMI scoring and additional support surrounding this. The Chair

stated that he would be concerned if they continued with waivers for existing arrangements. Brian Shipley responded by confirming that it was part of a clinical coding plan to improve the accuracy of coding and that it should be time limited and would therefore not be extended.

The Chair also expressed his continuing cause for concern in relation to the Amvale Patient Transport contract and the amount of waivers that continue to come through to the Committee. It appears that the transport side of the contract never seems to get bottomed and seems to just "roll on", and that a lot of money has gone through to Amvale on waivers. Stuart Hall shared the Chair's concerns over this.

6.6 Invoices without Purchase Orders Report

The report was taken as read. Ivan Pannell advised that the non-purchase order figure seems to be creeping up slightly; with clinical support services and Estates and Facilities being the main culprits. Procurement will work more closely with the divisions to understand the background and drive this figure down, although this would need to be done in a supportive way at present.

Andrew Smith raised a concern that the failure rate by volume was higher than by value in terms of invoices with no purchase order; querying how would this be addressed. Ivan Pannell agreed that he would propose to identify those with the large area of spend initially and then understanding the individual picture and underlying issues and work with the divisions going forward, acknowledging that it was quite a significant undertaking to delve into the detail.. Ivan Pannell stated that there was a mixed bag across the board, but that there were some areas for immediate focus to understand the underlying issues. Andrew Smith commented that it would be good to know if systemic issues were present.

The Chair thanked Ivan Pannell for the report and requested some additional narrative around the two areas of potential concern as discussed, along with details of work being done to address it, for the next meeting.

ACTION: Ivan Pannell

6.7 '400 Contracts' Progress Report

Ivan Pannell gave a brief update on the position on the Contracts Register. Refinement to the register is taking place but there is a significant amount of work still to be done. The report was pulled together with what the position will likely be at the end of the financial year as requested at the last ARG Committee; identifying high risk and urgent contracts and increasing the threshold.

As referred to earlier on in the meeting, Amvale has 3 contracts which are currently out to tender; the paramedic equipped 24hour discharge ambulance; cross site shuttle and courtesy care service. Ivan Pannell added that he had also identified a couple of other high value and high risk contracts including immunology, car parking and security, and outpatient's Lloyds Pharmacy. Successful contracts awarded recently included blood transfusion and testing and Med Locums.

Ivan Pannell noted that this is a live document which requires significant time to ensure it is kept updated whilst at the same time supporting the organisation with lots of new, fast moving capital projects such as the new ED's.

The Chair thanked Ivan Pannell for the report and added that this report had come on "leaps and bounds" within the last 18 months and extended his thanks to both the Procurement team and Finance team for the significant amount of work that had gone to turn this around, especially during the last 6 months. The Chair added that the report had made sense of the position which was really reassuring, whilst not underestimating the amount of work done.

Andrew Smith reiterated the Chair's comments, stating that it was a powerful governance mechanism. Andrew Smith went on to ask that, given the positivity and progress, along with the scale of the capital investment within the Trust, is the Procurement team adequately resourced to move forward on this or would they come under pressure. Ivan Pannell added that the Procurement team is relatively small and already under pressure with Covid-19 issues, however

there are plans to bolster the team on a permanent basis which would hopefully align the team to be "fit for purpose" and aligned to categories of spend throughout the Trust. Brian Shipley added that the Trust must not underestimate the impact Covid-19 and PPE issues had on the Procurement department. Hopefully, now Lee Bond is with the Trust joint working with HUTH may be a possibility especially given the large capital programme.

Stuart Hall commented that the approach was commendable. He queried the Amvale courtesy car service for £97k and asked what is it and why do we do it. Ivan Pannell confirmed that this was a patient courtesy car service and will be picked up within the transport review within Estates and Facilities. The Chair added that this was driven by service configurations to other sites, and had been needed to fill a gap, but needed resolving.

The Chair brought this item to a close by suggesting this is highlighted to the Trust Board; to advise that the Committee has a lot more confidence in how this is being managed. However concern remains about the issue of capacity within the Procurement team given the unprecedented demands of dealing with Covid-19 issues and the scale of capital investment happening in the coming months, and such concerns would remain until the matter is resolved.

ACTION: To include on Trust Board Highlight Report

10.45am Ivan Pannell left the meeting.

6.8 Salary Overpayment Report

Sally Stevenson spoke to the circulated paper noting that, since the last meeting there had been a serious spike in staff overpayments. There were a total of 408 staff overpayments involved in one particular overpayment issue, these were part of the national transition from Band 1 to Band 2 and totalled £95k. This was a result of human error by the Payroll Officer involved, and recovering all overpaid monies is currently taking place. Sally Stevenson added that the transition from Band 1 to Band 2 had been a complicated exercise and the error was picked up within the monthly budget meetings.

Stuart Hall referred to the non-compliance letters issued on page 5 of the report and asked why there had been no contact from some managers receiving the letters. Sally Stevenson confirmed that this had been picked up at a previous ARG Committee and the letter which is sent has been changed asking the recipient to contact her for the details of the overpayments involved. The ones showing no contact on the report therefore pre-dated the change in the letter or had only recently been issued. Sally Stevenson confirmed that the change in the letter was working,

The Audit Committee received and noted the Salary Overpayment Report.

6.9 Hospice Payroll Services Update

The Chair opened up this item by giving the Committee some background information. It had been brought to the Trust Board's attention earlier this year that there was an issue with one of the hospices not paying their payroll bill on time and therefore the Trust in effect were "bank rolling" the hospice. The sums involved had become quite considerable.

Sally Stevenson went on to note that meetings had now taken place with both Lindsey Lodge Hospice and St Andrews Hospice and it had been agreed that provision of payroll services would cease in March 2021, which would give them sufficient time to obtain a new payroll provider. Sally Stevenson did add that Lindsey Lodge Hospice now pay the Trust upfront for their payroll bill.

Sally Stevenson asked if the Committee would want another update in January 2021. The Chair confirmed he was content with the way forward and therefore did not require any further update. He did add that he would like to include this in the Highlight report to the Trust Board.

ACTION: To include on Trust Board Highlight Report

Item 7 10/20 **Management Reports for Assurance – Items for Noting**

7.1 Hospitality and Sponsorship Declaration

Helen Harris referred members to the circulated report and went on to note that due to the on-going Covid-19 situation there were not a lot of declarations coming through, however some that had come through had been challenged Helen Harris noted that this reporting would now be managed through the office of the Trust Secretary since taking over responsibility for it.

Item 8 10/20 **Losses and Compensations Report**

Brian Shipley was invited to outline the report. The report covered the first two quarters of this financial year. The main point to highlight was the drug wastage; the remote monitoring of the fridges had now been resolved as WIFI stability is now improved. The human element of drug wastage may need a Comms exercise to reiterate that drugs should not be left out of fridges. The Chair noted that this has also been discussed through the Quality & Safety Committee. Following review the report was noted and the Chair advised that the Committee would keep a continued focus on the drugs' fridges' issue.

Item 9 10/20 **Review of Board Assurance Framework and Strategic Risk Register**

The supporting paper was taken as read. Helen Harris advised that Becky Southall who was observing the meeting would be working with Helen on a full review of the BAF, as she felt it could be streamlined. Helen Harris also informed the Committee that she would be taking on the additional role of performance monitoring. The BAF does go through regular review and it has been received by the Trust Board and sub committee's with deep dives being carried out on Strategic Objective 1 and 2 which has further levels of assurance.

The Chair asked where the Brexit risks would be reported, to ensure adequately governed. Helen Harris noted that this was a good point and it may be that each committee may be responsible for reviewing but overall may be Trust Board.

Andrew Smith asked if the BAF and Strategic Risk Register were one in the same or is there a separate risk register. Helen Harris noted that there is a fundamental amount of work that is required and agreed that these do need to be split. Once the review is completed, hopefully by April 2021 things should be a lot more streamlined. Andrew Smith offered to talk further to Helen Harris about this outside of the meeting. The Committee noted the report and that there was no change in ratings. It was further noted that the report was under review and to be streamlined. The Chair suggested that the issue of where Brexit risks were discussed/adequately governed should be highlighted to the Trust Board.

ACTION: To include on Trust Board Highlight Report

11.05am the meeting was adjourned for a comfort break
11.15am the meeting reconvened and Liz Houchin joined

The following item was taken out of sequence on the agenda

6.10 Annual Review of Trust's Freedom to Speak Up Arrangements

The Chair welcomed Liz Houchin, Freedom to Speak Up Guardian to the meeting. Liz Houchin took the supporting paper as read and went on to highlight key issues from the last 12 months. A permanent appointment of a Freedom to Speak Up Guardian had been made which makes it the first time that the Trust has had a dedicated Guardian. There were plans to have a deputy but following an options' appraisal it was felt that the use of Champions would be more beneficial. The Freedom To Speak Up policy and procedure has been reviewed and amended with a new strategy written which, subject to minor amendments, had been approved by the Trust Board. The policy was attached to the report for the Committee to note the process.

During the last year Liz Houchin reported that 70 concerns had been raised which was an increase on the previous years of 35; showing that more staff are having confidence in the service. Liz Houchin added that it was important for staff to know that they all have an equal voice.

Next steps will be to look at the rolling out of the training package for all staff in the coming months, which will become part of the Trust's mandatory training. Liz Houchin added that she would become more proactive working alongside the Pride and Respect Lead and the Quality and Diversity Lead to ensure the Freedom to Speak Up message is promoted throughout the Trust to all staff groups.

Stuart Hall queried when something has been investigated and actions drawn from this, how do we know the actions have been implemented and lessons learnt. Liz Houchin added that this is something that the Trust need to ensure is completed; all divisions are informed of any concerns raised and actions from these concerns in the hope that learning from these would be rolled out across the divisions. There is some work to ensure that the change has been effective. Liz Houchin suggested that she would go back to the National Guardian office to seek their advice on how the Trust can ensure the steps we are taking have become embedded within the organisation.

The Chair asked if there were any hotspots in terms of areas or sites as this information would be useful for context and suggested a brief analysis of themes may be helpful, obviously not wanting to break any confidences; Liz Houchin confirmed that this was covered within the annual report to the Trust Board. Last years' top themes were around HR processes not being applied; bullying and harassment issues and patient safety.

The Committee received and noted the report.

11.25am Liz Houchin left the meeting

Item 10 10/20 **External Audit (Mazars)**

10.1 General Progress Report

Mark Surridge advised the Committee that there was not a huge amount to report since the last meeting; with uncertainty on national guidance still prevailing. Work continues with the Finance team on the original plan and timetable. Mark Surridge commented that he did not see anything new for the Finance team other than working through the potential impact of COVID, revenue recognition and agreement of balances. In terms of assurance for the Committee Mark Surridge confirmed that resources were in place to deliver the external audit on time. Brian Shipley went on to add that the revenue risks will be minimum for the second half of the year as the Trust remains on block contracts with commissioners so agreement of balances should be straight forward.

Andrew Smith added that he would like to see the internal control framework (Covid-19), given the context the Trust are currently working in.

10.2 Review of NAO Guidance of Financial Reporting and Management during Covid19

Jon Machej spoke to the supporting paper which, following receipt of the NAO guidance by the ARG Committee at their July 2020 meeting, a request was made for the contents to be reviewed by the External Auditor. Jon Machej explained that it had been a high level review of how the Trust stacks up, and he concluded that it stacked up pretty well as there were very few issues for the Trust. Review comments were embedded within the paper. Areas for further review either by the Finance team or Internal Audit were highlighted as:

- Contracts review to identify any that may be onerous and require providing against, could be combined with the on-going contract register review.
- Review of the Trust's business and financial planning processes for 2020-21 and its response to Covid-19.
- Review of the changes to the Trust's Internal Control Framework in response to Covid-19.
- Reflect Covid-19 within the Annual Report

Jon Machej added that apart from the above there were very few issues that the External Auditors thought the Trust should consider; these obviously were the Auditor's comments and should not detract from the fact that the Trust should carry out their own review of this guide to ensure it is comfortable with the issues.

Brian Shipley noted that the contracts' review would dovetail with the work that would be carried out by Ivan Pannell and the Procurement team. A paper which sets out the financial plan for the remainder of the year would be presented to the Finance & Performance Committee at the end of the month. Brian Shipley went on to add that the Planning Guidance for the next financial year would be very late and therefore assumptions used for long term planning for the financial framework.

A common approach will be used on the Internal Control Framework; the Covid-19 expenditure is signed off at Executive Level and has recently been audited; although other control processes may need further work.

Tom Watson confirmed Brian Shipley's comments and added that audit work had already been carried out on Covid-19 expenditure process and around the revised Covid-19 governance arrangements.

The Chair would be looking for a combination between internal and external audit and finance colleagues to ensure key areas of potential concern have been captured and pulled together.

Helen Kemp-Taylor went on to advise that an exercise has been completed to review the Phase 3 planning letter and what Audit believe they need to focus on to be able to provide a meaningful Head of Internal Audit opinion at the year-end; with changes to governance and the core financial processes key to this. A close eye will be kept on this to ensure assurance going forward.

The Chair expressed his thanks to External Audit on behalf of the Committee for the review and report which he thought to be a very useful piece of work.

Item 11 10/20 **Internal Audit (Audit Yorkshire)**

11.1 Internal Audit Progress Report

Tom Watson took the supporting paper as read and went on to highlight the key points contained within noting that 5 reports had been finalised since the last meeting; 4 with significant assurance; 1 limited assurance. A number of reviews are currently in progress. Tom Watson noted that, whilst audit work is progressing there have been some delays in meeting people and obtaining information which has an impact on the audit work. A process is in place for escalation to Sally Stevenson and this is working well. Tom Watson highlighted a specific issue with engagement from an Executive Director which is delaying the planned audits both from this financial year and last. The Executive Director has requested that these be deferred to quarter 4 and has stated whether it would be credible still to undertake the work.

Tom Watson noted that there had been a request to change the audit plan around the CQC registration and move to quarter 4. A brief will be drafted in preparation for the audit to be ready to go.

Tom Watson advised that the KPI work is going well with targets being met or exceeded on the work including the management response to the draft report which is positive to report. From page 4 onwards within the report progress against the individual assignments within the plan were outlined; page 9 onwards the summaries against the individual reports were outlined.

Andrew Smith added that he thought the report was in a good format and easy to follow; he went on to note one particular area relating to self-assessment costing data (ref page 13/14) - *"Management checks/self-assessment takes place to ensure data quality / formal plan has not yet been established to further develop and embed the use of costing data within the organisation….."* and asked how concerned should the Trust be about this and do we need to be focussing more on this given the formal planning still left to complete. Brian Shipley advised that

a paper would be presented to the next TMB around the self-assessment of costings and limitations together with a process to improve some of the data flows. There are re-occurring issues which Finance will need the wider clinical engagement with in terms of improving these data flows. The Chair added that this is tracked through the Finance and Performance Committee who are driving it, and the ARG Committee need to keep a focus on it as a risk issue, as it is a continuing concern.
Stuart Hall went on to query the audit of medical staff personnel files (page 24) and whether this would impact on the Trust's indemnity cover if the necessary records were not in place. The Chair thought that the Committee would have to look to the Medical Director's office to provide an answer to the query and a more comprehensive update for the next meeting of the Committee. The Chair agreed to request this from the Medical Director.

ACTION: Tony Bramley

The Committee received and noted the report; and agreed to the request of deferring the audit plan around the CQC registration. The Chair acknowledged the issues that audit were having with engagement of an Executive Director and suggested that a conversation is held outside of the meeting to find a way forward. Sally Stevenson advised that she had emailed the Executive Director concerned and asked if these planned audits were now not required, were there any other areas that they would like audits to be carried out as there would be circa 40 or 50 days in the plan; a response from the Executive Director concerned is awaited. Sally Stevenson will update the Chair accordingly as to whether or not a response is received. Sally Stevenson did note that there were quite a lot of areas for audits on the reserve list so a swift response would allow audit days to be planned from the reserve list if appropriate.

ACTION: Sally Stevenson

11.2 Insight Technical Updates Report

The Committee received the Insight Reports for 2020 for information and had nothing in particular to follow up or refer this time.

11.3 Internal Audit Recommendations Follow Up Report

Tom Watson presented the report and highlighted that good progress had been made with 42 recommendations implemented since the last meeting, acknowledging that there were a few historic ones still to clear.

Andrew Smith went on to ask what the protocol was for setting deadlines on internal audit actions and, how many were "actually" overdue as he was struggling to see this within the report. Tom Watson acknowledged Andrew Smith's comment and added that this level of detail is not within the report and he would look to including a summary on aged analysis for the next report.

Helen Harris added that looking through the old recommendations there were some names for those who had left/moved on and suggested maybe a re-alignment of some of these. Tom Watson did confirm that all the current details are tracked to the current post holder, but agreed a review would be beneficial.

ACTION: Tom Watson

The Committee received and noted the report.

11.4 Questions on Membership of Audit Yorkshire Proposal (refers to private item 16.5)

The Chair moved on to this item advising that this section would be a question and answer session only with the decision being made in item 16.5 in the private section of the agenda.

Helen Kemp-Taylor went on to update the Committee by advising they are in the third year of the Internal Audit Contract and the Audit Yorkshire Board wanted to invite the Trust to consider membership as part of the discussions about the future provision of Internal Audit. Meetings have been held with Sally Stevenson and the former interim Director of Finance to provide the relevant information on this. Helen Kemp-Taylor stated that the key point is that it fits clearly with direction of travel for system working and collaboration of partnership. Currently Audit

Yorkshire was on the SBS framework and have recently been successful in retaining this place and received the second highest place out of 15. Helen Kemp-Taylor also announced that Audit Yorkshire had also recently won the CIPFA Excellence in Public Sector Audit award.

The Chair thanked Helen Kemp-Taylor for the update and extended the Committee's congratulations on the achievements. The Chair then opened up for comments and questions. There were none at this point.

Item 12 10/20 **Counter Fraud**

12.1 LCFS Progress Report

Nicki Foley was invited to outline the key issues contained within the latest LCFS Report. Nicki Foley took the paper as read and went on to note some key points contained within:

Counter Fraud Collaboration from the 1 September 2020 expanded to include Lincolnshire Partnership NHS Foundation Trust and Lincolnshire Community Health Services NHS Trust. A new LCFS should be joining the team in early December 2020 following a second successful recruitment exercise (following the first successful candidate withdrawing at the eleventh hour).

Fraud Risk Assessment was peer reviewed again in September 2020 with 3 minor changes. There were also minor changes to the Counter Fraud operational plan.

The Cabinet Office has introduced a new set of Counter Fraud Functional Standards and it is hoped by the end of the current financial year they will be the replacement for our current standards issued by the NHS Counter Fraud Authority (NHSCFA). Guidance material should be sent out to the Trust in the new year.

Included at the end of the progress report is the latest CFP Newsletter in which Fraud Awareness Month (FAM) is mentioned; FAM will be very different this year as face to face sessions will not be able to take place due to social distancing restrictions; Nicki Foley added that she would offer virtual sessions and comms regarding Fraud Awareness will still be going out to staff.

Nicki Foley noted that, since the last meeting, there had been 1 new referral with regards to allegedly falsifying overtime claims; work on this is ongoing.

Nicki Foley then went on to advise about a case, involving falsifying information on an application form, for which a prosecution file was referred to the CPS. The CPS has now responded to say that on the basis of the evidence provided by the Defence solicitor it would not be possible to prove dishonesty. The Trust submitted an appeal with the support of the NHSCFA, but this was unsuccessful.

The Chair thanked Nicki Foley for the comprehensive report as usual and added that the counter fraud collaborative is a great idea and was pleased to note that the recruitment has now been successful.

Following the review and subsequent discussion the LCFS progress Report was noted.

Item 13 10/20 **Policies for Review / Approval**

13.1 Standards of Business Conduct Policy – Revisions

Sally Stevenson noted that this updated document was by way of formalising the policy to change all references from Director of Finance to the Trust Secretary, following the commencement of a pilot exercise in November 2019 to transfer responsibility for this function to the Trust Secretary.

The Committee received and approved the revisions to the policy.

Item 14 10/20 National Publications of Interest

14.1 None to note at this meeting.

Item 15 10/20 **Action Logs & Highlight Reports from other Board Assurance Committees**

Action Logs and Highlight reports from the following Board Assurance Committees had been provided for information to the Committee:

15.1 Finance & Performance Committee

The Chair noted the Clinical Data Improvement Programme and the continuing concerns of under investment in staffing to provide more effective business intelligence reporting in the Trust which has been raised at both the Finance & Performance and Quality & Safety Committees as well as here, which will be flagged again at the Trust Board.

15.2 Quality & Safety

The Chair pointed out the new CQC Emergency Framework on page 2 including new standards. The Q&S Committee will keep a focus on this.

15.3 Workforce Committee

Report noted.

15.4 Health Tree Foundation (HTF) Committee

The Chair noted concern re ICS Lead Charity Role; the national charity funding run through the STP will be run by HTF. The Chair queried if the ARG Committee would have a role with the HTF. The Chair suggested he would write to the Chair of HTF to ensure that there was a common understanding of the relationship between the ARG Committee and the HTF Committee.

15.5 RATS Committee

The Chair noted that this was the first time a report from the RATS Committee had come to the ARG Committee for information.

Following review the ARG Committee noted the Highlight Reports.

Item 16 10/20 **Any Other Business**

16.1 Any Other Urgent Business

The Chair went on to inform the Committee of his intention to stand down as a NED and Chair of the Audit, Risk and Governance Committee at the end of January 2021 after the next ARG Committee meeting. Andrew Smith would be taking on the role as Chair designate, and would provide a very strong ready-made candidate for the role.

16.2 ARG Committee Terms of Reference – proposed amendments

The amendments made were around the split responsibilities between the Finance & Performance Committee and the ARG Committee in relation to cyber security and information governance arrangements. Helen Harris queried if there should be more than 3 NEDs on the Committee. Sally Stevenson added that membership is in line with the latest HFMA NHS Audit Committee Handbook.

The Committee received, noted and approved the proposed amendments to the ARGC Terms of Reference.

16.3 ARGC Annual Workplan – proposed amendments

The Committee received, noted and agreed the proposed amendments to the ARGC Annual Workplan.

16.4 Schedule of ARG Committee Meeting Dates 2021

The schedule of ARG Committee meeting dates for 2021 were received.

The Chair brought the public section of the ARGC to a close, thanking everyone for their input. Audit Colleagues were asked to leave the meeting to allow for the following section of the meeting to be held in private.

Items 16.5 and 16.6 were discussed, and minuted, in the private section of the Committee meeting.

Item 17 10/20 **Matters for Escalation to the Trust Board**

The following items were agreed to be highlighted to the Trust Board:

- Document Control
- IG Steering Group Highlight Report items
- WebV Data Breaches Investigation Outcome
- Contracts Progress update
- Hospice Payroll Services
- Audit Yorkshire Membership
- Brexit

Item 18 10/20 **Matters to Highlight to other Trust Board Assurance Committees**

There were no items to be highlighted to other Trust Board Assurance Committees:

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Item 19 10/20 **Review of ARG Committee Workplan**

No matters to note.

Item 20 10/20 **Review of the Meeting**

The Committee was of the view that it had been a good meeting with lots of good items being discussed.

Item 21 10/20 **Date and Time of the next meeting**

Thursday, 21 January 2021 – 9.30am-12.30pm – via GoToMeeting

The Chair closed the meeting at 12.33pm

NLG(21)054

DATE	2nd February 2021
REPORT FOR	**Trust Board of Directors – Public**
REPORT FROM	Andrew Smith, Chair of Audit, Risk and Governance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**Results of the Audit, Risk and Governance Committee Annual Self-Assessment Exercise**
BACKGROUND DOCUMENT (if any)	Audit, Risk & Governance Committee Agenda Papers 21st January 2021
PURPOSE OF REPORT	For Information and Approval
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	Audit, Risk and Governance Committee members/ regular attendees attended the annual self-assessment meeting on the 7th January 2021 to complete the latest HFMA Audit Committee self-assessment checklist. Those present during the session were: 1. Tony Bramley – NED / ARGC Chair 2. Michael Whitworth – NED / ARGC Deputy Chair 3. Andrew Smith – NED / ARGC Chair Designate 4. Neil Gammon – NED 5. Stuart Hall – Associate NED 6. Lee Bond – Chief Financial Officer 7. Sally Stevenson – Assistant DoF – Compliance & Counter Fraud 8. Helen Kemp-Taylor – Head of Internal Audit, Audit Yorkshire 9. Tom Watson – Internal Audit Manager, Audit Yorkshire Helen Harris, Trust Secretary, was unable to attend the meeting but advised she had no adjustments to make to the draft self-assessment document circulated in advance of the meeting.

	The results of the 2021 self-assessment exercise are recorded on the attached checklist. In addition, an addendum paper was prepared by the Chair of the Committee (Tony Bramley) outlining the discussions which took place at the meeting on the 7th January 2021 regarding the subject of the ARG Committee's cross-committee role and its relationship with other Trust Board sub-committee's, specifically the Ethics Committee and the Health Tree Foundation Committee. This addendum is submitted to the Board for approval to include the two sub-committees in the Committees formal Terms of Reference.

ACTION REQUIRED

Approval	Information	Discussion	Assurance	Review

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

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	N/A
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: 1. Note the results of the self-assessment exercise performed by the Audit, Risk and Governance Committee in January 2021; 2. Consider the addendum paper and approve the Ethics Committee and Health Tree Foundation Committee being formally added to the Committee's Terms of Reference.

Northern Lincolnshire and Goole NHS Foundation Trust

Audit, Risk and Governance Committee

Self-Assessment Review of Committee Processes - HFMA NHS Audit Committee Handbook, 2018

7th January 2021

Area/ Question	Yes	No	Comments/Action
Composition, establishment and duties			
Does the audit committee have written terms of reference and have they been approved by the governing body?	√		Latest version freely available on the Trust intranet. Last approved by the Trust Board in August 2020.
Are the terms of reference reviewed annually?	√		Part of the Committee's annual work plan. Last updated by the Committee for minor amendments in October 2020.
Has the committee formally considered how it integrates with other committees that are reviewing risk?	√		The Committee's ToR specifically refers to how it integrates with other Trust Board Assurance sub-committees. This is achieved by reviewing their work, specifically in terms of the management of risks, through the routine receipt of action logs and highlight reports at each meeting of the Committee, and identifying any issues that the Committee feel further assurance is required on. Additionally, there is formal ARG Committee member representation on each of the other Board assurance sub-committees.
Are committee members independent of the management team?	√		The Committee's membership comprises 3 Non-Executive Directors.
Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?	√		Minutes and highlight reports submitted to Trust Board. Chair of ARG Committee presents highlight report at TB (as do all other sub-committee Chairs).
Does the committee prepare an annual report on its work and performance for the governing body?	√		Annual report also submitted to the CoG for information.

Area/ Question	Yes	No	Comments/Action
Has the committee established a plan of matters to be dealt with across the year?	√		Formal work plan first adopted in 2012, reviewed annually thereafter and any ad-hoc changes made as necessary in between. Rolling twelve month work plan adopted in July 2020. Due for scheduled annual review at January 2021 ARG Committee meeting.
Are committee papers distributed in sufficient time for members to give them due consideration?	√		In line with ToR – 5 working days before each meeting.
Has the committee been quorate for each meeting this year?	√		Five meetings during 19/20 and all were quorate. Four meetings to date during 20/21 and all were quorate.
Internal control and risk management			
Has the committee reviewed the effectiveness of the organisation's assurance framework?	√		Through internal audit annual review. The Committee also routinely reviews the BAF and Strategic Risk Register report at each meeting.
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?	√		Through minutes from other sub-committees. As from April 2017 the Committee has received a quarterly report on the Strategic Risk Register and BAF for oversight and scrutiny purposes.
Has the committee reviewed the accuracy of the draft annual governance statement?	√		ARG Committee minutes will evidence this.
Has the committee reviewed key data against the data quality dimensions?	√		***New question in 2018*** - The Trust's Data Quality Strategy was refreshed and submitted to the July 2019 meeting of the ARG Committee for review/comment. External audit review performance indicators as directed by NHSI as part of their year-end audit work, and report the results accordingly to the Committee. The Committee also receives reports from Internal Audit on the outcome of reviews of targeted KPI's as part of the IA annual plan.

Area/ Question	Yes	No	Comments/Action
Annual report and accounts and disclosure statements			
Does the committee receive and review a draft of the organisation's annual report and accounts?	√		Annual Accounts.
Does the committee specifically review: • The going concern assessment • Changes in accounting policies • Changes in accounting practice due to changes in accounting standards • Changes in estimation techniques • Significant judgements made in preparing the accounts • Significant adjustments resulting from the audit • Explanations for any significant variances?	√		Facilitated as necessary through reports from Finance / External Auditor and discussion at Committee meetings.
Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?	√		Prior to submission to NHSE/I.
Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?	√		Robust discussions involving annual accounts. Letter of Representation includes explanations for areas of non-adjustment.
Internal audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?	√		Formal Internal Audit Charter and Internal Audit Working Protocol with Internal Audit Provider (currently Audit Yorkshire).
Does the committee review and approve the internal audit plan, and any changes to the plan?	√		Annual and strategic plans are approved prior to the beginning of each financial year. Changes are documented and approved through IA progress reports to each ARG Committee meeting as necessary.
Is the committee confident that the audit plan is derived from a clear risk assessment process?	√		ARG Committee members and Executive Team participate in an annual workshop event to identify risks and discuss inclusion in audit plan. Postponed from 7 January 2021 due to Covid-19 pressures and re-scheduled for 4 March 2021 (previously held 9 January 2020).

Area/ Question	Yes	No	Comments/Action
Does the committee receive periodic progress reports from the head of internal audit?	√		At each meeting.
Does the committee effectively monitor the implementation of management actions arising from internal audit reports?	√		At each meeting.
Does the head of internal audit have a right of access to the committee and its chair at any time?	√		Specifically referred to in ToR.
Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?	√		Could be raised at the annual private meeting between the auditors and the Committee (May meeting), or by calling an ad-hoc private meeting at any time or during Committee meetings if such an issue arose.
Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*?	√		Audit Yorkshire's work is undertaken in accordance with their detailed Internal Audit Quality Assurance Manual which ensures a consistent approach and compliance with all relevant regulatory standards. In addition they use an Internal Audit Quality Assessment Framework biennially and an external review every five years to objectively assess the quality of our service. Audit Yorkshire agreed with their Board to perform a self-assessment in 2019/20 to confirm compliance for the organisation, with an external review planned for 2020. This external review was duly undertaken by CIPFA in February 2020 with the following outcome: *'It is our opinion that Audit Yorkshire's self-assessment is accurate and, as such, we conclude that Audit Yorkshire FULLY CONFORMS to the requirements of the Public Sector Internal Audit Standards.'*
Does the committee receive and review the head of internal audit's annual opinion?	√		ARG Committee minutes will evidence this.

Area/ Question	Yes	No	Comments/Action
External audit			
Do the external auditors present their audit plan to the committee for agreement and approval?	√		ARG Committee minutes will evidence this. Scheduled for January 2021 meeting.
Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?	√		ARG Committee minutes will evidence this.
Does the committee review the external auditor's value for money conclusion?	√		ARG Committee minutes will evidence this.
Does the committee review the external auditor's opinion on the quality account when necessary? **[Note: this question is not relevant for CCGs]**	√		ARG Committee minutes will evidence this.
Does the committee hold periodic private discussions with the external auditors?	√		Once a year (May meeting) or at any other meeting if requested in advance by the auditors.
Does the committee assess the performance of external audit?	√		On-going assessment by exception. However, a more formalised approach adopted in July 2020 with a paper to the Committee providing a formal annual evaluation of performance by the External Auditor.
Does the committee require assurance from external audit about its policies for ensuring independence?	√		Formal confirmation in audit strategy/fee documentation.
Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?	√		Policy for Engagement of External Auditors on Non-Audit Work devised and approved in February 2015 and subject to annual review thereafter. Revised in January 2019 to reflect new NAO guidance on this area and reviewed again in January 2020. Scheduled for review at January 2021 meeting. Details of non-audit work included in the annual ISA260 report from the External Auditor. Value of non-audit work is also identified separately in the annual accounts.

Area/ Question	Yes	No	Comments/Action
Clinical audit [Note: this section is only relevant for providers]			
If the committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?	√		The Quality & Safety (Q&S) Committee are responsible for monitoring the delivery of clinical audit activity. Q&S Committee minutes received by the ARG Committee. The clinical audit annual plan for 2020/21 was received by the ARG Committee in July 2020 for information. The Chair of ARG Committee is Deputy Chair of Q&S Committee, and appropriate links will continue to be made.
If the committee is responsible for monitoring clinical audit has it: • Reviewed an annual clinical audit plan? • Received regular progress reports? • Monitored the implementation of management actions? • Received a report over the quality assurance processes covered by clinical audit activity?	N/A	N/A	Part of the formal terms of reference for the Q&S Committee.
Counter fraud			
Does the committee review and approve the counter fraud work plans, and any changes to the plans?	√		Plan agreed with Chief Financial Officer and received by the ARG Committee for review.
Is the committee satisfied that the work plan is derived an appropriate risk assessment and that coverage is adequate?	√		Counter fraud work plan informed by register of fraud risks, internal audit, NFI, NHS Counter Fraud Authority (NHS CFA) intelligence reports, etc. Work plan areas based on national provider standards established by the NHS CFA.
Does the audit committee receive periodic reports about counter fraud activity?	√		Standing agenda item for written counter fraud progress reports from the LCFS at each ARGC meeting.
Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?	√		ARG Committee minutes will evidence this where appropriate.
Do those working on counter fraud activity have a right of direct access to the committee and its chair?	√		Contained within ToR in relation to the LCFS.

Area/ Question	Yes	No	Comments/Action
Does the committee receive and review an annual report on counter fraud activity?	√		This has always been the case in relation to counter fraud work since 2000.
Does the committee receive and discuss reports arising from quality inspections by NHSCFA?	√		ARG Committee minutes will evidence this where appropriate.

ADDENDUM TO HFMA SELF-ASSESSMENT 2020/21:

THOUGHTS ON THE CROSS-COMMITTEE ROLE OF AR&G COMMITTEE

Introduction

At the annual AR&G Committee *'HFMA'* Self-Assessment meeting held on 7th January 2021 a debate occurred among members on that aspect of the Committee's work which relates to its relationship with other sub-committees of the Board. [Relevant extracts from AR&G's ToR attached for reference.]

1. **Ethics Committee**:

1.1. Following the decisions at Board on 5th January 2021 to both approve the revised ToR of the Ethics Committee and for it to be added to the list of committees with which AR&G has a governance relationship, this sparked a debate amongst AR&G members about whether this was necessary/appropriate.

1.2. A view was expressed by some members that the unique nature of this (new) Committee's ToR made it inappropriate to include in AR&G's orbit; countered by others who viewed it more as a general point of governance principle in relation to ARG's role with any/all Trust Board sub-committees.

1.3. With no consensus, but a majority view that the Ethics Committee should be included, the proposition remains that this Committee's conduct should be included in the AR&G's ToR, and reviewed as necessary after 12 months

2. **Health Tree Foundation**:

2.1. The discussion above then sparked a further conversation about AR&G's relationship with HTF.

2.2. The question of whether HTF should be within the purview of AR&G has been discussed periodically since at least 2018 and, guided by the advice of various previous interim DoFs at the time, has been left out of scope on the basis that it was 'quasi-independent' with its own income stream of charitable donations and its own separate audit of accounts (albeit by the Trust's own external auditors).

2.3. However the continuing validity of this position was questioned in the meeting given that: (a) HTF is in effect an entity which (at least for now) is *'wholly controlled'* by the Trust, and; (b) its finances are consolidated with the Trust's own accounts for statutory reporting purposes.

2.4. Consequently it appeared counter-intuitive that AR&G should not have a formal interest in the conduct of HTF since it would be accountable for any adverse accounting or audit issues reported in the Trust's consolidated accounts upon which the AR&G makes a recommendation to the Trust Board.

2.5. The proposition therefore is that HTF should also be added into section 7.9.3 of the HTF's ToR.

Extracts from AR&G ToR

7.2.5 *As part of its integrated approach, the Committee will have effective relationships with other Trust Board Sub Committees (which may include reciprocal membership) to provide an understanding of processes and linkages and particularly to enable oversight of the other Sub Committee's governance of risk. This will include the exchange of their chair's action logs and highlight reports to the Trust Board.*

7.9.3 *In addition, the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular this will include any clinical governance, risk management or quality committees that are established. The Committee shall receive the action logs and highlight reports to the Trust Board of the following Board sub-committees for information:*

- *Finance and Performance Committee*
- *Quality and Safety Committee*
- *Remuneration & Terms of Service Committee*
- *Workforce Committee*

NLG(21)055

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	2 February 2021
REPORT FOR	**Trust Board of Directors (Public)**
REPORT FROM	Neil Gammon, Non-Executive Director / Chair of Health Tree Foundation Trustees' Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**Health Tree Foundation Trustees' Committee – Minutes from 3 September 2020**
BACKGROUND DOCUMENT (if any)	**-**
PURPOSE OF REPORT	For Information
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	HTF Committee – 5 November 2020
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	Minutes of the Health Tree Foundation Trustees' Committee held on 3 September 2020 and approved at its meeting on 5 November 2020.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	N/A
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report.

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **3 September 2020 – Via GoToMeeting**

Present:	Neil Gammon	Non-Executive Director / Chair of HTF
	Peter Reading	Chief Executive
	Tony Bramley	Non-Executive Director
	Jim Hayburn	Interim Director of Finance
	Ellie Monkhouse	Chief Nurse
	Dr Kate Wood	Medical Director
	Paul Marchant	Chief Financial Accountant
	Victoria Winterton	Head of Smile Health
	Clare Woodard	HTF Charity Manager
	Adrian Beddow	Associate Director of Communications
	Andy Barber	Chief Executive of Smile
In attendance:	Matthew Balerdi	Consultant Cardiologist (For item 6.1)
	Anne Barker	Finance Admin Manager (For the Minutes)

Item 1 09/20 **Apologies for Absence**

Apologies for absence were received from Linda Jackson; Sandra Hills; Jug Johal; and Terry Moran

It was noted that Peter Reading would be late attending due to other meeting commitments.

Item 2 09/20 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declaration of Interests". None were raised.

Neil Gammon read from an e-mail received from Terry Moran which confirmed Neil Gammon's appointment as Independent Chair of the Health Tree Foundation Trustees Committee until 31 March 2021, which was consistent with his original appointment, and would be considered for renewal in the usual way at that time.

Item 3 09/20 **Minutes of last meeting held on 2 July 2020**

The minutes of the meeting held on 2 July 2020 were reviewed.

Neil Gammon raised two issues from the minutes:

- **Rear into Gear Appeal -** Clare Woodard highlighted that the supplier of the equipment had been contacted regarding training the Trust's Medical Engineering Team. This was currently with Gavin Cogley, Head of Medical Engineering who is waiting for clarification from the supplier. **Add to Action Log**
- **Development of Action Plan Updates** – Clare Woodard had updated that an action plan would be brought back to the HTF meeting in November 2020. **Add to Action Log**

Following review the minutes from the meeting held on 2 July 2020 were agreed as an accurate record.

Ellie Monkhouse referred to the attendance record on the last page of the Minutes and asked if rep attendance could be shown when apologies have been given. Kate Wood was not aware that reps were required to attend. Neil Gammon agreed to take away as an action and take advice from the Trust Secretary in terms of other Assurance Committees. Jim Hayburn thought that HTF would be different from other Assurance Committees because reps would not be Trustees, but suggested it would be helpful if Dr Kate Wood and Ellie Monkhouse could send reps if not able to attend but it would need to be noted that reps would not have voting rights.

Action: Neil Gammon

Item 4 09/20 **Matters Arising / Review of Action Log**

The Action Log was reviewed as follows:

3 – Clinical Scholarship – Clare Woodard advised that the work undertaken by Arusu Kuppaswamy and Elaine Coghill had been reviewed and she would like to progress and asked Ellie Monkhouse for a rep from Nursing to sit on the meetings. Ellie Monkhouse suggested Jenny Hinchliffe and Clare Woodard agreed to contact her direct.

Action: Clare Woodard

5.2 – Management Policy – Clare advised that she had met with the Risk Management team and had undertaken initial training. She also discussed with Sarah Davis so any risk identified as a team she would bring to this Committee for discussion and if it would affect the Trust it would be entered onto the Trust Risk Register.

Neil Gammon understood the need to ensure that risks likely to affect the Trust should be captured but at the original time of discussion it was in relation to the running of the Health Tree per se and asked if that would also be captured. Tony Bramley suggested that the risk register should be for specific risks owned by HTF and if as a consequence it is also related to the Trust then need to be aware of that, which Jim Hayburn supported.

Neil Gammon asked if there was anything of best practice from NHS Charities Together that could be used; without creating an industry of it.

11 – Fusion Biopsy Machine for Urology – Claire advised that the machines were due to be trialled in the Summer but postponed until later in September. She added that she is in constant contact with the team and had reminded them that the Trust Procurement Team should be involved. An update would be given to the next HTF meeting in November.

Action: Clare Woodard

4 - Patron – Neil Gammon advised that he had spoken to Sir Reginald Sheffield and had agreed to revisit in November 2020 at which time the letter of agreement would be sent out. The Trustees were content with this approach.

Dr Kate Wood suggested it would be worthwhile having a virtual meeting to celebrate him as Patron and to send out the letter anyway and look for a start of New Year.

Neil Gammon agreed to contact Sir Reginald again to advise that the letter would be coming out.

Action: Neil Gammon

6.1 – Ultrasound Scanner for SGH – Clare Woodard advised that she had spoken with the service and this is now going through the normal process, therefore this item can be **closed on the Action Log.**

All other items were included within the agenda.

Following review the action log was noted.

Item 6 09/20 **Items for Discussion / Approval**

6.2 Future NHS Charities Together (NHS CT) Plans

Neil Gammon commented that the situation is moving quickly and there is a need to understand all the separate phases, therefore he proposed spending some time on this item.

10.30am Andy Barber joined the meeting

Clare Woodard referred to a late paper that had been circulated the previous evening that had just been received. She explained that she is working closely with NHS CT and Smile Health and handed over to Victoria Winterton to take the Committee through the paper.

Victoria Winterton highlighted that the second round of grants was now available from NHSCT aimed at supporting community partnerships. As part of this, Victoria Winterton explained that the Heath Tree Foundation had been chosen to be the lead charity for the Humber Coast and Vale region and will work with other member charities in this area to submit one application from all the NHS charities in the ICS patch. A process had been put in place and the first meeting would be held the following week as an introduction to all those involved and to agree a way forward so it was timely having the HTF this week to hear any thoughts or ideas ahead of the meeting next week.

Victoria Winterton drew the Committee's attention to the grant application process and timelines and in particular the examples where the partnerships could help NHS organisations including preventing admission to NHS facilities; facilitating discharge; supporting patients in the community following discharge from hospital; and supporting initiatives to remove health inequalities with a focus on diversity in the population.

The allocation of £623,746k is across the Humber Coast and Vale region.

Andy Barber commented that this would give an opportunity that had previously been discussed at this meeting, to look beyond the hospital four walls and to reach out to the Community and to give back following all that had been given over the last few months. Andy Barber went on to say that this had the support of Stephen Eames and the lead charity had been chosen as it had been seen as a progressive Board and Trust and spends at pace. Whilst it was acknowledged that £623k was not a huge sum of money split across the patch it could help to promote further opportunities for other areas of funding.

Dr Kate Wood commented that this was an exciting time to receive this pot of money although had concerns on the longevity and how to sustain in the future as this amount can be spent quite quickly and wondered how long term benefits could be built in. She highlighted that the Trust had entered into Opal 3 that day which had not happened for a long time; there were available beds but due to no longer funding available for intermediate care could not accept any more patients resulting in long waiting in A&E.

10.40am Peter Reading joined the meeting

It was highlighted that there were key areas at both NL and NEL areas that were potential places to spend money, specifically the NL Community Response Team during Covid-19 who proactively worked to keep patients out of hospital but whose continued funding was uncertain. At the NEL patch, CCGs and the Local Authority were looking at opening up a number of care homes to facilitate intermediate care but again it was not sure whether funding was available for that. The question was posed; was NLAG the best organisation to identify areas for investment or should that be a regional decision?

Victoria Winterton explained that one of the biggest challenges was that there is no specific direction given. Whilst HTF have been given this opportunity to lead and facilitate meetings for each charity to come together with ideas, they would also have to manage those ideas and facilitate consensus decision making.

Jim Hayburn acknowledged the good news about the leadership role but noted that the whole ICS must benefit. He suggested that a patient flow idea would need to be on a large scale for it to make a significant difference.

Ellie Monkhouse stated that her initial thoughts had been that the document was quite "woolly" and it was difficult to define opportunities across the ICS. With such a small amount of money benefitting all organisations would be quite a tall order.

Ellie Monkhouse also asked if this would be exclusively for NHS organisation as she was aware of a couple of organisations that are not NHS but provide services to the Trust. She went on to ask about community providers at both sites and suggested that whilst not major players, could CCGs also be included given that if something was put in place would we be looking for CCGs to fund as well? She added that if the money was directed solely at NHS related charities it would be difficult to move forward without involving the voluntary sector, CCGs and LAs which she felt was another tall order.

Tony Bramley referred to the aggregation of £623k across various organisations and suggested that whilst ideas would come from across the patch there would need to be some sort of central control. He said that his view would be to spend some of the money on coming up with ideas that were radical and could take a couple of years to put in place but this would have to be led by ICS senior leadership to build a new way of working for the future noting the four requirements. Tony Bramley added that if something was done immediately then the money would just be gone. He also wanted to agree with earlier comments on the need to work with the voluntary sector, NAVIGO etc. which would make the money go a lot further.

Jim Hayburn agreed that the CCGs would have a role to play but not to lead and suggested that the Trust should remain the focus for ideas of where the money should be spent.

Neil Gammon asked Peter Reading for his views. Peter Reading stated that this would need to move at pace and not get too democratic. He agreed that mental health and other community sectors should be contacted but the decisions/ideas should remain central, he was not sure that CCGs have a role as the money was given back to providers so whilst advice could be sought this should be moved forward in a centralist way. He also acknowledged that the money could disappear quite quickly and agreed that consideration should be given for lasting impact.

Dr Kate Wood questioned the involvement that would be required from herself and Ellie Monkhouse as Exec Leads of HTF.

Neil Gammon suggested that as a Trustee of HTF the roles and responsibilities are set out in the TORs. As a result of Covid-19, charities have been fortunate to be in receipt of grant money under NHS CT Stage 2, but this is not being given to individual charities but ICSwide. Therefore, whilst all Trustees' advice in their specialist area is welcome, HTF, on this occasion, are working within the remit of NHS CT rather than rather than alone so he did not see any requirement for separate involvement from Trustees.

Neil Gammon added that it would be a great opportunity to lead from the front and get the services for the benefit of our patients. It was agreed to highlight this matter to the Trust Board.

Victoria Winterton spoke about Stage 3 grants, which again she acknowledged was very "woolly" but explained that it is recovery grant money and is allocated on staff headcount based on £22 per head; which equates to £140k for NLAG. Applications could be submitted from 1 September 2020 with a closing date of 31 March 2021. at the intent was to support staff and Victoria Winterton asked the Committee for ideas on how they would like to progress this.

Dr Kate Wood advised that Claire Low would be setting up a Health & Well-Being Board and suggested they should be involved in this debate. It was noted that Clare Woodard would be a member of that Board.

6.2(i) Phase 1 NHS CT Funding – BAME Wellbeing Project

Clare Woodard presented the report which was an update following the successful HTF application to NHS CT, with HTF securing an initial £50k grant towards setting up this project. Following the last meeting Clare Woodard advised that a meeting had been held with Neil Gammon, Dr Arusu Kuppuswamy and Karl Portz to agree next steps and a Job Description for a working project coordinator role had been discussed.

Jim Hayburn had a slight concern that the project seemed weighted in project management rather than a tangible service or benefit. Neil Gammon suggested that the project requires someone to drive it, adding that the total funding of £100k is split between Health Tree and Health Stars, who had also secured their own £50k grant, and would cover both areas where they operate.

Tony Bramley acknowledged that Jim Hayburn's comments were fair but suggested that part of the difficulty was the lack of regional infrastructure to build on so there would be a need for initial set-up costs and suggested that this would be a catalyst. It would also be an opportunity to bring together voluntary groups which could be built upon and whilst he did not necessarily disagree with Jim Hayburn the next steps probably needed to be done in this way.

Andy Barber added that it could be an opportunity for other funding with the potential benefit of expanding knowledge and connecting with other areas that are further forward. He also added that if money comes to an end at some point we would need to be sure that building blocks were in place.

In reference to the appointment of a project coordinator, Neil Gammon noted that no HTF Trustee would be on the interview panel. Dr Kate Wood thought that there should be one if the Foundation was providing money. This was agreed. Victoria Winterton noted that as well as herself and Clare Woodard, Dr Kuppaswamy, and Grace Gava, BAME lead from Humber Teaching NHS FT an additional person would mean having six on the panel as there would then be a need to include a Trustee from Health Stars. Andy Barber made the suggestion of the Trustees having the final say but this was not agreed.

Neil Gammon reiterated that the Trustees would like to be represented on the interview panel and suggested that in the absence of a volunteer that he would approach Jug Johal in the first instance, with himself as a reserve. This was agreed.

Victoria Winterton confirmed that the advertisement for the post would be on the Charity Job platform, NHS jobs and possibly Indeed job site. It was agreed to add this item to the Trust Board highlight report.

6.3 Bus Shelter

Clare Woodard presented the paper which outlined a proposal to replace the existing bus shelter at DPOW due to its condition. She explained that it was proposed to use some of the marketing budget which had not been used due to covid-19. It was proposed that this could be made a focal point for HTF to help promote and advertise the work of the charity.

Tony Bramley suggested the picture showed quite a small shelter compared with the existing one, and nor did it appear very Covid-19friendly. Clare Woodard confirmed that it was a similar footprint than the current shelter and similar to the smoking shelter at the front of the hospital apart from the fact that it would have a front to provide protection from the elements.

Jim Hayburn also noted that it did not look wheelchair friendlyand queried why this was not the responsibility of the Council to provide a shelter.

Clare Woodard advised that the pictures provided were examples only and the shelter purchased would have seating and lighting. She also confirmed that the shelter is on private land therefore the Council would not provide any support.

Peter Reading agreed that the bus shelter should be bigger to allow for social distancing.

Dr Kate Wood commented that the current bus shelter was in a shocking state and agreed with other suggestions that the shelter should be bigger adding that as a hospital there are more people with accessibility needs and if providing a new bus shelter it should be suitably sized.

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Neil Gammon summarised that whilst the Committee were approving the purchase of a replacement bus shelter the concerns expressed needed to be taken into consideration. It was agreed that the purchase of the shelter does fall within the remit of the HTF Committee and he questioned if more money could be allocated than had been requested, given the concerns raised. He asked if Stagecoach had been

approached and also suggested the local councillor Tim Mickleborough who was a keen bus enthusiast could perhaps advise on routes for additional funding. Neil Gammon agreed to contact Councillor Mickleborough.

Action: Neil Gammon

It was agreed that the bus shelter needed to be bigger, Covid-19 compliant and wheelchair accessible. The provision of the bus shelter by HTF had the potential to boost donations as well as helping patients and visitors to keep dry.

Clare Woodard asked if the Committee required the proposal to be brought back for approval of funding following any increase in costs. It was agreed that given the timescale the Committee would approve the funding up to £20k, which was agreed.

Item 7 09 20 **Update from Health Tree Foundation**

Clare Woodard presented the report and highlighted key issues to note including the Pin Badges for staff in recognition of the Covid-19 pandemic. Clare Woodard advised that comments had been received from the Trustees and the majority favoured the blue heart design.

Ellie Monkhouse raised the blue heart design which she advised represented staff who had lost their lives through the pandemic so was not entirely sure that this was the message that we would want to convey. She further commented that she was surprised that the rainbow had not featured in the design acknowledging that having a number of colours could add to the cost, nor did she like the wording of “working through covid” and suggested 2020 should feature.

Neil Gammon invited Adrian Beddow’s thoughts. Adrian Beddow was not aware of the meaning of the blue heart symbol so felt it was a good point to consider, and also accepted the comment that the rainbow was a recognisable symbol. Adrian Beddow noted that the badge is quite small so there was perhaps little scope for too much to be included but agreed consideration should be given to the wording and the use of the rainbow.

Dr Kate Wood agreed that the blue heart was not appropriate and also agreed that the rainbow should feature.

Peter Reading advised that the rainbow had already been captured by LGBT colleagues and he had been approached to have the badge available for staff who want them so felt there would be potential confusion and would rather togetherness or linked arms was included. Peter Reading also questioned if Covid 2020 is appropriate as it may run into 2021.

Following the discussion, Neil Gammon summarised that the Committee would prefer to avoid the blue heart because of its connotations and consider carefully the wording as well as the use of the rainbow emblem because of other implications and not wishing to engender confusion.

Dr Kate Wood disagreed with not including a rainbow as it was still very much part of the Covid-19 pandemic adding that pictures are still in windows everywhere you look, chalked on pavements and walls and suggested that the rainbow was one of the significant symbols of the pandemic and proposed that it should be considered.

Peter Reading commented that he was uncomfortable making this decision solely by the HTF Committee and should include staff and unions in the final decision. This was agreed.

On that point, Neil Gammon asked Clare Woodard to obtain two options from the design consultants, one with a rainbow and one without and 2020 is to appear on both, which was agreed by the Committee. Whilst £8k had been allocated for the badges it was agreed to give a top limit of £10k to save having to return to the Committee for agreement on any additional funding requirements.

Action: Clare Woodard

Clare Woodard continued with the update of the Health Tree Foundation Report and highlighted the Sea View Street Cancer Shop that had been awarded a £20k Local Authority Business Relief grant. She advised that work was underway to undertake a full re-fit, including having assistance from Humberside Fire Solutions helping with their H&S and risk assessments to ensure the shop is Covid-19 secure. The volunteer team at the shop are desperate to re-open but realistically this would not be until January 2021.

The shop had been unable to secure a rent payment holiday from the landlord but receiving the £20k grant had made things easier.

Clare Woodard advised that the HTF had nominated Pru Stillings (Manager and Leaseholder) and the shop for a Pride of Britain award and it was now up to them if they wished to continue with that award.

Tony Bramley noted a word of caution that given the lack of support and help from the landlord he would not want improvements made to the shop using public money to result in an increase in value of the shop and therefore a potential rent increase.

Clare Woodard drew the Committee's attention to the information contained within the report from the two Community Champions, Katie Hubbert and Emma Hartley and in particular the challenges faced by the team as a result of the recent events. Traditional fund raising events were clearly not taking place so the team looked at virtual events but now felt that donor fatigue had set in. It was clear that the fund raising landscape had changed and would affect how the HTF worked so needing to look at diversifying. NHS CT grants have helped and the public lottery would be launching with contactless donation points in the hospitals and also ensure continuing reporting the positive impact of wishes.

Neil Gammon asked Clare Woodard to reassure the champions that the Trustees are well aware of the current difficulties and support the work that they do.

Tony Bramley noted that national charities are also reporting difficulties and given that forecasts and setting of budgets would soon be taking place, suggested that a campaign should be undertaken to highlight that HTF had suffered too.

It was agreed to add a cautionary note in the highlight report to the Trust Board to keep them in the picture.

It was noted that good governance was shining through the report.

8.1 Sparkle Report

Clare Woodard presented the report and commented that following comments made at the previous committee meeting the report now included information on progress made. Clare Woodard advised that Ellie Rodger was moving into Estates & Facilities (E&F) Directorate and Russ "Woody" Wood at SGH had secured a job within E&F. Dan Artley at DPOW is still available if needed although he too has moved into E&F.

Clare Woodard advised that she would be meeting with Simon Tighe to discuss next steps.

Tony Bramley commented that given the scepticism of the Handyman idea when first suggested it has been embraced as a benefit to the Trust and suggested to Clare Woodard that the benefits are pointed out to Simon Tighe when they meet and ensure that future opportunities are not lost. It was agreed that it would be left with Clare Woodard to discuss with Simon Tighe and bring an update to the next meeting with a proposal how to move forward.

Action: Clare Woodard

12.05pm Matt Balerdi joined the meeting for item 6.1

6.1 Cardiology Electronic Diagnostic Testing

Matt Balerdi joined the meeting to present the report. Neil Gammon welcomed him to the meeting and suggested that he could take the report as read by the Committee.

Matt Balerdi explained that the software would allow a more robust and safer process for patients in cardiology. The current software links to WebV but does not allow updates which means the requests are still paper based and reported manually into the system which not only creates more work but also more risk of human error. Currently the results appear on WebV but no notification is received and this therefore causes delays.

Tony Bramley commented that the report was very clear and understandable and given the improvement to service and care to patients, on the face of it would be strongly in support.

Ellie Monkhouse was also in support of the proposal.

Dr Kate Wood supported the request adding that if this were purely a patient safety issue then it would be provided by the Trust and this is absolutely beneficial to patients and it will help support patients and staff in delivery of care and fits within HTF remit.

Neil Gammon asked for assurance that by providing this interface there would be no potential costs downstream. Matt Balerdi confirmed that further system upgrades would be compatible with current software. He suggested obtaining this statement in writing if the Committee wished, but it was stated that it was not necessary.

Following the presentation and discussion Neil Gammon thanked Matt Balerdi for attending and he left the meeting.

Paul Marchant confirmed that the funding was available through the Big Red Heart Fund. Neil Gammon proposed approving the funding, which was agreed. Clare Woodard was asked to take the further action required following this committee approval.

Item 9 09/20 **Finance Update – May 2020**

9.1 Finance Report

Paul Marchant presented the report and highlighted that income for the year to July 2020 was £424k including £272k of Covid-19 related income. Expenditure for the year to July 2020 was £432k including £203k of expenditure on Covid-19 items. The £50k BAME grant was received in August and is not included in these figure

Expenditure on equipment in July 2020 includes £53k of CQC equipment (with the balance spent in August), £20k on a mobile scanner for Rheumatology and £13K on 3 RITA machines. Both the birthing and mother and child mannequins are now fully funded.

Investment balances at the end of the June quarter resulted in a gain of £221k which almost matched the previous quarter losses of £224k. Heather Lamont from CCLA will provide an update to the November meeting.

Tony Bramley suggested that it would be useful to highlight the NHS CT Grant income compared with the underlying income, given the challenges heard earlier around fundraising.

Action: Paul Marchant

Dr Kate Wood queried why the Maldi-Tof system was no longer needed to be supported. Victoria Winterton advised that the system linked across a number of service providers and it was built into the procurement bid for the service so no longer required HTF funding.

Neil Gammon welcomed this news.

Following discussion and review the report was noted.

Item 10 09/20 **Matters for Escalation to the Trust Board**

The following items had been highlighted during the meeting for inclusion on the public highlight report to the Trust Board:

- HTF appointed as lead Charity for Humber Coast & Vale region for NHS CT grant applications
- Appointment of project co-ordinator role for BAME project
- HTF fund raising difficulties in current climate

Item 11 09/20 **Any Other Business**

There was no other business raised.

The meeting finished at 12.30pm

Item 12 09/20 **Date and Time of the next meeting**

Thursday, 5 November 2020 – 10.00am-1.00pm – via GoToMeeting

Attendance Record:

Name	May 2020	July 2020	Sept 2020	Nov 2020	Jan 2021	March 2021
Neil Gammon	✓	✓	✓			
Peter Reading	✓	✓	✓			
Terry Moran	Apols	✓	Apols			
Linda Jackson	✓	Apols	Apols			
Tony Bramley	✓	✓	✓			
Sandra Hills	Apols	Apols	Apols			
Jim Hayburn	✓	✓	✓			
Marcus Hassall	-	-	-			
Jug Johal	✓	✓	Apols			
Kate Wood	✓	Apols	✓			
Ellie Monkhouse	✓	✓	✓			
Paul Marchant	✓	✓	✓			
Andy Barber	-	✓	✓			
Victoria Winterton	✓	✓	✓			
Clare Woodard	✓	✓	✓			
Adrian Beddow	✓	✓	✓			
Total	**12**	**12**	**11**			

NLG(21)056

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	2 February 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Helen Harris, Trust Secretary
CONTACT OFFICER	As above
SUBJECT	Documents Signed Under Seal
BACKGROUND DOCUMENT (if any)	Trust Standing Order 45
PURPOSE OF REPORT	For Information
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The report below provides details of documents signed under Seal since the date of the last report (August 2020 – NLG(20)184)

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	N/A
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report

Use of Trust Seal – February 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**
266	Grimsby MRI	30.09.2020
267	Grimsby CT Enabling Works	15.12.2020

Action Required

The Trust Board is asked to note the report.

NLG(21)057

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	02/02/21
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Adrian Beddow, Associate Director of Communications
CONTACT OFFICER	Charlie Grinhaff, Communications Manager
SUBJECT	Communications update (infographic)
BACKGROUND DOCUMENT (if any)	N/A
PURPOSE OF REPORT	To provide the board with an update on Communications activity
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	• The team's key priority is communication around the staff vaccination programme • An additional Communications Officer is starting in post soon with a focus on Capital • More resources are being dedicated to the Humber Acute Services Review

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

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

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

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

Communications Team update
January 2021

Northern Lincolnshire and Goole NHS Foundation Trust

Keeping staff informed

Our key priority is currently supporting the vaccination team: one member of the team has been dedicated to working on vaccine comms

We continue to draft and send a daily COVID-19 all staff email on behalf of the Chief Exec

We responded to 1,377 Ask Peter questions in 2020

Our staff Facebook group continues to grow with more than 3,100 members

Staff use the group to ask questions, raise concerns, thank each other and share positive stories

30,000

comments have been made on the group since it launched in March 2020

Celebrating staff

We held a virtual staff awards ceremony which attracted just under 900 views on YouTube

We worked with Community Services on their awards entry which led to them being shortlisted in the HSJ awards 2020

-Coming up:

- A new Communications Officer will be starting with us in Feb. This is a temporary role, funded by capital monies to focus on the Capital programme. They will be based at Grimsby.

- Website redevelopment work is starting

- The team will be moving off site to New Beacon house

- More resources will be dedicated to the Humber Acute Services review

Supporting other teams

We've been working to support:

- The rollout of digital appointment letters
- A public engagement event with our CCG colleagues
- Redevelopment of the staff app
- New Emergency Department project
- The rollout of Continuity of Carer
- North East Lincs Council with their 'break the chain' campaign

Working with the media

Media activity, including radio and TV interviews, remains limited due to the Level 4 incident but:

600+

Media enquiries handled in 2020

November was the busiest month with 100

- Staff member Leanne Dean, who made 'pick me up' packs for staff, has appeared on local TV and on Radio 5 Live
- Our new nursing assocaties were featured in the Nursing Times
- An appeal for volunteers resulted in 140+ coming forward to offer their help
- Dr Meadows was interviewed on psychological first aid and how we are supporting staff who are feeling burnt out
- A 24 hour online gaming event in aid of the Health Tree Foundation made national media including NME magazine