Northern Lincolnshire and Goole NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 1 June 2021, via MS Teams, 10.00 am – 1.00 pm

For the purpose of transacting the business set out below

		Note / Approve	Time	Ref
1.	**Patients' Story and Reflection** Jo Loughborough, Senior Nurse – Patient Experience	Note	10:00 hrs	Verbal
2.	**Business Items**			
2.1	**Chair's Opening Remarks** Terry Moran, Chair	Note	10:10 hrs	Verbal
2.2	**Apologies for Absence** Terry Moran, Chair	Note		Verbal
2.3	**Declarations of Interest** Terry Moran, Chair	Note		Verbal
2.4	**To approve the minutes of the previous Public meeting held on Tuesday, 6 April 2021** Terry Moran, Chair	Approve		NLG(21)103 Attached
2.5	**Urgent Matters Arising** Terry Moran, Chair	Note		Verbal
2.6	**Trust Board Action Log - Public** Terry Moran, Chair	Note		NLG(21)104 Attached
2.7	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note	10:20 hrs	NLG(21)105 Attached
2.8	**Performance Report against 2020/21 Priorities** Dr Peter Reading, Chief Executive	Note		NLG(21)106 Attached
2.9	**Operational and Financial Plan 2021 / 22**		10:30 hrs	
2.9.1	**Financial Plan 2021 / 22** Lee Bond, Chief Financial Officer	Note		NLG(21)107 Attached
2.9.2	**Operational Plan** Shaun Stacey, Chief Operating Officer	Note		NLG(21)108 Attached
2.10	**Integrated Performance Report (IPR)** Helen Harris, Director of Corporate Governance	Note	11:00 hrs	NLG(21)109 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Executive Report – Quality & Safety** Dr Kate Wood, Medical Director & Ellie Monkhouse, Chief Nurse	Note	11:05 hrs	NLG(21)110 Attached
3.2	**Executive Report – Performance** Shaun Stacey, Chief Operating Officer	Note	11:10 hrs	NLG(21)111 Attached

3.3	**Quality & Safety Committee Highlight Report and Board Challenge** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	Note	11.15 hrs	NLG(21)112 Attached
3.4	**Finance & Performance Committee Highlight Report and Board Challenge – April & May 2021 (Performance only)** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:20 hrs	NLG(21)113 Attached
3.5	**Nursing, Midwifery & AHP Strategy** Ellie Monkhouse, Chief Nurse	Approve	11:25 hrs	NLG(21)114 Attached
BREAK (11:35 hrs)				
4.	**Strategic Objective 2 – To Be a Good Employer**			
4.1	**Executive Report - Workforce** Christine Brereton, Director of People	Note	11:40 hrs	NLG(21)115 Attached
4.2	**Workforce Committee Highlight Report and Board Challenge** Michael Whitworth, Non-Executive Director & Chair of the Workforce Committee	Note	11:45 hrs	NLG(21)116 Attached
4.3	**Freedom to Speak Up Guardian Update – Quarter 4 including Annual Report** Liz Houchin, Freedom to Speak up Guardian	Note / Approve	11:50 hrs	NLG(21)117 Attached
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Executive Report – Finance – Month 01** Lee Bond, Chief Financial Officer	Note	11:55 hrs	NLG(21)118 Attached
5.2	**Executive Report – Estates & Facilities** Jug Johal, Director of Estates & Facilities	Note	12:00 hrs	NLG(21)119 Attached
5.3	**Finance & Performance Committee Highlight April & May 2021 (Finance only)** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	12:05 hrs	NLG(21)120 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Executive Report – Strategic & Transformation** Ivan McConnell, Director of Strategic Development	Note	12:10 hrs	NLG(21)121 Attached
6.2	**Health Tree Foundation Trustees' Committee (HTFTC) Highlight Report & Board Challenge – May 2021** Linda Jackson, Vice Chair	Note	12:15 hrs	NLG(21)122 Attached
6.3	**Health Tree Foundation Trustees' Committee Terms of Reference** Linda Jackson, Vice Chair	Approval	12:20 hrs	NLG(21)123 Attached
7.	**Strategic Objective 5 – To Provide Good Leadership**			
7.1	No items	Note		
8.	**Governance**			
8.1	**Audit Risk & Governance Committee (AR&GC) Higlight Report & Board Challenge – April 2021** Andrew Smith, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	Note	12:25 hrs	NLG(21)124 Attached
8.2	**Non-Executive Director Statutory Roles** Helen Harris, Director of Corporate Governance	Note		NLG(21)125 Attached

8.3	**Executive Director Statutory Roles** Dr Peter Reading, Chief Executive	Note		NLG(21)126 Attached
8.4	**Health & Safety Policy Statement** Jug Johal, Director of Estates & Facilities	Approve		NLG(21)127 Attached
8.5	**Trust Board – Business Reporting Framework** Helen Harris, Director of Corporate Governance	Approve		NLG(21)128 Attached
9.	**Approval (Other)**			
9.1	**Committees in Common Terms of Reference** Terry Moran, Chair	Approve	12:50 hrs	NLG(21)129 Attached
10.	**Items for Information / To Note (please refer to Appendix A)** Terry Moran, Chair	Note	12:55 hrs	
11.	**Any Other Urgent Business** Terry Moran, Chair	Note		Verbal
12.	**Board Performance and Reflection** Terry Moran, Chair	Note		NLG(21)130 Attached
13.	**Questions from the Public**	Note		Verbal
14.	**Date and Time of Next meeting** **Board Development** Tuesday, 6 July, Time TBC **Public & Private Meeting** Tuesday, 3 August 2021, Time TBC	Note		Verbal

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

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

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

APPENDIX A

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

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

10.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
10.1	**Finance & Performance Committee Minutes – February and March 2021** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(21)131 Attached
	Quality & Safety Committee	
10.2	**Quality & Safety Committee Minutes – January, February, March & April 2021** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(21)132 Attached
	Workforce Committee	
10.3	**Workforce Committee Minutes** Michael Withworth, Non-Executive Director & Chair of the Workforce Committee	NLG(21)133 Attached
10.4	**Guardian of Safe Working Hours Quarterly Report – Quarter 4** Dr Kate Wood, Medical Director	NLG(21)134 Attached
	Audit, Risk & Governance Committee	
10.5	**Audit, Risk & Governance Committee Minutes – January & April 2021** Andrew Smith, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(21)135 Attached
	Other	
10.6	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(21)136 Attached
10.7	**Documents Signed Under Seal** Helen Harris, Director of Corporate Governance	NLG(21)137 Attached

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 6 April 2021 at 10.00 am
Via Video Conference

For the purpose of transacting the business set out below:

Present:

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

In Attendance:

Mr Abdi Abolfazl	Acting Deputy Chief Operating Officer
Ms Diana Barnes	Governor
Mr Adrian Beddow	Associate Director of Communications
Mrs Christine Brereton	Director of People
Mr Martin Cheyne	Capsticks Solicitors
Ms Laura Colby	Liaison Workforce
Mrs Elaine Criddle	Deputy Improvement Director
Mr Marc Goddard	ConvaTec
Mr Stuart Hall	Associate Non-Executive Director
Mrs Helen Harris	Trust Secretary
Mr Jug Johal	Director of Estates & Facilities
Mrs Jo Loughborough	Lead Nurse – Patient Experience
Mr Ivan McConnell	Director of Strategic Development
Mrs Shauna McMahon	Chief Information Officer
Mr Crispin Pettifer	Capsticks Solicitors
Mr Ian Reekie	Lead Governor
Mrs Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Trust Secretary (note taker)

1. Patients' Story and Reflection

Jo Loughborough shared the Patient Story of "Jan" who had experienced various services at Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) after a

Covid-19 diagnosis. During the time spent in hospital Jan's son in law had also been poorly with Covid-19 but had sadly passed away.

Positive comments had been received regarding the care provided by the care assistants as nothing had been too much trouble. However Jan would have been happier if the communication had been better in terms of advising what was happening at the various stages of care. Other positive feedback had been received in terms of the physiotherapists as they had been supported. The overall experience had been good but there had been some inconsistency of care in some areas. Due to this further review would be undertaken in certain areas.

Terry Moran sought reflections on the story shared.

Dr Kate Wood felt the story reflected on the "good" stuff and was balanced with what still needed to be put in place to improve the service. Neil Gammon felt it had emphasised the importance of the care assistant role achieving 100% establishment at the Trust. Linda Jackson queried whether stories such as this were shared with new care assistants as part of the induction programme. Jo Loughborough advised initial thoughts had been that it would be easy to gather stories from patients on experiences during the pandemic but some had found it difficult to share.

Terry Moran thanked Jo Loughborough for the story shared.

2. Business Items

2.1 Chair's Opening Remarks

Terry Moran welcomed everyone to the meeting and declared it open at 10.00 am. Terry Moran welcomed Abdi Abolfazl to the meeting and advised this was due to the acting role for Shaun Stacey that had been put in place.

Terry Moran advised the Trust had recently recruited a new Non-Executive Director (NED), Gill Ponder who would be Chair of the Finance & Performance Committee (F&PC). Approval had been received by the Council of Governors, with a start date of the 12 April 2021, which would then allow a period of transition with Neil Gammon the current Chair of the committee. Terry Moran passed on his thanks to Neil Gammon, for the commitment and passion he had provided during his time at the trust.

Terry Moran wanted to recognise the tremendous work that continued to be undertaken by staff across the Trust at this difficult time. Once colleagues were able to visit wards and departments this would show the appreciation to staff by the board.

The April Trust Board introduced the new format agenda which focussed around strategic objectives. The new approach helped demonstrate where the Trust were working well and where the Trust needed to focus more. Feedback on the new agenda would be welcomed.

2.2 Apologies for Absence

No apologies for absence were received for the meeting.

2.3 Declarations of Interest

No declarations of interests were declared.

2.4 To approve the minutes of the Public Meeting held on Tuesday, 2 February 2021 – NLG(21)064

The minutes of the meeting held on the 5 January 2021 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made.

- Lee Bond referred to page five, 2.8, final paragraph an amendment needed to be made to read “lead times”.
- Lee Bond referred to page ten, 5.1, second paragraph and queried if more description could be provided in respect of the reference “bed position was 20% higher than last year”. Mike Proctor advised this was in reference to the four hour standard being similar this winter to the previous winter. Shaun Stacey had identified it was 20% lower in terms of the beds the Trust were operating out of. After some discussion it was agreed Shaun Stacey would clarify the wording for the minutes.
- Lee Bond referred to page ten, 5.2, third paragraph. A word in the first sentence needed to be changed to say inherent not inherited. Andrew Smith highlighted the minute referenced the Estates Strategy discussion that would be deferred to the development session held that afternoon but due to timing this had not been discussed. In light of this the item should be closed at some stage. Terry Moran agreed this would be discussed during the private board meeting.
- Terry Moran referred to page eleven, 5.5, the first paragraph should read “work in progress”.

2.5 Urgent Matters Arising

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

2.6 Trust Board Action Log – Public by exception NLG(21)065

Terry Moran invited Board members to raise any further updates by exception in relation to the Trust Board Action Log. Ellie Monkhouse advised the item in relation to Ockenden would be covered within the paper later in the meeting, it was agreed this action could be closed.

2.7 Chief Executive’s Briefing – NLG(21)083

Dr Peter Reading referred to the Chief Executive’s Briefing. The government had published the White Paper in February and a summary of this was included within the report. The White Paper had included significant detail, but much of this was still

to be worked out. Dr Peter Reading indicated that due to changes with the 2012 Health & Social Care Act it could potentially help Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) in respect of seeking major capital funding as there would likely be different criteria for determining investment.

Dr Peter Reading referred to the NHS Operational Planning & Contracting Guidance for 2021/22. The headline referred to the health and wellbeing of staff due to Covid-19. It had recognised the enormous burden on staff due to pressures over the past year. The Trust would be expected to maximise capacity and focus on the reduction of elective care backlog in collaboration with Acute Partners. There would be an elective recovery fund available to enable some support to put this in place.

The interim financial arrangements in terms of Covid-19 had been rolled over for the first six months of this year.

The pandemic national incident level had now reduced to three and the Trust currently had 20 positive patients which was the lowest number since early autumn.

Dr Peter Reading referred to the progress made with capital projects which had principally been led by Jug Johal and his team. The Trust had received the largest grant in the NHS from the Public Sector Decarbonisation Fund and also secured planning approval for the new A&E Units. The new scanners would become operational from May 2021 and the Trust had also secured investment into the digital schemes.

2.8 Integrated Performance Report – NLG(21)066

Helen Harris referred to the Integrated Performance Report and advised this had been reviewed by the F&PC and Quality & Safety Committee (Q&SC). This was a retrospective review of the performance of the Trust which meant the data was not up to date. Each of the Executive Directors had provided a significant amount of detail on performance in the Trust. The NED highlight reports from each committee would also provide further assurance.

Dr Kate Wood advised the report had moved on tremendously but was still developing. Dr Kate Wood was grateful to Helen Harris and the team for the work undertaken. The Q&SC would continue with oversight of the report and would advise of thoughts and recommendations. Terry Moran felt that once the report was used more in terms of the variance data it would provide more direction of travel and would support better understanding of key issues.

Mike Proctor recognised the significant progress but queried whether it could be reviewed so that everything was not in a chart format. Dr Peter Reading advised the workforce element had not been included at the moment due to further work but it was a huge step forward. More understanding would be required around the report as it was a public access document, to support this additional text would need to be added for clarification. An additional column should also be added which showed what the comparisons were in terms of national or neighbouring Trusts.

Neil Gammon referred to SHMI chart 12 and queried whether NLAG would have a

bad “lagging” effect due to Covid-19 with the SHMI figures, similarly in respect of the structured judgement reviews there were areas of concern. Neil Gammon’s final query was in respect of sepsis as this was under target and so queried what the Trust would be doing to tackle the issues. Dr Kate Wood referred to the SHMI query and advised this was always six months behind so the numbers had already reflected Covid-19 numbers. The Covid-19 numbers had been taken out that was how SHMI calculated the data. The Trust had also been measured against everyone in the country, this meant the average related to other Trust movements as well. In respect of the structured judgement review the Trust had had challenges. In the first lockdown reviews were up to date due to doctors completing them whilst shielding so this had enabled lessons learnt to be reviewed and applied. All deaths now go through a screening questionnaire, the new medical examiner was now in post so all deaths would be reviewed by clinicians and follow the examiner process. Although Dr Kate Wood felt more could be done it was the right process to have a number of pathways to escalate if required. Dr Kate Wood referred to the query regarding sepsis, this had been included as a quality priority for the year but the data provided relied on what was entered onto the WebV System. Going forward the data input needed to be in one place to enable improved oversight. There would be a need to ensure patients were escalated appropriately.

Stuart Hall queried whether NLAG could future proof it by looking at some of the standards that may be implemented, for example average waiting times in Accident & Emergency rather than focus on the four hour standard.

Terry Moran thanked board members for the points raised and wanted to thank everyone for the work undertaken. This would enable the Trust to move in the right direction.

3. Strategic Objective 1 – To Give Great Care

3.1 Executive Report – Medical Director & Chief Nurse - NLG(21)067

Dr Kate Wood highlighted that the report shared an update in respect of Ockenden and Serious Incidents (SIs). Ellie Monkhouse referred to the nurse staffing indicators as this continued to be a struggle due to the difficulties of staffing areas. As staff had been redeployed it had been incredibly difficult to show information around this within the report. This would continue to be an issue over the next 18 months.

Terry Moran referred to the Infection Prevention Control (IPC) Assurance Framework in relation to the Covid-19 outbreak risks that related to staff testing as to whether there had been some resistance. Dr Kate Wood advised lateral flow tests were not mandatory so some staff had not engaged in the process. Due to this the Trust would not be aware of a-symptomatic spreaders. Stuart Hall referred to the hospital acquired infection rates and queried where the Trust sat in terms of the table with infection rates that were hospital acquired. Ellie Monkhouse advised that considering the Trust had a lack of isolation facilities and that there was overcrowding in both Accident & Emergency Departments (A&E), NLAG were doing incredibly well at the moment. There had been changes to the IPC Framework so it was important the board had oversight.

Linda Jackson referred back to the IPC as there had been proactive effort by the executives in the implementation of the Redirooms and this had meant NLAG had coped well with hospital acquired infections. Linda Jackson asked if the reinfection rate at NLAG could be noted as it would be nice to highlight what the infection rate was. Terry Moran asked for this to be included in future reporting.

Action: Ellie Monkhouse

3.2 Executive Report – Performance – NLG(21)069

Abdi Abolfazl referred to the report and advised there had been huge challenges within emergency care over recent weeks at both sites due to pressures. The report also included detail in respect of ambulance handover and the ring fencing of beds at the Scunthorpe site.

Linda Jackson felt the report was clear, however, queried whether the turnaround time for Covid-19 swabs was as good as it could be. A further query was whether NLAG had achieved the 52 week Outpatient Department (OPD) risk stratification by the end of March 2021. Abdi Albofazl advised the time for the receipt of swabs had improved, the Trust had also reviewed the process in A&E as the results in that area were coming back within 15 minutes. In terms of the second query most areas were on trajectory for 52 weeks but the Trust faced serious challenges around all outpatient risk stratification. This had not been achieved in all specialities by the 31 March deadline. Terry Moran asked if the vulnerable areas could be advised within the report. Neil Gammon agreed with the point raised and asked if this could include specific numbers.

Ellie Monkhouse referred to current complaints which had achieved 83% compliance of responding within timescales, old complaints from the previous process had now been closed. Ellie Monkhouse wanted to record thanks to the team for the achievement. The same process had been introduced within the Patient Advice & Liaison Service (PALS) and this was now at 45% of responding within timescales.

3.3 Quality & Safety Committee Highlight Report and Board Challenge – NLG(21)070

Mike Proctor referred to the report and highlighted the outpatient follow up waiting list as this had 27,000 patients in this position. A concern was that a third of the patients were ophthalmology patients which could be coming to harm. There was a gap in providing the board with assurance on this so the Quality Governance Group (QGG) had been asked to undertake a piece of work. The report was to be shared at the next meeting of the Q&SC. The Ockenden Report had stated Maternity Serious Incidents (SIs) should be shared at the board on a monthly basis. This process was being undertaken in detail by the Q&SC. It was felt the full report should not be shared at Public Board due to confidential identifiable information.

Ellie Monkhouse referred to the point raised by Mike Proctor in respect of SIs being shared with the board. The requirement for this was not clear at the moment so the discharge of this would be overseen by the Q&SC and Maternity Transformation Board as the two strong mechanisms to ensure assurance. Terry Moran thanked

Ellie Monkhouse for highlighting this.

3.4 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(21)071

Neil Gammon highlighted that an excellent brief had been received from Jackie France regarding the Outpatient Transformation Programme, Neil Gammon wanted to urge Trust staff to use the Patient Initiated Follow Up (PIFU) system to the maximum extent.

Terry Moran felt the highlight reports shared in this part of the meeting may benefit from a standard format to enable highlights to be included. Terry Moran asked if all reports could adapt the same information in terms of whether anything required escalation to the board.

Terry Moran queried if any other issues needed to be raised. No comments were received.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Executive Report - Workforce – NLG(21)072

Christine Brereton highlighted the committee had undertaken work on the Integrated Performance Report (IPR) which had resulted in more confidence around the positions of KPIs for workforce.

Linda Jackson referred to the staff survey and queried what work would be required to address team working. In respect of the recruitment part of the report it would be useful to share what staff were leaving. Christine Brereton advised that work in respect of the staff survey would be triangulated with ongoing work currently being undertaken in respect of culture. Further work was to be undertaken in relation to leavers which would include comparisons within the Humber Coast & Vale (HCV), retention would also be included within this. Ellie Monkhouse felt some of the results that related to team working were due to Covid-19 as some staff had not worked within teams for the last year due to redeployment and working at home. It was felt this had been reflected in the results as it had impacted on staff.

Terry Moran hoped focus groups would be arranged to see why those results were what they were to get a better understanding of the action needed to address them going forward. Stuart Hall was pleased to hear work that was being undertaken around culture and queried if the data shared could be site specific to see if this made a difference. Christine Brereton advised this could be undertaken and also agreed with the point raised by Terry Moran as she hoped to arrange staff focus groups. Data could be split more but in doing this if the data related to smaller numbers it would not be acceptable as it may identify which staff had raised issues. Terry Moran raised concern that bullying and harassment had again been raised within the report and the number of them had risen.

4.2 Workforce Committee Highlight Report and Board Challenge – NLG(21)073

Michael Whitworth advised the meeting due to be held in April 2021 would be used to set the work programme for the year. The previous meeting had been reassuring around what could be put in place going forward for health and wellbeing of staff.

4.3 Freedom to Speak Up Guardian Update – NLG(21)075

Liz Houchin advised there had been 55 concerns received during the quarter. Further to previous requests the report now included benchmarking for comparison and a case study around patient safety. Liz Houchin assured the board that any patient safety issues were escalated and discussed as appropriate. From April 2021 there would be reporting on worker safety and this was partly due to Covid-19 and psychological safety. The board were asked to note and approve the report.

The board approved and noted the Freedom to Speak up Guardian Quarter 3 report.

4.4 Gender Pay Gap Report – NLG(21)076

Christine Brereton advised the Gender Pay Gap Report had been discussed at the Workforce Committee. More work was required as it had been highlighted that NLAG still had a gender pay gap. There was a standard format to follow as the data had to be published on the Government website. An explanation had been included within the report to address why NLAG's gender pay gap was in this position.

Dr Peter Reading recognised the work undertaken and queried what would be the next step as the highest paid staff were clinicians and senior managers. A comparative would need to be undertaken to see where NLAG was in terms of the rest of the NHS. Dr Peter Reading would be interested to see where NLAG was in terms of the medical workforce as it was felt the Trust had more of a male workforce than other areas. Mike Proctor queried whether the Trust could consider women only within shortlisting. Dr Kate Wood advised it would be more difficult to recruit as not enough females applied for the roles. Christine Brereton felt a more positive approach could be looked at in terms of encouraging females to apply when there were recruitment campaigns. Dr Peter Reading agreed further review should be undertaken to see why women were not applying for the roles. Terry Moran agreed further discussion and work should take place on this issue outside of the meeting.

The Trust Board agreed to approve the Gender Pay Gap Report.

4.5 Modern Slavery Statement – NLG(21)077

Christine Brereton advised the report had been discussed and approved at the Workforce Committee.

The Trust Board approved the Modern Slavery Statement report.

5. Strategic Objective 3 – To Live Within our Means

5.1 Executive Report - Finance – Month 11 - NLG(21)078

Lee Bond shared the Month 11 report and advised Month 12 would be finalised that week. There had been some impact due to electives being lower than planned. Key messages were highlighted from the report. Neil Gammon wanted to assure the board that finances would be within plan.

5.2 Finance & Performance Committee Highlight Report and Board Challenge – February & March 2021 – Finance - NLG(21)079

Neil Gammon advised the F&PC had not been assured that NLAG could move forward from the £21.94 million deficit from 2019/20.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Executive Report – Strategic & Transformation – NLG(21)080

Ivan McConnell advised this showed the key areas where the Trust had promoted a more collaborative role. Ivan McConnell wanted to thank the Estates and Facilities, Strategic and Finance teams for the support.

Stuart Hall referred to the active participation in respect of the number of responses received and queried how this would be built into the approach and how this would be fed back. Ivan McConnell confirmed 10 areas had been identified and agreed through consultation exercises. There had now been 3,700 responses received as of that day. The responses would be collated and feedback provided on what key areas people wanted to look at. The process would be undertaken again in the summer and this would then go to consultation to see if anything had changed.

Andrew Smith queried whether the IPR and mitigations in operations were contingent on collaboration and at what stage they may see the benefits come through to support operational staff; secondly whether this should be more visible at board level to address issues. Ivan McConnell advised that the critical elements in terms of operational challenges would be through programme one of the plan. A single clinical leadership team would be appointed which would then lead to governance discussion and other issues. Delivery would commence in quarter three this year, however, the implementation would need to be supported. It had been recognised that more work was required in the support of individuals.

Terry Moran advised the board would soon be invited to consider a proposal to establish Committees in Common (CiC) with Hull University Teaching Hospitals (HUTH) to oversee the joint work and service design and implementation requirements for improved quality and access to hospital services with HUTH. The Terms of Reference for the committees would be subject to approval of both Trust Boards with the hope meetings would start from May 2021.

6.2 Clinical Strategy – NLG(21)081

Ivan McConnell wanted to note thanks to all colleagues who had taken part and supported the Clinical Strategy. This had been through a lengthy process which included engagement with a number of stakeholders. The paper shared that day was the public facing document. Terry Moran also wanted to note thanks and recognised the work undertaken and sought for formal approval.

The Trust Board approved the Clinical Strategy.

6.3 Health Tree Foundation Trustees' Committee (HTFTC) Highlight Report & Board Challenge – March 2021 – NLG(21)082

The Trust Board received the report for information.

7. Strategic Objective 5 – To Provide Good Leadership

7.1 Board Assurance Framework – Strategic Objectives Description, Structure, Risks and Risk Appetite – NLG(21)084

Dr Peter Reading recognised a considerable amount of work had been undertaken by board members on the Board Assurance Framework (BAF). Agreement was requested on what had been presented at the meeting. Included was a revised version of the risk appetite that required approval. A further 11 pages would be included for each strategic risk. Helen Harris wanted the board to consider the reporting requirements that had been suggested and sought agreement on whether this was shared monthly, bi-monthly or quarterly. Terry Moran felt the frequency of the report could be considered during the development session of the board that afternoon. Helen Harris agreed with this proposal.

Terry Moran sought comments and questions.

Andrew Smith referred to strategic objective five and felt this should have more range as the other objectives had. It was agreed to reflect on this further outside of the meeting.

The Trust Board approved the Board Assurance Framework. Terry Moran thanked those who had been involved in updating the BAF.

7.2 Trust Priorities 2021 – 22 – NLG(21)085

Dr Peter Reading advised the priorities had been presented for approval following discussions at private board meetings. It was highlighted that the priorities were not a business plan but were for staff and stake holders to see what the Trust would commit to.

Terry Moran queried how the Trust would track progress of the priorities and whether risks were being highlighted. Elaine Criddle referred to the balance between finance and quality and how this would be mitigated throughout. Secondly would there be an

Improvement Plan that would sit behind them to describe how they would be delivered. Terry Moran felt the updated risk appetite addressed the first query raised by Elaine Criddle. Christine Brereton felt that information included within the BAF and IPR would highlight whether the priorities were being met.

Dr Peter Reading felt it was important to not have multiple tracked documents, this information would be included in the business plan. There would be a need to look at the reports already provided and include detail within them.

The Trust Board agreed to approve the Trust Priorities.

8. Approval (Other)

8.1 Trust Management Board (TMB) Terms of Reference – NLG(21)086

Helen Harris referred to the paper and asked for the board to formally ratify the updated Terms of Reference. As the paper shared was not the complete document it was agreed to circulate this after the meeting to receive virtual approval.

Post Meeting Note:

Following circulation of the paper the Trust Board agreed to ratify the updated Trust Management Board Terms of Reference.

8.2 Executive Team Terms of Reference – NLG(21)087

Helen Harris referred to the paper and asked the Trust Board to formally ratify the updated Terms of Reference.

The Trust Board agreed to ratify the paper.

9. Items for Information

10. Any Other Urgent Business

There were no items of any other urgent business raised.

11. Board Reflection – NLG(21)088

Terry Moran wanted to thank the board for being open in feedback provided and asked for this to continue going forward.

12. Governor Questions

No questions were received.

13. Date and Time of the next meeting

Board Development
Tuesday, 4 May 2021, Time TBC

Formal Trust Board Meeting
Tuesday, 1 June 2021, Time: TBC
Via video conference

The Private Trust Board meeting was due to follow at 13.30 hours via video conference.

Terry Moran closed the meeting at 12.30 hours.

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

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

NLG(21)104

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2021/2022

Kindness · Courage · Respect

ACTION LOG & TRACKER

Trust Board Public Meeting

2021/22

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
4.3	02.02.2021	Ockenden Review		Clarification of how the audit of challenge and assurance would be undertaken in terms of an internal process or part of the external audit plan.	Ellie Monkhouse	Apr-21	Update to be provided at the April 2021 meeting.	Completed		

Key:

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

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Public Meeting

2021/22

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
1.8	01.12.2020	Chief Executive's Breifing - Integrated Care Systems		Discussions took place with the Executive Team and NEDs, in respect of how to move forward with Integrated Care Systems across the NHS in the future. Agreement was reached on the preferred way forward. The Board was asked to consider two options and the preferred option was two.	Dr Peter Reading	Dec-20	Action completed	Completed		
3.1	04.01.2021	Digital Strategy		Executive team to consider where the oversight should sit for the delivery of the Digital Strategy	Shauna McMahon	Apr-21	Update to be provided at the February 2021 Trust Board meeting. Update to be provided at April 2021 Trust Board. Oversight for the Strategy will be monitored through the Finance & Performance Committee.	Completed		
2.3.1	04.01.2021	Risk Assessments for Staff		Clarification to be provided as to whether a generic risk assessment would be sufficient in circumstances where an individual Risk Assessment was unable to be completed	Christine Brereton	Feb-21	Update to be provided at the February 2021 Trust Board meeting. Update to be provided at April 2021 Trust Board. Update provided at the February 2021 meeting.	Completed	February 2021 Public Board Minutes	Shared on sharepoint site

Key:

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)105

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board - Public
REPORT FROM	Peter Reading, Chief Executive
CONTACT OFFICER	Peter Reading, Chief Executive
SUBJECT	Chief Executive's Briefing
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	The report provides an overview of the following: • NHS White Paper related developments in Humber Coast and Vale • Pandemic response, recovery planning and key operational pressures

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	1.1 1.2 1.6 2 4				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Chief Executive's Overview

1. NHS White Paper related developments in Humber Coast and Vale

Work nationally, regionally and across our Integrated Care System or ICS (Humber Coast and Vale Health and Care Partnership) continues intensively in response to the NHS White Paper and anticipated legislation. This includes national discussions about the governance and leadership arrangements at ICS Board level, planning for the human resources consequences of the proposed abolition of Clinical Commissioning Groups, the development of provider collaboratives (of which NLaG is a member of both the acute and the community collaboratives in our ICS), and developments at Place (or top tier local authority) level. A workshop at Place level is scheduled for the East Riding of Yorkshire in early June (at which NLaG will be represented by the CEO) and a series of development sessions have taken place in North East Lincolnshire (again with Board level representation). Proposals are at an advanced stage in North East Lincolnshire to establish an Integrated Care Partnership and it is anticipated that NLaG will be part of this.

2. Pandemic response, recovery planning and key operational pressures

On Friday 21 May, the Trust was able to report that it had no Covid-positive inpatients, for the first time since early autumn last year. This was a significant milestone but concerns about new variants of Covid-19 possibly spreading in the UK mean that the Trust (and the whole NHS) remains alert to the risks of a further wave of Covid infections.

In the meantime, our attention has switched to recovering the huge amount of 'ground lost' with respect to elective, outpatient and diagnostic patient care during the pandemic. The clinical divisions are mobilising at pace to maximise the numbers of patients we can see and treat, against a backdrop of two substantial constraints. The first of these is the limitations on working arrangements created by the need to maintain the highest standards of infection prevention and control, in the face of continued risk of Covid-19. The second is the strain on our staffing resources, due to the impact on staff health and well-being of the pandemic. The Trust introduced multiple measures last year to support the health and wellbeing of staff, and it is redoubling its efforts this year. At the same time, we continue to focus heavily on recruitment – with notable successes recently in recruiting health care support workers, and the arrival in recent months of an anticipated (by year end) 100 overseas nurses. These successes notwithstanding, ensuring our wards and departments are staffed safely, is a major daily operation challenge.

Our capacity to invest resources into recovery of elective, out-patient and diagnostic work is partly constrained by the demands of urgent and emergency care and non-elective work. It had been anticipated across the country that A&E attendances would continue to be lower than pre-pandemic levels for some time, but this has not transpired at NLaG. Our A&E attendances over recent months have been at effectively the same level as in the year before the pandemic, and the number of days when the combined attendance at our two acute sites exceeds 500 (pre-pandemic an extremely rare phenomenon) has grown very substantially. We are working with system partners across Northern Lincolnshire, NHSE/I and ECIS (the Emergency Care Intensive Support Team) to understand this – through patient audits – and then, we hope, to address its causes.

Peter Reading

NLG(21)106

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board - Public
REPORT FROM	Dr Peter Reading, Chief Executive
CONTACT OFFICER	Dr Peter Reading, Chief Executive
SUBJECT	End of Year Report on Performance against Trust Priorities 2020-21
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Executive Team meetings Trust Board (Private), 4 May 2021
EXECUTIVE SUMMARY	In May 2020 (decision delayed due to pandemic), the Board agreed Trust Priorities for 2020-21. This report has been compiled by the Executive Team, with input from Non-Executive Directors, as a formal End of Year Report on Performance against those Priorities. It should be noted (1) that responding to the pandemic and its many associated impacts on staff, waiting lists, facilities, etc was not included among these Priorities, and was therefore handled as additional pressure; and (2) that the pandemic affected significantly Trust performance against some objectives where key personnel/organisational focus was diverted to pandemic response. The Board is asked to note and approve the Report.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	All

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

End of Year Report on Performance against Trust Priorities 2020/21

Priority		Measure/KPI – what will be different by 31 March 2021
Leadership and Culture		
1	**Further development of the Trust Board and senior leadership of the organisation** Partially achieved due to Covid (DTC)	• Undertake six Board Development Days during the year focused on key risk areas. Achieved - 10 Board Development events undertaken (modified DTC). • Improvement in the CQC well-led domain from requires improvement to good. No CQC inspection DTC but substantial work on well-led development (Board appointments, IPR, BAF, etc.). • In the absence of a National staff survey due to Covid, a local culture and morale barometer to be undertaken. Local barometer not undertaken DTC, how National Staff Survey was undertaken. • 10% improvement in number of staff who have attended Pride and Respect training. Pride and Respect Training was stood down DTC, so not achieved.
2	**Develop and implement a leadership development programme targeted principally at divisional leadership structures (Bands 6, 7 and 8)** Not achieved (DTC)	• Establish a leadership development programme for Bands 6, 7 and 8. • Increase the number of Bands 6, 7 and 8 attending leadership programme courses by 30%. • Develop a coaching/mentoring programme for the Trust using a Systemwide approach. The development of a leadership programme for leaders at bands 6, 7 and 8 was put on hold DTC. This is still an important objective and as a result has formed part of the Trust's Priorities for 2021/22 and is a key focus within the implementation of the People Strategy. It is hoped that a leadership programme will be scoped out by December 2021 which will focus on leadership at all levels, and if approved and supported, rolled out from 2022. • Increase Insights roll out from 120 in 2019/20 to 200 during 2020/21 Small numbers of Insights were achieved (24) but this was significantly reduced DTC.
3	**Deliver quality improvement projects using QSIR methodology showing demonstrable improvement** Partially achieved (DTC)	• Revise and develop the Trust's Quality Improvement Strategy Increase the number of staff who have undertaken QI training by 10%. • Further measures to be agreed, e.g., number of projects undertaken and impact delivered. ▪ Executive leadership of Quality Improvement (QI) transferred to Chief Nurse, September 2020 (transfer delayed from April 2020 DTC). ▪ From March 2021, 102 Junior doctors have had new and updated online training on QI. NLaG doctors will deliver a QI project as part of their rotation. ▪ Working with NHSI, the Trust now has access to the QSIR Virtual training package allowing the organisation to resume the first QI training since the start of the pandemic. QSIR Virtual will commence on 5 April. ▪ Associate Director for QI has been appointed. A new Framework has been developed for the Trust, with a QI platform ready to launch.
4	**Achieve all Trust targets for mandatory training and PADR** Partially achieved (DTC)	• Achieve Trust target of 90% for core mandatory training and 85% for role specific training Core training compliance was 91% - fully achieved. Role specific training compliance was 80% - partially achieved. • Achieve Trust target of 85% for PADRs PADR compliance was 80% - underachieved by 5%.
Workforce		
5	**Sustain and improve recent improvements in staff retention rates** Not achieved (partly DTC, partly due to other reasons)	• In the absence of a National staff survey due to Covid, a local culture and morale barometer to be undertaken Local barometer not achieved DTC but National Staff Survey undertaken. • Maintain the current staff turnover rate Staff turnover at March 2020, was 9.1% and at March 2021, it was 9.3%, therefore not quite achieved. This is based on a 12 month rolling period. *Note: we have used the standard NHS calculation via ESR to calculate this. • Improvement in the retention rate by 5% We are unable to calculate this, as we do not have a standard and agreed definition for retention so do not have a baseline against which to establish whether there has been an improvement or reduction. • Reduction in the overall vacancy rate to 6%. Vacancy rate at March 2021 is 9.4% - SPC charts available for the 12 month rolling period. Not achieved. • Improve the number of applicants who report a positive experience of the recruitment process Not undertaken during 2020/21, put on hold DTC. This will restart in 2021.

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<tr><td></td><td></td><td>

- In the absence of a National staff survey due to Covid, a local culture and morale barometer to be undertaken
  Not undertaken DTC although National Staff Survey did happen.

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<tr><td>6</td><td>Reduce the Trust vacancy rates with particular focus on nursing and medical staffing resulting in a reduced usage of temporary staffing

Limited achievement (unclear how much of this was DTC)</td><td>

- Maintain the staff current staff turnover rate
  Not achieved. Small increase:

<table>
<tr><th>Turnover Rate (12m)</th><th>2020 / 03</th><th>2021 / 03</th></tr>
<tr><td>Medical and Dental</td><td>10.00%</td><td>10.53%</td></tr>
<tr><td>Nursing and Midwifery</td><td>8.99%</td><td>10.21%</td></tr>
</table>

- Improvement in the retention rate by 5%
  As above. We are unable to calculate this, as we do not have a standard and agreed definition for retention so do not have a baseline in order to establish whether there has been an improvement or reduction.
- Maintain the medical vacancy rate at 11% with overall ambition to reduce by 1.5%
  Not achieved. Medical vacancy rate at March 2021 was 11.9% - SPC charts available for 12 month period.
- Maintain the nurse vacancy rate at 7.7%
  Not achieved. Nursing vacancy rate at March 2021 was 10.1% - SPC charts available for 12 month period.
- Reduction in unregistered vacancy rate to 3.5%
  Achieved. Vacancy rate at March 2021 is “operationally” Zero as determined by national NHS – to allow for turnover/recruitment.
- Full implementation of Safe Care Live to reduce the unnecessary agency costs in nursing by the workforce rosters reflecting the clinical demand of each service.
  Safe care Live was implemented in April 2020 in response to the pandemic to help provide assurance to the CNO in relation to acuity, safe staffing levels and managing clinical risk. This continues to be embedded across the organisation but is used on a daily basis to help manage staffing levels appropriately.

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<tr><td>7</td><td>Ensure safe staffing across our clinical areas, focussing specifically on A&E, paediatrics and critical care

Substantially achieved – in spite of Covid</td><td>

- Participate in any national reviews for safe staffing levels
- Staffing levels on wards/departments meet national minimum requirements
- Maintain safe staff fill rate at greater than 95%
- Ensure that safe staffing report actions are linked to strategic workforce plan.
  Shift fill rate has fluctuated throughout the pandemic, with a fill rate of around 100% during the months we had the support of the 3rd year student nurses, to our lowest of 83% in December 2020. A combination of winter, escalation beds and sickness. This is increasing back to more normal levels of 93%. This gives an average over the year as 96%. There have been no national reviews of safe staffing. Staffing levels have continued to be monitored and reported to Q&S Committee throughout the pandemic. We have successfully bid and been awarded money as part of the CNO England’s Workforce mandate to support HCSW and International recruitment.

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<tr><td>8</td><td>To agree and implement strengthened support to staff experiencing mental health problems

Substantially achieved - different programme</td><td>

- Creation of a Wellbeing Board.
- Reduce the intervention time for the first support mechanism from 28 days to 14 days for all staff identified with a sickness absence reason of mental health, anxiety and stress.
- 100 managers to be trained in mental health awareness.
- Survey Monkey undertaken to measure satisfaction with the service.

- As a response to the pandemic, Health and Wellbeing (HWB) had a significant investment from April 2020, to support staff when they needed it the most. A HWB steering group was formed and the support systems below were introduced as an interim HWB Framework including:
- Launch of ‘Care for Each Other’ – a one stop shop advice page on intranet where all initiatives and support services are accessible to all staff.
- New Employee Assistance Programme support provider including 24/7 phone counselling and new pathways created with all providers including digital platform with self-help guides.
- A ‘stepped care’ approach to mental health support was introduced led by the Lead Clinical Psychologist in partnership with all external providers.
- Partnering with Remploy ‘Mental Health at Work’ programme which offers every staff member 9 months full support from specialist consultants to support with staying well at work or returning to work after a period of sickness. Remploy consultant work with staff and their manager sin developing written wellbeing plans.
- Wobble Rooms created.

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		▪ Staff donations and welfare packs donated to all staff. ▪ Wellness Wednesday launched to support mental, physical and financial health – a weekly virtual platform. ▪ Virtual counselling sessions created for face to face support. ▪ Group counselling sessions arranged following traumatic events. ▪ CEO daily email emphasised the importance of taking annual leave and all health and wellbeing offers available to staff. ▪ Upskilling of managers to support staff – over 170 managers received bespoke training in identifying and support mental health issues including signs of burn out, distress and anxiety. ▪ Introduction of a dynamic online risk assessments process that married physical health risks related to working conditions and the pandemic with the impact on mental health, with mental health conversations embedded in the RA process. ▪ All staff, students and contractors encouraged to access Lateral Flow kits with the introduction of digital result submitting platform for all to access from home. The digital system also provides a 'confirmation of test result' back to the recipient for displaying to partners such as care homes in order to further safeguard our patients. ▪ Creation of x2 Hospital Hubs to support Covid 19 vaccine roll out to all our staff and the wider Health & Social Care community. ▪ HWB Guardian introduced and our lead NED for workforce. ▪ BAME Wellbeing Coordinator appointed, funded through Health Tree Foundation. ▪ Roll out of vaccine programme for all Health and social care workers. ▪ Improvement in staff survey results relating directly to HWB.
Quality and Safety		
9	**Achieve the must do actions identified in the CQC report** Substantially achieved - strong CQC engagement	• To develop an action plan with clear trajectories to deliver the CQC recommendations which has been signed off by the CQC • Deliver improvements against regulatory actions in the agreed timeframe. • Overall improvement in CQC ratings against the 2019 report, but particularly in the Safety Domain. • Staff can articulate what the Trust quality priorities are and how they are engaged in their delivery. ▪ Action plan developed, monitored monthly. Trajectories amended due to the impact of Covid. Monthly report identifying progress. ▪ Nine actions have not been delivered within the timeframe (6.4% of all actions). These relate to mandatory training and PADRs, the diagnostic waiting lists and areas where additional resources are required to meet the CQC standard, e.g. community nursing. ▪ Given Covid, it has not been possible to engage with staff in detail on the Quality Priorities, and there has not been a CQC inspection to amend the rating.
10	**Reduce mortality rates and strengthen end of life care** SHMI target achieved, but only partial achievement against other measures (DTC)	• Reduction in the Trust SHMI to within expected range • Improvement in initial mortality screening to 50% and number of structured judgement reviews (SJR) undertaken on 100% those identified from screening as requiring SJR. • Improve timeliness of observations on adults and children to 85% within 30 minutes of due time. • Improve frequency of sepsis screening and robustness of reporting. • Develop method of gathering patient and carer feedback for end of life care with local hospices • 80% of all inpatients (excluding maternity) to be screened for alcohol and tobacco use • 90% of all inpatients (excluding maternity) to receive brief advice on tobacco use if they smoke ▪ SHMI has had a sustained statistically significant improvement and is within expected range at 107. ▪ Initial mortality screening has achieved 50% except August and September 2020. SJRs have a backlog due to the increased volume of referral to SJR and the impact of Covid. ▪ Sepsis observations on adults has achieved 85%, with children the achievement was partial, with slippage in April, October and November 2020. ▪ Frequency of screening and robustness of reporting re sepsis not achieved, being carried forward to 2021/22 ▪ Patient and carer feedback for end of life in hospice not measured DTC. ▪ The alcohol and tobacco priorities did not progress DTC.
11	**Improve the management**	• Monthly audit to be designed and implemented to determine appropriate quality

	of diabetes Substantially achieved	measures. This will include improvement in monitoring of blood sugar in patients with diabetes. • Reduction in insulin errors which cause significant harm to less than 5% of overall reported insulin incidents • Achieve 85% compliance with role specific mandatory training for diabetes • Blood glucose taken in ECC if NEWs over 1 for adults, PEWs over 6 for children in 95% of cases ▪ Monthly audit designed and implemented, but the results indicate work still to do to attain and embed the standards across the board. ▪ Insulin errors of significant harm is less than 5%. ▪ 85% Mandatory training for diabetes achieved. ▪ The BM taken in ECC has fluctuated. The addition of the PEN team has led to a change to be set down in protocol, to allow for clinical judgement from a Paediatric expert.
12	**Improve the quality and timeliness of complaints responses using a more individualised approach** Achieved	• Improvement in the time taken to respond to complaints (trajectory to be determined) • Quality measures to be determined. ▪ 100% of complaints >120 days have been now closed (at March 2020, there were 97, with one at >700 days). ▪ Significant reduction in open complaints despite only slight reduction in incoming complaints during Covid - 219 open complaints in March 2020 - 64 open complaints March 2021. ▪ Trust wide adoption of new process, with lead investigator role taking responsibility for investigation as opposed to central team. ▪ Quality of responses is much improved, and learning evidenced in responses.
Access and Flow		
13	**Improve the Trust waiting list with a focus on 40 week waits, total list size and out- patient follow-ups** Objective changed DTC- nevertheless, strong recovery performance achieved by regional comparison	• Reduce delayed transfers of care to 60 (move flow and access) The Trust has reduced DTOCs to 8.3 from the position shown above and is currently 4th in the region for length of stays over 14 days. • Reduce the overdue follow up waiting list to below 9,000 by 31 March 2021 This reduced from 31,323 in March 2020 to 21,969 in March 2021, this would have been reduced further in the year if it was not for COVID-19 not enabling follow up patients to be reviewed. The Trust also introduced patient initiated follow up during the year to support better management of follow up patients and new referrals. • 52 week waits to be at zero The Trust submitted 1,187 RTT 52 Week breaches at the end of March 2021. Based on the previous 2 years delivery of 52ww, the trust would have hit zero RTT 52 week waits if it was not for COVID-19 where elective activity was reduced due to the associated risks. The Trust's RTT 52 week is markedly better than other trusts within the region. • The overall RTT waiting list to be less than it was on 31 January 2020 The RTT waiting list on 31st January 2020 was 25,227, on 31 March 2021 the waiting list was at 28,853. The Trust was unable to reduce the overall waiting list due to the requirements of COVID-19 to reduce the elective activity.
14	**Improve the effectiveness of cancer pathways focussing on time to diagnosis** Not achieved DTC	• Time to diagnosis and patient informed by day 28 to be at 75% 28 day faster diagnosis was at 59.7% in March 2021. This has been severely hampered by COVID-19 throughout the year • Care of patients with confirmed diagnosis transferred by day 38 to be at 75% March 2021 was at 20% performance but the numbers of patients ready to transfer was low in month (5 in total for March). As with all Cancer pathways COVID-19 has had a significant affect. • Request to test report turnaround to be no more than 14 days in 100% of cases DTC this target was not achieved. Currently across most Cancer diagnostic tests the wait is greater than 14 days. • Develop a clear service model and a Trust target to ensure that cancer services are maintained The Trust has established the Humber Cancer Board which meets monthly to support the management of Cancer Services across the Humber. The Group has progressed the faster access to diagnostics and earlier treatment in a number of tumor types. Unfortunately the progress of these development has been significantly delayed DTC. • Number of combined site MDTs to be 100% Achieved. All MDTs across the Trust are now combined and through the Humber Cancer Board work has commenced on combining MDTs across the Humber in a

		number of tumor types.
15	**Improve safe flow and discharge through the hospital focusing on outliers, late night patient transfers and discharges before noon** Substantially achieved - where not affected by Covid	• Reduction in the average length of stay to less than 4 days 2020/21average length of stay was 4.06, this is shorter than 2019/20 but is not where we had planned for the year mainly due to the complexity of managing patients with Covid. • Increase in the zero length of stay to 32% Zero length of stay was at 27.23% for 2020/21. • Sustained improvement in the 0–1 day length of stay Discharges with length of stay less than 2 was 5,953 in March 2020 and 6,578 in March 2021, demonstrating significant improvement in this approach to care. • Reduction in non-elective length of stay to less than 4.1 days 2020/21 non-elective average length of stay was 4.22, mainly due to the COVID-19 patients requiring more complex input prior to their discharge. • Reduction in elective length of stay to less than 2.4 days 2020/21 elective average length of stay was 2.00, a significant improvement from previous years. • Reduction in the number of medical outliers (target to be agreed) Percentage of ward outliers was 22.66% in March 2020, this increased to 47.44% in March 2021, however this figure is difficult to report as throughout the year wards changed their classification and clinical patient type due to the need to manage Covid-19 patients. There was also a significant impact on this position related to the overall reduction in beds due to requirements of social distancing and temporary cubicles which were used throughout the COVID-19 pandemic. • 85% of discharge letters to be completed within 24 hours post discharge The Trust achieved 50% of letters being submitted within 24hrs in April 2020 but the position has not been held and is currently at 40% of letters being submitted within 24hr of a contact with the Trust. To support this action further the trust has engaged with clinicians and agreed a new category of letter 'Dictated but not Signed' to reduce the delays to letters being submitted on time. • Identify a robust mechanism for recording golden discharges Discharges and times are recorded on PAS, in March 2020 there was 1,480 golden discharges rising to 1,491 in March 2021. • Number of early supported discharges to increase by 10% The Trust embarked on the discharge to assess programme in April 2020. Through this programme, the number of early supported discharges has increased to an achievement of 44% of discharges happen within 7 days against a national ambition of 40%. • Improvement in the number of patients that have admission prevention services provided by the community services in North and North East Lincolnshire (target to be agreed) In March 2020 in response to the Covid-19 pandemic response the Community Team added a GP to the single point of access and crisis team. This has resulted in 450 patients in the North Lincolnshire locality being maintained at home rather than attending ED. • All patients requiring mental health support in ED will be assessed within 4 hours of referral During the last year the data collection development around Symphony has not enabled this statistic to be collected specifically related to a diagnosis type. Monitoring of patients' requirements mental health support has shown that there have been 4 patients who had their final decision on a treatment pathway after being within the department for 12hours. • Patient in in-patient wards will be assessed and have a plan in place within 8 hours of referral The latest audit of 7 day services has shown that 60% of patients have a plan in place within 8 hours of admission rising to 83% within 72hours.
Finance		
16	**Deliver the statutory finance performance targets** Substantially achieved - TBC at year-end, including achievement of revised CIP target	• Delivery of the Trust year-end control total as part of the Humber and Northern Lincolnshire system financial targets The Trust reported a £0.16m surplus for the 2020/21 financial year. This was in line with plan. The Humber system and the wider HCV ICS collectively reported achievement of the overall financial plan set by NHSE/I for the year. • Achievement of the financial recovery fund (£43m) This wasn't applicable in 2020/21 due to the revised finance regime introduced on the back of the Covid pandemic. See comment above regarding performance against financial targets. • Delivery of a cost improvement programme of £13m fully supported by a quality

		impact assessment process A revised plan of £10.3m was agreed within the financial plan. Delivery in year was £10.4m, of which, £6.3m was recurrent in nature. • A balanced plan set for 2020/21 in conjunction with system partners A balanced financial plan across HCV for H1 of 2021/22 has been submitted to NHSE/I. This provides for a £0.22m deficit within NLaG. • Development of a robust business case process A revised business planning arrangement will be introduced across the organisation for 2022/23 following the interruption to normal planning processes DTC. The Business Case Review Group will continue to provide a central focal point to the coordination and prioritisation of business cases.
Service and Capital Investment Strategy		
17	**Continue to be actively involved in the Humber Acute Services Review** Very substantially achieved	• Work with the Humber system to develop a plan to deliver Trust sustainability • Work with the Humber system to develop a plan for service sustainability • Agree options for future models of care post Covid • Leadership of fragile services workstreams at sub system level ▪ Governance revised and Programme Team in place. NLaG is providing the overall Director to the Programme, SRO for Interim Clinical Plan and Leadership of Core Service Change and Capital Programmes. ▪ Clinical leads appointed and working across the system on pathway redesign, including out of hospital and primary care transformation. ▪ Programme Plans developed and agreed with NHSE/I and ICS teams. ▪ Programme Gateway Review undertaken by NHSE/I, Initial options development work undertaken and engaged with over 450 staff, OSCs and initial survey of what matters to you undertaken – 3,900 responses received in 4 weeks.
18	**Complete the Wave 4 capital business cases and commence construction** Very substantially achieved, plus substantial additional achievements in attracting investment	• Delivery of the SGH MRI business case with NHSI/E approval NSHI/E approval of the AAU business case • Reduction in backlog maintenance • Maintain Statutory Compliance and Physical Condition ▪ Estates Strategy and Green Plan developed and approved by Board. ▪ Delivery of the SGH MRI Full Business case with approval from NHSE/I to proceed to construction onsite. ▪ Construction commenced onsite at SGH for the MRI development with an estimated project handover date of October 2021. ▪ The Strategic Outline Case (SOC) and Outline Business Case (OBC) for the Acute Assessment Units at both Scunthorpe General Hospital (SGH) and the Diana Princess of Wales Hospital (DPOW) were completed and have been approved by NHSE/I. A Full Business Case (FBC) is now in development and will be submitted for October 2021. ▪ Additional Funding Secured outside Wave 4 STP Capital. ▪ CT Unit open and operational onsite at DPOW. ▪ New back-to-back MRI at DPOW commenced onsite with first patients treated April 2021 (builders off site for part of Wave 1 of pandemic). ▪ For additional Urgent and Emergency Care (UEC) Funding, a business case was developed and approved by the national NHSE/I Urgent and Emergency Care Leads for an additional £30m of Emergency Department (ED) Funding into the Trust. This has enabled the Trust to build on from the AAU and complete a full suite of key UEC works. ▪ Key enabling works for ED have commenced on-site including major refurbs for staff relocations. ▪ The AAU and Emergency Department projects includes the demolition of the Admin Block and War Memorial buildings at SGH which would reduce the Trust Back Log Maintenance (BLM) by c£5.7m. ▪ £1.4m Critical Care and Medical Gases Funding to enable improvements to the oxygen systems at SGH and DPoW, along with the supply of mobile isolation facilities. ▪ **Critical Infrastructure:** The Trust secured £3.5m critical infrastructure funding for fire and water infrastructure. The first phase of the work is focused on replacing the fire alarms and upgrading the water infrastructure at DPOW. ▪ **A&E Infection Prevention and Control Capital Works:** The Trust committed £1.8m from its Capital Programme to fund further winter/infection prevention and control and COVID-19 social distancing works in accordance with NHSE/I guidance. The work which was completed in March 2021, included isolation pods on Wards and sliding doors on A&E cubicles in SGH and DPOW.

		▪ **Energy scheme: T**he Trust has secured £40.3m of Decarbonisation funding through the Government department for Business, Energy and Industrial Strategy (BEIS) and Salix – a non-governmental organisation which works alongside BEIS. The funding which was the highest award across the NHS will be used to replace the coal-fired boilers at Goole, a new Energy Centre at SGH and several other Energy preservation measures including solar panels, LED lighting and new windows.
19	**Commence the development of the strategic outline business case for the investment in Humber's hospitals** Achieved	• Development of the strategic outline case for a capital masterplan for Humber Acute Services programme • Development of Estates Strategy Strategic capital options work commenced: ▪ Capital brochure developed. ▪ Economic and social impact study undertaken. ▪ Framework for capital options developed. ▪ Initial discussions with NHSE/I funding routes undertaken. ▪ Capital programme embedded within Humber Acute Services Programme given capital requirements of implementation – investment linked to future pathways and models of care.
20	**Develop interim clinical services plan for presentation to Scrutiny Panels by the end of the year** Achieved - with issues still in Ophthalmology	• Presentation of the interim clinical plan to the Scrutiny Panels by end of December 2020. • Identification of fragile and vulnerable services which require improvement by 31 August 2020 • Lead the ophthalmology improvement programme for North and North East Lincolnshire by 30 September 2020 ▪ Interim Clinical Plan embedded within HAS Programme. ▪ OSC presentation on workplans undertaken in September 2020 and follow up session in March 2021. ▪ Interim clinical plan pathways and target operating model defined by March 2021, with implementation plan agreed by EOG in January 2021. ▪ Ophthalmology programme split between Interim Clinical Plan and acute collaborative work programme for high volume low complexity work. Core service change will be delivered through Programme 2 of HAS, eg implementation of integrated reporting system and work with community optometrists – initial implementation outstanding
21	**Develop a Digital Transformation Strategy with the aim of investing in modern digital infrastructure to transform how we deliver services** Achieved	• Chief information officer appointed • Digital Strategy developed and approved • Review of digital transformations implemented during Covid to ensure that these are continued as appropriate ▪ Chief Information Officer appointed and started in post 1 November 2020. ▪ Strategy developed and approved at January 2021 Board Meeting. ▪ Received Digital Aspirant funds of £5m spread over Fiscal years 2020/21 and 2021/22 to support Digital Transformation. ▪ The Digital transformations implemented during Covid are reviewed to ensure these are continued as appropriate. These include remote working, expanded use of laptops for mobile working, virtual consultations. ▪ Performance data on remote working indicates activity increased from a normal peak average of 100 simultaneous connects to now averaging 400 simultaneous connections. ▪ 90% of Computers/Laptops upgraded to Windows 10, utilising a combination of new devices for old or upgrading existing devices where possible, giving staff access to an up to date, modern Microsoft operating system. ▪ Unified communications systems deployed and now consolidated to a single platform utilising Microsoft Teams throughout the Trust with licences for all staff to use. ▪ Completed electronic referrals from NHS111 into our Emergency Department system in November 2020. ▪ Completed a Phase 1 Business Intelligence (BI) review to support transformation BI and reporting processes in December 2020.

NLG(21)107

DATE OF MEETING	1 June 2021
REPORT FOR	**Trust Board of Directors**
REPORT FROM	Lee Bond, Chief Financial Officer
CONTACT OFFICER	Brian Shipley, Deputy Director of Finance
SUBJECT	**Financial Operational Plan 2021/22**
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	F&P Committee – 28 April 2021
EXECUTIVE SUMMARY	The attached paper outlines the 2021/22 Financial Plan for H1.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Risk 6				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓	✓	✓	

2021-22 Interim Budgetary Framework Allocation

1. Purpose of this Document

The purpose of this report is to outline the Trust's approach to budget setting for the first six months of 2021/22 and present the overall draft 6 month plan (H1) for approval.

2. Background

Official planning guidance has now been released that sets out the details of the finance and contracting arrangements for the six-month period from 1 April 2021 to 30 September 2021 ('H1 2021/22' or 'H1').

As expected, the Trust will receive block allocations from Commissioners, including the additional top-up funding for its underlying deficit position as per those received in 2020-21, adjusted for inflation at 0.78% less a 0.28% efficiency requirement, a net 0.50% uplift.

Systems have retained additional funding to cover COVID-19 related cost pressures. The Trust will receive the same level of funding it received in H2 of 2020-21 (£6.4m).

NHS England and NHS Improvement have nationally calculated the ICS and individual organisations financial plans for the H1 period. and have been generated based on Q3 2020/21 actuals. The overall ICS system is required to deliver a break-even financial plan. The Trust reported a surplus for the Q3 period of £1.5m and this has been extrapolated requiring the Trust to deliver an indicative surplus of £3m for H1 of 2020-21. As part of the system planning process, this has been reduced and the Trust is required to deliver a financial planned **deficit of £0.22m**.

3. Budgetary Plan

As reported previously, the initial assessment of the Trust's underlying financial position in the absence of planning guidance was a forecast underlying deficit for 2021-22 of circa £24.9m. This has been refined further following the publication of planning guidance and is revised to an underlying forecast deficit of £20.7m. The movements of note relate to non clinical income with the confirmation of HEE funding, revised inflationary pressures, tariff adjusted to confirmed values and the removal of additional funding support for CQC investments.

(The initial assessment and revised assessment are included in **Appendix 1).**

At this point, it is unclear what the H2 financial framework maybe. Therefore the assessment of the Trust financial position is based on a full year of the H1 framework. With the continuation of the block and top up funding the forecast deficit is reduced to £4.37m. It is on this basis that the proposed budget allocation for the H1 period has been set.

The Trust has continued to maintain its budgetary allocation framework throughout 2020-21 which builds from the 2019-20 outturn position, adjusted for non-recurrent items, full year effects, inflation and new recurrent developments in 2020-21. Directorate Budgetary Allocations will therefore follow the same principles, starting from the underlying deficit rollover allocation of £14.76m with a forecast full year deficit of £4.37m and are included in **Appendix 2.**

The forecast is not derived in equal twelfths, predominantly through depreciation phasing and seasonal variation for expenditure i.e. Utilities. Therefore, the forecast deficit for the six month period of H1 is a **deficit of £0.22m** as per the agreed System planning requirement.

The full year and part year effect of the forecast Trust income and expenditure are as follows:

	£000's	
	6 Months PYE	Full Year
Income Assumption		
Block as per 20/21 excl COVID	201,906	403,812
Chargeable patient Income	554	1,107
R&D Income	337	673
Education Income	8,026	16,053
Parking Income	421	842
Catering Income	11	23
Accomodation Income	1,088	2,175
Non Patient Care Contracts	7,654	15,308
All Other Income	615	1,230
COVID Funding	6,581	13,161
TOTAL INCOME	**227,193**	**454,385**
Expenditure Assumption		
Opening Expenditure Budgets 20/21	(217,061)	(437,971)
Pay Awards & Incremental Drift	(1,087)	(2,174)
Non Pay Inflation	(415)	(829)
CNST	(184)	(368)
Cost of Captial, PDC & Interest Expenses	(724)	(1,537)
Investment Programme	(5,858)	(11,716)
Efficiency Target	4,501	9,002
COVID Expenditure	(6,581)	(13,161)
TOTAL EXPENDITURE	**(227,409)**	**(458,754)**
Surplus/ (Deficit)	**(216)**	**(4,369)**

Potential Upsides not included in the Forecast Financial Plan:

- Elective Recovery Funding – The Trust can earn additional funding at 120% of National Tariff values if it delivers additional activity above the 85% threshold outlined in the planning guidance. However, this is dependent on the ICS as a whole achieving activity delivery above the thresholds.

- Included within its investment programme (Appendix 2) the IAAU and Diagnostic business cases were underpinned by additional savings opportunities namely bed closures and mobile van hire reductions. This should be in addition to the base 2% savings target that was required as part of the Trust long term plan and represents an upside if the Trust can deliver its 2% savings requirement without the benefits of these schemes included.

- Car Parking Income – The current plan assumes car parking income will continue at the level witnessed in H2 of 2020-21. This level of income should increase as recovery plans increase patient activity but will be partially offset with the continuation of reduced face to face outpatient attendances.

- The Trust has a significant investment programme proposed. Not all schemes have been finalised and there will undoubtedly be slippage and delays in recruitment and mobilisation.

Potential Risks not included in the Forecast Financial Plan:

- COVID-19 Expenditure – An assessment has been made of the ongoing cost pressures relating to Covid-19, which overall could be circa £13.2m in total with confirmed funding to that level. The total spend incurred in 2020-21 was £20m and whilst the position included material non recurrent items there is a risk a repeat would create additional costs pressures. Therefore, it is imperative that the Trust minimises all additional COVID related expenditure where possible.

- Savings Programme - The Trust five year long term plans required a stretch target over and above the base tariff efficiency at 2%. This forms the basis for the 2% target applied for 2020-21. As it stands, the current 2% target does not have a robust delivery plan constructed and therefore there is inherent delivery risk.

4. Budgetary Principles

The following principle set out the proposed treatment for the key bridging items, and provides explanation of material changes to the initial planning assumptions.

Investments:

The proposed investment programme included in Appendix 2, will be allocated to base Directorate budgets where formally agreed and approved by Trust Management Board. For those investment proposals that are still in development and require formal sign off and agreement, they will be held in reserves and released once finalised and costs are incurred.

The initial planning assumptions assumed receipt of additional growth funding to help mitigate investments linked to CQC recommendations. There is currently no identified funding for any new developments in 2021/22.

Inflation Assumptions:

In the absence of guidance the initial planning assumptions assumed inflationary pressures as per the Long Term planning guidance. These have been revised following the publication of the planning guidance as follows and are closely aligned to the assumed inflationary in tariff of 0.78%:

Inflation Assumptions	2021/22 £m	%	Notes
Pay Award & Incremental Drift	2.17	0.69%	% of total pay spend
Drugs Inflation (Non Pass Through)	0.10	0.31%	% of forecast drug spend
Clinical Non Pay	0.30	0.89%	% of forecast spend
Other Non-Pay	0.43	1.90%	% of forecast spend
CNST	0.37	2.37%	% of forecast CNST spend
Total	**3.37**	**0.76%**	**% of Total Operating Expenditure**

The following principles have been applied for the different inflationary pressures:

- Pay budgets have been increased for the incremental drift element only and the confirmed Junior Doctor pay award.
- As per previous years, Non-pay Inflation will be held centrally to be able to be drawn down on once inflationary pressures arise.
- The Trust has received notification of its CNST premium for 2021-22 and will be allocated to base budget.
- Cost of Capital will be allocated to base budgets.

Savings Targets:

Divisions and Directorates were allocated savings targets for 2020-21 to their base budgets. In line with the underlying financial deficit evaluation, any in year recurrent shortfall has been reset in order to create a clear baseline for the 2021-22 targets to be applied and in order to assess savings delivery and performance in year.

The outline 2021-22 financial plan assumes a savings programme requirement that will deliver £9.0m of savings, 2% of Operating Expenditure which is significantly greater than the 0.28% efficiency requirement included in tariff.

An increased efficiency requirement is driven by the material investment programme of £11.72m, residual inflation pressures not covered in full by Tariff and the increased cost of capital. In the absence of receipt of any additional funding, the Trust must fund these requirements itself through increased efficiency.

Savings targets have currently been applied to Directorates/Divisions at 2% of their expenditure budgets.

It is recognised that this crude approach of allocation may not be directing savings targets to where the potential savings opportunities prevail but is intended as a planning guide whilst the programme is developed and will remain fluid until finalised.

Individual Divisional and Directorate savings targets are outlined in **Appendix 2**.

2020-21 COVID-19 Expenditure:

A planning assessment has been made of the ongoing cost pressures relating to Covid-19, which overall could be circa £13.2m in total for a full year if spend remains at 2020-21 exit run rate levels.

Whilst the ongoing pressures are still to be assessed, it is proposed that the outline budgetary envelope is retained centrally and will be released each month. Expenditure will continue to be captured separately and subject to the regular scrutiny as part of the national reporting requirements.

Activity Assumptions:

Budget allocations for non-pay remain at 2019-20 spend levels. It is recognised that the services are currently working through the activity that could be delivered in the first half of this year and consequently budgets will be adjusted accordingly. It is envisaged that activity will be lower and clinical consumable budgets etc will be reduced and flexed accordingly to actual delivery.

5. Conclusion & Recommendations

The Trust Board is asked to note the budget setting principles described and approve the draft budgets for the first six months of the year, recognising the ongoing review and validation of investment developments and COVID expenditure, and the potential scale of the risks to be managed in order to deliver the planned Trust deficit of £0.2m and overall ICS break-even requirement.

Brian Shipley
Deputy Director of Finance
June 2020

Appendix 1 – Financial Gap Bridge Analysis

	Draft Plan £m	Updated Plan £m	Movement £m
2019-20 Outturn Deficit	**(21.94)**	**(21.94)**	**0.00**
Add Back Non Recurrent Items	(28.46)	(28.46)	0.00
FYE 2019-20 Clinical Income Adjustments	(2.90)	(2.90)	0.00
FYE 2019-20 Investments	(4.45)	(4.45)	0.00
2019-20 Non Recurrent Savings	(2.97)	(2.97)	0.00
2019-20 Underlying Deficit	**(60.72)**	**(60.72)**	**0.00**
2020-21 Indicative FRF & MRET	45.98	45.98	0.00
2019-20 Underlying Deficit incl FRF	**(14.75)**	**(14.75)**	**0.00**
2020-21 Income Tariff Adjustments	6.99	6.99	0.00
2020-21 Inflation & Incremental Drift	(9.90)	(9.90)	0.00
2020-21 CNST Premium Increase	(2.11)	(2.11)	0.00
2020-21 Increased Cost of Capital	(1.18)	(1.18)	0.00
2020-21 Loan Interest conversion to PDC	1.53	1.53	0.00
2020-21 Recurrent In Year Investments	(1.23)	(1.04)	0.19
2020-21 Gross Loss of Non NHS Clinical Income	(4.05)	(0.60)	3.44
2020-21 Recurrent Savings Delivery	6.55	6.31	(0.24)
2020-21 Underlying Deficit incl FRF	**(18.15)**	**(14.76)**	**3.40**
FYE 2020-21 Investments	(11.22)	(11.72)	0.50
CQC Investment Funding	3.50	0.00	(3.50)
2021-22 Tariff Adjustments	4.33	1.71	(2.62)
2021-22 Inflation & Incremental Drift	(9.96)	(3.00)	6.96
2021-22 CNST Premium Increase	(0.37)	(0.37)	0.00
2021-22 Increased Cost of Capital	(2.03)	(1.54)	0.49
2021-22 Efficiency Target 2%	9.03	9.00	(0.03)
2021-22 COVID-19 Expenditure	(13.16)	(13.16)	0.00
2021-22 COVID-19 Funding	13.16	13.16	0.00
2021-22 Underlying Deficit incl FRF	**(24.87)**	**(20.66)**	**4.77**
Add Block Clinical Income & Top Up Funding	14.96	16.29	1.33
2021-22 Full Year Deficit	**(9.91)**	**(4.37)**	**5.54**
H1 PYE Adjusted Deficit	**(4.95)**	**(0.22)**	**4.73**
AAU Business Case Savings		**Tbc**	
Diagnostic Business Case Savings		**Tbc**	

Appendix 2 – Budgetary Allocations

Division/Directorate	2020/21 Recurrent Allocation	FYE Investment (Appendix 2)	2021/22 Inflation	Savings Target 2%	Block Income "Top Up" & COVID-19 Funding	2021/22 Allocation
NHS Clinical Income	385,802		1,707		29,397	**416,906**
Other Clinical Income	648					**648**
Education Income	13,831					**13,831**
Trust Management	(1,810)	(17)	(5)	33		**(1,799)**
Medical Directors	(22,137)		(383)	100		**(22,419)**
Chief Nurses Office	(4,531)	(113)	(25)	122		**(4,548)**
Finance	(4,649)	(18)	(20)	169		**(4,518)**
Central Finance	(16,829)		(1,456)			**(18,285)**
P&OE	(5,313)	(197)	(8)	151		**(5,368)**
Estates & Facilities	(29,005)	(563)	(510)	651		**(29,426)**
Digital Services	(9,682)	(190)	(27)	249		**(9,650)**
Strategic Development	(565)		(0)	12		**(553)**
Operations Directorate	(845)		(1)	20		**(826)**
CSS	(62,475)	(1,802)	(246)	1,606		**(62,917)**
C&TS	(29,368)	(53)	(153)	641		**(28,932)**
Medicine	(107,318)	(2,574)	(506)	2,304		**(108,095)**
Surgery	(75,451)	(1,800)	(377)	1,599		**(76,030)**
Family Services	(41,437)	(497)	(280)	889		**(41,325)**
Inflation Reserves	(3,629)	(3,893)	(829)	448		**(7,903)**
COVID-19 Reserve					**(13,161)**	**(13,161)**
Deficit	**(14,763)**	**(11,716)**	**(3,119)**	**8,992**	**15,736**	**(4,369)**

Appendix 3: 2020-21 Recurrent Investments

Scheme	£000's	Allocated to Budgets
IAAU	2,903.1	**Y**
CQC - Anaesthetic Middle Grade Support	1,077.6	**Y**
CQC - ED Dr's Cover **(Estimate TBC)**	1,391.0	
CQC - Community Nursing **(Estimate TBC)**	564.7	
CQC - ED Paediatric Nursing **(Estimate TBC)**	466.5	
Chief Nurse Midwifery Review	496.9	**Y**
Ockenden Review Recommendations	0.00	
LCSH Pathology	632.0	**Y**
Digital Aspirant	515.8	
DPoW MRI Staffing	477.0	**Y**
DPoW CT Staffing	356.0	**Y**
Ophthalmology Capacity Expansion	285.4	**Y**
E&F Car Parking & Security Tender	265.0	**Y**
GDH HOB's	253.0	**Y**
DPoW 2nd CT (NHSI Supplied PYE)	249.2	**Y**
SGH New MRI (PYE)	201.5	
POE Restructure	196.8	
Chief Nurse QI Team	193.0	
GDH OOH'S Site Cover	144.0	**Y**
N365 Business Case	103.3	**Y**
Digital Services - CNIO & CMIO	86.8	**Y**
Chief Nurse Directorate Support	68.6	**Y**
Redirooms Maintenance	60.0	
TCAM	59.9	**Y**
Maternity Theatre Scrub ODP	40.3	**Y**
ED Clinical Educator	49.0	**Y**
Communication Officer	17.0	**Y**
Chief Nurse 15 Steps	19.8	**Y**
Procurement Support	17.5	**Y**
Consultant Clinical Lead ACP	18.0	**Y**
Chief Nurse ACP Post	6.9	**Y**
Sub Total – Agreed Investments	**11,215.6**	
Unallocated Investment Reserve	**500.0**	
Total Investments	**11715.6**	

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)108

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Shaun Stacey, Chief Operating Officer
CONTACT OFFICER	Sarah Smyth, DGM Zoe Plant, Assistant Director of Finance Lynsey Chessman, Business Planning Manager
SUBJECT	Operational Plan, H1, 2021/22
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Executive Team – 18 May 2021 F&P Committee – 26 May 2021
EXECUTIVE SUMMARY	The attached paper outlines the Operational Plan for H1 2021/22

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	1) Performance 2) Quality ("Risk of non-delivery of agreed quality and clinical improvements (includes the risk of non-delivery of a reduction in the mortality ratio)") 3) Workforce: Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and longer term 6) Finance ("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.")				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓	✓	✓	

2021/22 Operational Plan H1 (April – September)

1. Purpose of this Document

The purpose of this paper is to outline the Trust's response to the planning guidance for the first six months of 2021/22 and present the activity, financial and workforce plans for approval.

2. Background

Official planning guidance has now been released that clearly describes how the pandemic has shone a brighter light on health inequalities and gives clear direction on steps to develop population health management approaches to address these in access, experience and outcomes, working with local partners across health, social care and beyond. To support this, priority areas have been set out within the guidance for particular focus within the first half of 2021/22.

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention
B. Delivering the NHS Covid vaccination programme and continuing to meet the needs of patients with Covid-19
C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities
E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for ED patients and reduce length of stay
F. Working collaboratively across systems to deliver on these priorities

3. Activity & Performance

System activity thresholds have been set nationally, measured against the value of total activity delivered in 2019/20, and taking into account productivity constraints due to infection prevention and control (IPC) measures.

There will be a staged increased in thresholds, recognising the ongoing challenges in re-establishing affected services and workforce recovery. The thresholds, as a percentage of the value of the 2019/20 activity, will be:

• 70% for April 2021

• 75% for May 2021

• 80% for June 2021

• 85% from July to September 2021

The scope of the activity covered is:

- Elective activity (ordinary or day case), including cancer, with a published tariff price
- Outpatient procedures with a published tariff price
- Outpatient attendances for all treatment function codes (TFCs) apart from mental health, maternity and diagnostic imaging, whether consultant-led, non-consultant-led or non-face-to-face.

Alongside this, the guidance also advices we plan non-elective activity at 19/20 levels. We have also discussed with our local partners to agree that our referral numbers will be set at 100% of 19/20 levels as reflected within our partner organisations.

The below tables outline details of the NLAG submission.

RJL: NORTHERN LINCOLNSHIRE AND GOOLE HOSPITALS				Apr 2019 Mar 2020	Apr 2019 Sep 2019	Apr 2021-Sep 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
Total OP												
	E.M.32	Count/Total	Total outpatient attendances (all TFC; consultant and non consultant led)	388,606	196,972							
	E.M.32a	Count	Total outpatient attendances (all TFC; consultant and non consultant led) - Face to face	369,260	188,126	116,726	18,548	18,296	20,590	20,061	19,257	19,974
	E.M.32b	Count	Total outpatient attendances (all TFC; consultant and non consultant led) - Telephone/virtual	19,346	8,846	74,649	12,672	12,185	13,648	12,211	11,723	12,210
1st OP												
	E.M.8	Count	Consultant-led first outpatient attendances (Spec acute)	102,680	52,222	48,855	7,699	7,712	8,617	8,382	8,076	8,369
	E.M.8b	Count	Consultant-led first outpatient attendances with procedures (Spec acute)	18,288	9,359	7,367	1,200	1,172	1,279	1,256	1,216	1,244
FU OP												
	E.M.9	Count	Consultant-led follow-up outpatient attendances (Spec acute)	184,138	91,488	92,394	15,552	15,165	16,895	15,151	14,543	15,088
	E.M.9b	Count	Consultant-led follow-up outpatient attendances with procedures (Spec acute)	31,659	15,809	16,808	2,687	2,554	2,952	2,916	2,783	2,916
Electives												
	E.M.10	Count/Total	Total number of Specific Acute elective spells in the period	59,828	30,397	29,605	4,449	4,743	5,252	5,130	4,969	5,062
	E.M.10a	Count	Total number of Specific Acute elective day case spells in the period	53,172	26,982	26,769	4,092	4,320	4,736	4,609	4,467	4,545
	E.M.10b	Count	Total number of Specific Acute elective ordinary spells in the period	6,645	3,415	2,836	357	423	516	521	502	517
	E.M.10c	Count	Total number of Specific Acute elective day case spells in the period of which children under 18 years of age	1,084	594	431	66	70	76	74	72	73
	E.M.10d	Count	Total number of Specific Acute elective ordinary spells in the period of which children under 18 years of age.	302	156	236	30	35	43	43	42	43
A&E 1-4												
	E.M.12	Count/Total	Total number of attendances at all A&E departments, excluding planned follow-up attendances (Types 1&2 + Types 3&4)	150,946	76,603	70,283	11,255	11,630	11,355	12,320	11,630	12,093
	E.M.12a	Count	Total number of attendances at all Type 1 and Type 2 A&E departments, excluding planned follow-up attendances	150,931	76,603	67,931	11,898	12,339	11,865	12,873	12,024	11,688
	E.M.12b	Count	Total number of attendances at all Type 3 and Type 4 A&E departments, excluding planned follow-up attendances			2,352	412	427	411	446	416	405
Non-Electives												
	E.M.11	Count/Total	Number of Specific Acute non-elective spells in the period	44,442	21,573	22,522	3,713	3,866	3,540	3,875	3,874	3,654
	E.M.11a	Count	Number of Specific Acute non-elective spells in the period with a length of stay of zero days	11,943	5,740	7,339	1,210	1,260	1,153	1,263	1,262	1,191
	E.M.11b	Count/Total	Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days	32,495	15,833	15,183	2,503	2,606	2,387	2,612	2,612	2,463
	E.M.11c	Count	Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days (COVID)	89		541	89	93	85	93	93	88
	E.M.11d	Count	Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days (Non-COVID)	32,405	15,833	14,642	2,414	2,513	2,302	2,519	2,519	2,375

Elective activity plans for 21/22 are modelled on the following theatre capacity assumptions:
Actual theatre sessions pre-Covid at 95 sessions per week and once all of the capacity is available as detailed below will be delivery 110 sessions per week.

- Goole - 2 lamina flow elective, 1 local green, 1 local yellow all currently in use
- DPOW - 8 theatres including 1 trauma, 1 Emergency, 4 elective theatres currently running
    - o 5th back 3rd May
    - o 6th back 24th May
- SGH - 5 theatres, including 1 trauma, 1 emergency, 1 elective theatre currently running
    - o 2nd back w/c 10th May
    - o 3rd back by end of July due to refurbishment work

Once all available theatres operational there will be a risk to weekend and evening working as clinicians will fit back into their weekly job planned sessions. For any future recovery weekend and evening working, if funding approved, significant risk on staff of lists for both clinicians and support staff.

3.1 Non-Elective demand / Impact of 111

Non-elective activity within NLAG is currently at 98.9%, therefore demand has been modelled at 100% of 2019/20 levels throughout the remainder of H1.

Currently within NLAG no further modelling has taken place to date in relation to the below as it is not expected that impact of these schemes will be delivered within the H1 planning period:

- Single Point of Access
- 2hr Community response
- EMAS pilot

3.2 Bed Modelling

The latest bed modelling has been run on a reduced LOS using same assumptions as IAAU (non-elective LOS running at or below 4.2 days)

Beds (100%)	641	657	629	663	661	647
Available	722	722	722	722	722	722
Forecasted Occupancy	89%	91%	87%	92%	92%	90%

To note, there are significant variables around split of sites and elective/non-elective beds.

Non-elective attendances are increasing at a higher rate than modelled in the draft submission. The assumption that all current elective ring-fenced beds (8-12% of bed demand) will remain available has been made within the final activity plan due to the escalation plan in place to protect these beds.

3.2 Diagnostic Activity

Activity Count Exams	Proposed Planning Numbers 21/22						2122 v 1920 Activity					
							2122 v 1920 Activity					
Service Line	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Audiology - Audiology Assessments	197	197	207	207	207	197	57%	49%	56%	48%	56%	44%
Cardiology - echocardiography	901	901	944	944	944	901	72%	68%	69%	43%	50%	66%
Colonoscopy	589	589	617	617	617	589	96%	96%	109%	99%	100%	102%
Computed Tomography	8,152	8,152	8,540	8,540	8,540	8,152	105%	104%	120%	103%	104%	104%
Cystoscopy	336	336	352	352	352	336	83%	86%	98%	82%	88%	96%
DEXA Scan	158	158	165	165	165	158	68%	63%	60%	62%	72%	76%
Flexi sigmoidoscopy	133	133	140	140	140	133	117%	92%	128%	108%	123%	109%
Gastroscopy	513	513	538	538	538	513	96%	82%	102%	92%	98%	96%
Magnetic Resonance Imaging	3,987	4,337	4,177	4,177	4,177	3,987	101%	112%	112%	103%	120%	117%
Neurophysiology - peripheral neurophysiology	113	113	119	119	119	113	56%	48%	43%	80%	58%	80%
Non-Obstetric Ultrasound	4,454	4,454	4,666	4,666	4,666	4,454	83%	75%	87%	82%	92%	83%
Urodynamics - pressures & flows	129	129	135	135	135	129	136%	145%	178%	124%	141%	115%
Grand Total	**19,663**	**20,013**	**20,600**	**20,600**	**20,600**	**19,663**	**94%**	**92%**	**102%**	**90%**	**97%**	**96%**

General risks to recovery within diagnostics identified as:

- Audiology - Planned changes to the audiology pathway have resulted in an immediate increase in demand and a conscious temporary deterioration of the DM01 position. Funding has been requested to support with the recovery. Further pathway changes are in discussion which will further streamline the hearing loss pathway and therefore affecting both ENT and Audiology's planning.
- NOUS - Increase in obstetrics work significantly impacting on NOUS. IPC controls and productivity significantly impacting. Working with CCGs and private providers to support with recovery
- CT/MRI - group recovery, loss of vans, IPC protocols
- Endoscopy – recovery plan achieving as expected. Expecting to see pre covid DM01 by the end of May. Risk of impact of demand due to group recovery plans, funding to support ongoing recovery
- Medical Physics – impacts to specific areas due to Medicine recovery plans (medinet/medipher) – impact to demand and ability to flex up capacity
- CT Colonoscopy – Capsule endoscopy will support recovery but ongoing shortfall of demand v capacity.

4. Transformation & Demand Management

The Trust has a well-established Primary & Secondary Care Interface Group whose membership includes senior clinicians, GP's and LMC representative. GP's have worked with the Trust to review patients on the medicine specialties overdue follow-up list – this has proved successful in that c25% of patients have been identified for future management in primary care. Patients remaining on the Trust waiting list have been risk stratified by GP's using the Trust risk stratification matrix.

This work has also identified a huge opportunity for shared care pathway, supporting an increased number of patients being managed in primary care. Fast track back into secondary care for a 12month period after discharge to primary care has been provided to support and encourage earlier discharge. There is a plan to extend this exercise for surgical overdue patients. A number of shared care pathways are being developed within Gastroenterology, Colorectal, ENT, Diabetes, Respiratory and Urology.

Development of a new model of outpatient service delivery continues and we have secured funding to extend this into a further 9 specialties during 2021/22.

Our Medical Director has facilitated a Task & Finish Group across the ICS to review opportunities for providing greater insight into patients prioritised as P4. This has led to the scoping of a piece of AI work. The ICS have commissioned an external company (Health Navigator) to review P4 patients, utilising data from across the primary and secondary care systems to provide further intelligence and insight on these patients in order to risk stratify and identify alternative management options.

There is a focus on A&G for 2021/22. In conjunction with primary care we are developing an A&G data form, to encourage GP's to use this facility and to ensure a more informed request and response.

PIFU has been introduced across all specialties to reduce the demand on the follow-up waiting list.

4.1 Out-patient Transformation Assumptions

Connected for Health Pilot

Following a recent 6 month pilot with Cardiology and Meridian PCN, the results have shown:

- 65% of patients were discharged to their GP
- 5% were in receipt of shared care
- Only 30% required secondary care
- Reduction in waiting time for new patients from 16 weeks to under 2 weeks

It is anticipated that these results will be replicated in the remaining 7 PCNs as the Cardiology CHN rolls out through 2021/22

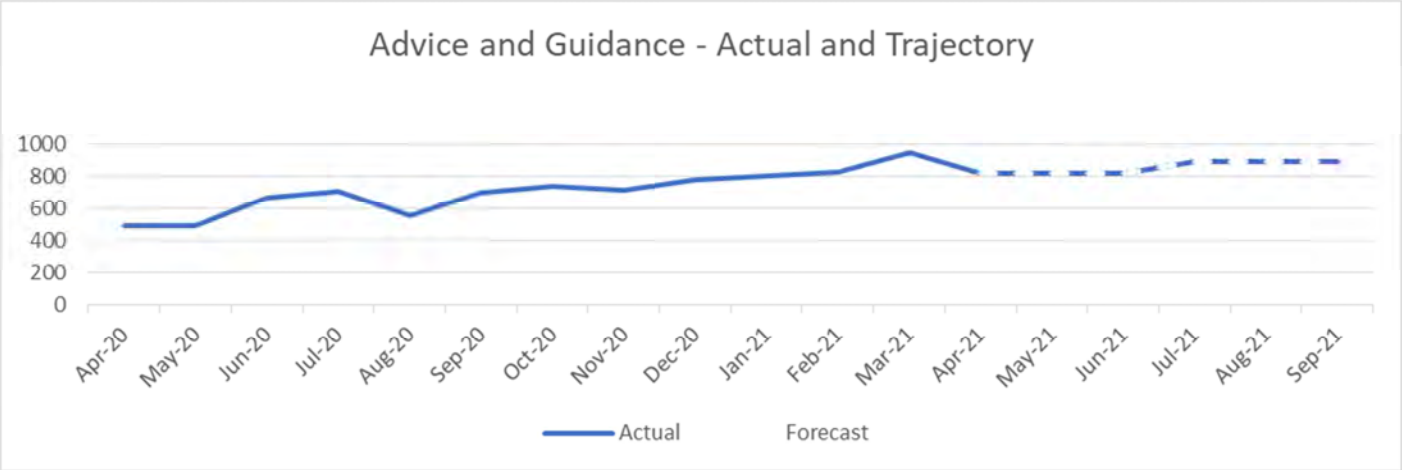
9 further specialty CHNs will commence in 2021/22 – ENT; Rheumatology; General & Colorectal Surgery; Paediatrics; Urology; Gastro; Diabetes and Respiratory

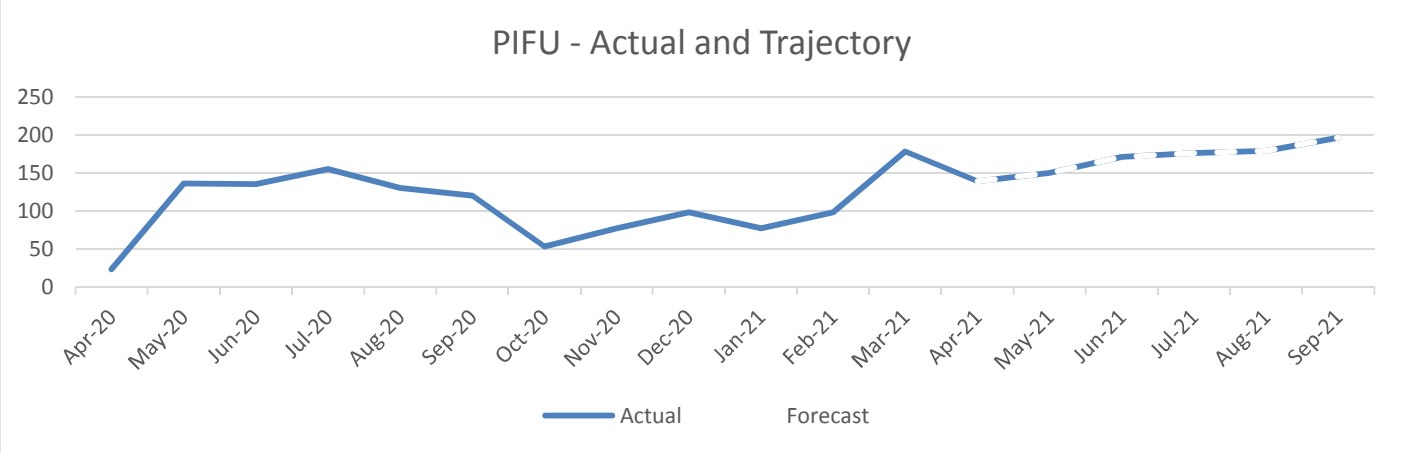
There is a risk that this transformation scheme will have a negative impact on the ability to meet 19/20 levels of activity, and therefore ERF thresholds. Work is ongoing to continue to review this impact with Primary Care and CCGs.

Virtual v FTF

- H1 activity plan shows delivery of 42% non face to face appointments
- Assumptions
    - Family Services and Medicine based on performance during 2 weeks in January
    - Surgery based on performance during quarter 4

4.2 Advice & Guidance / Patient Initiated Follow-Ups





It is expected that Advice & Guidance will be equivalent to 2.8% against current waiting list figures.

The impact of PIFU will be a positive, but delayed impact on the Trust's waiting list positions (currently >1%) due to the timescales required to fully embed processes and realise the outcomes within Q3/4.

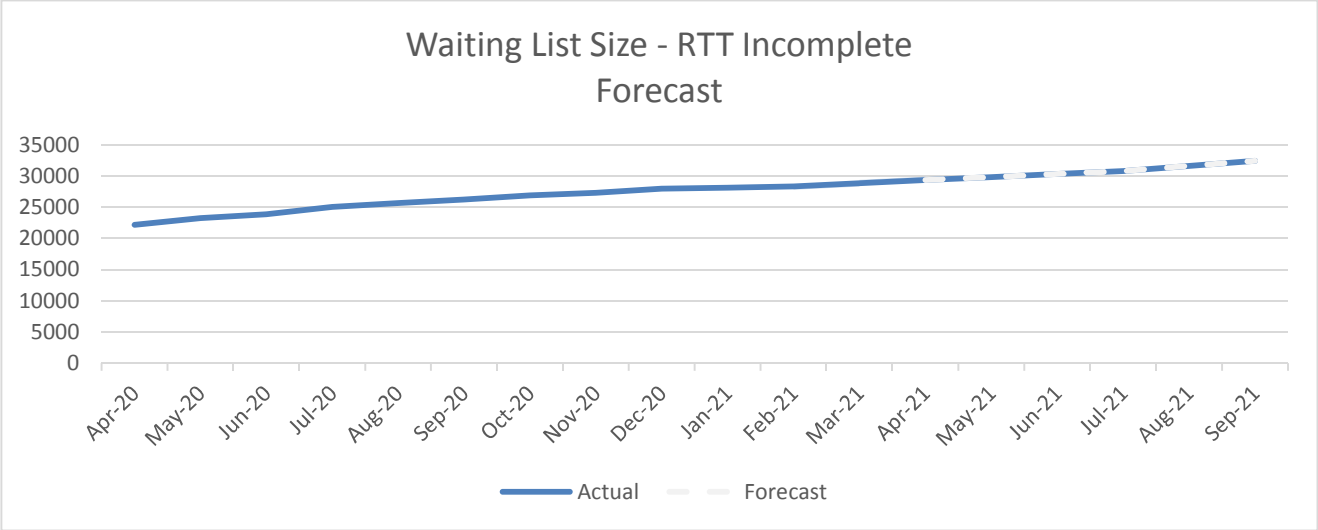
5.0 NLAG Performance Trajectories based upon H1 plans

5.1 Total Waiting List Size

Assumptions made for the below:

- Elective and out-patient activity plan followed
- January/March 2021 stop ratios
- Referral numbers based upon 19/20 phased to working days.

An increasing position is forecast due to a rise in referral rates and elective/out-patient rates not meeting previous activity levels.

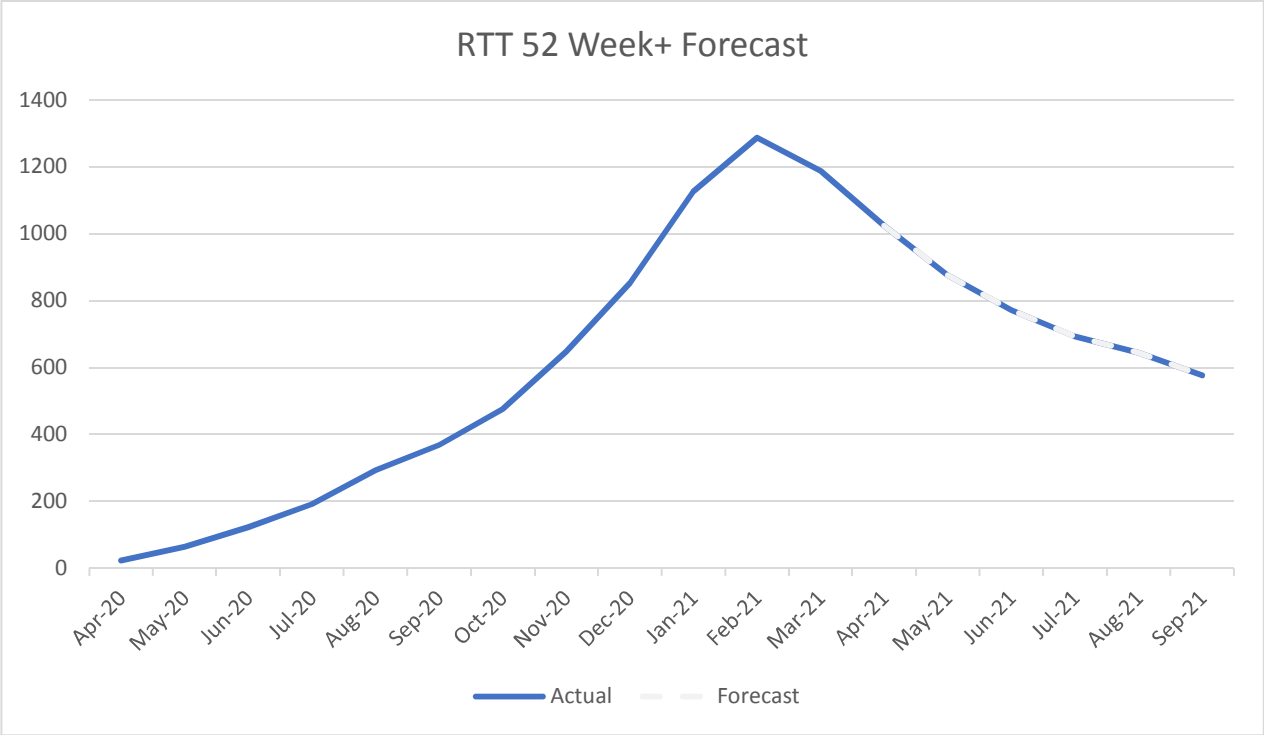


5.2 52+ Week Waiters

Assumptions made for the below:

- Elective and out-patient activity plan followed
- January/March 21 stop ratios – phased forward with long waiting stops
- Activity already within the system

A steady lowering of 52+ weeks position forecast mainly due to the & of activity to be aimed at long waiting patients. To note, this will potentially cause further backlogs in the future with less stops being focussed earlier in patient pathways.



5.3 Priority 2 Patients

Assumptions made for the below:

- Slight reduction of P2 list size and increasing performance for incompletes
- Same methodology as RTT with open pathways snapshot at the end of the month

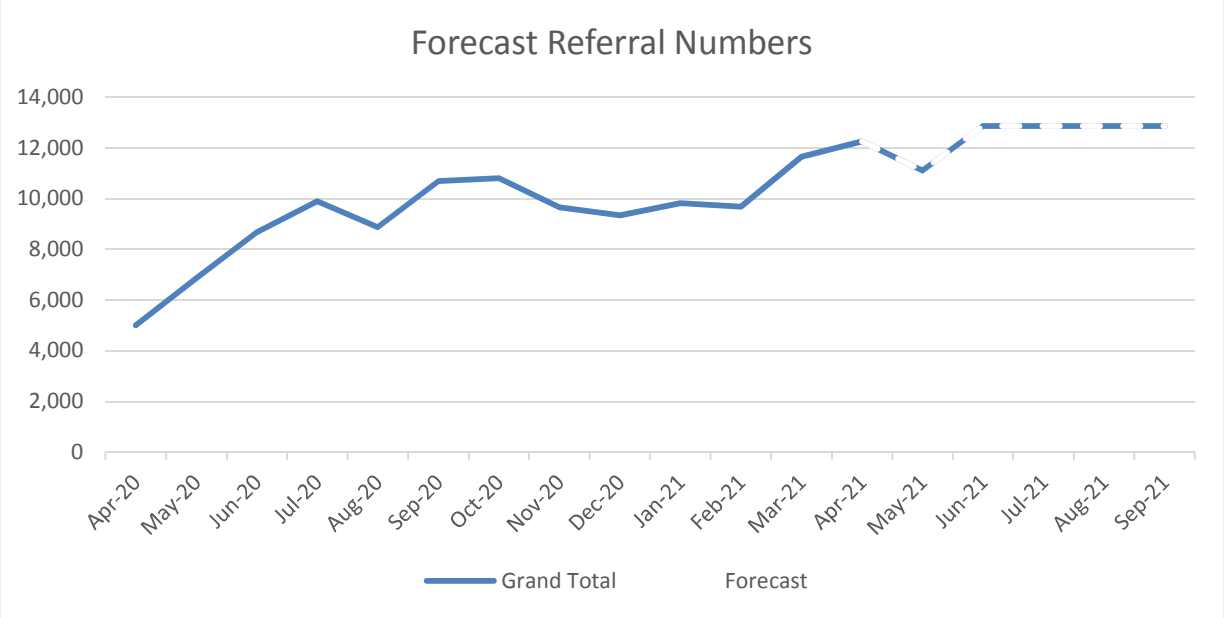
	Forecast					
	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021
Incomplete P2 pathways at end of month	652	628	604	580	556	532
Incomplete P2 pathways over 4 weeks (28 days)	313	264	230	203	161	133
Percentage of P2 pathways under 4 weeks	52%	58%	62%	65%	71%	75%

5.4 Referral Assumption / Trend

The following graph shows the forecast of GP referrals.

Forecast back to 19/20 levels from May following current trend phased over working days.

No assumptions within activity planning made on an increased referral demand.



5.5 Cancer Trajectories

The below table demonstrates Step changes to be implemented in 28 day FDS, 70% by end Sept, 75% by end March 22.

Plans to improve the 28 day faster diagnosis standard should improve performance in both the 62 day standard, and the 38 day IPT standard.

Screening : low treatment numbers. Additional capacity for bowel screening identified – subject to funding of additional PA sessions. Breast & Cervical screening achieve around 87-88% against the 90% national standard.

Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
2ww Referrals Seen (excl Breast Symptomatic)*	1,141	1,098	1,065	1,174	1,081	1,038	1,186	1,143	1,051	1,041	1,017	1,067
First Treatments*	145	147	141	151	155	141	152	151	138	145	130	140
28 Day Faster Diagnosis	68%	69%	70%	71%	69%	70%	72%	73%	75%	70%	75%	75%
62 Day Urgent GP Referrals Treatments*	68.5	89.5	81.5	78.5	81.5	73.5	92.5	83.5	75.5	88.5	75.0	86.5
62 Day Urgent GP Referrals Breaches*	18.5	28.5	29.0	22.5	24.0	27.5	30.5	25.0	19.5	31.0	23.5	22.0
62 Day Urgent GP Referrals Performance*	73.0%	68.2%	64.4%	71.3%	70.6%	62.6%	67.0%	70.1%	74.2%	65.0%	68.7%	74.6%
62 Day Screening Treatments*	5.0	4.0	6.0	5.5	4.0	6.5	4.5	6.5	5.0	5.5	3.0	6.0
62 Day Screening Breaches*	0.5	1.0	1.0	1.0	0.5	0.5	0.5	1.0	1.0	1.0	0.5	1.0
62 Day Screening Performance*	90.0%	75.0%	83.3%	81.8%	87.5%	92.3%	88.9%	84.6%	80.0%	81.8%	83.3%	83.3%
62 Day Consultant Upgrade Treatments*	3.0	3.5	3.0	3.0	2.5	1.5	3.5	3.5	3.5	2.5	4.0	3.5
62 Day Consultant Upgrade Breaches*	1.0	1.5	0.5	0.5	0.5	0.5	0.5	0.5	1.0	0.5	1.0	0.5
62 Day Consultant Upgrade Performance*	66.7%	57.1%	83.3%	83.3%	80.0%	66.7%	85.7%	85.7%	71.4%	80.0%	75.0%	85.7%

5.5.1 28 day faster diagnosis

The below assumes a step change to move from current 68.4% achievement to 70% (end September 2021) and 75% (end March 2022)

There is a Divisional requirement to improve performance in line with below table, but significant challenges remain with Colorectal and Upper GI, who have the furthest gains to make.

28 Day Faster Diagnosis - by Tumour Site

Improving Trajectory to meet 70% by September 21 and 75% by March 22

Tumour Site	Apr-21 (as of 19th Apr)	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Breast	94%	94%	94%	94%	95%	94%	95%	95%	95%	95%	92%	97%	97%
Colorectal	21%	30%	40%	50%	60%	60%	70%	72%	73%	75%	70%	75%	75%
Gynaecology	69%	68%	69%	70%	71%	69%	70%	72%	73%	75%	70%	75%	75%
Haematology	-	68%	69%	70%	71%	69%	70%	72%	73%	75%	70%	75%	75%
Head and Neck	72%	68%	69%	70%	71%	69%	70%	72%	73%	75%	70%	75%	75%
Lung	64%	68%	69%	70%	71%	69%	70%	72%	73%	75%	70%	75%	75%
Skin	83%	68%	69%	70%	71%	69%	70%	72%	73%	75%	70%	75%	75%
Upper GI	34%	40%	50%	60%	70%	65%	70%	72%	73%	75%	70%	75%	75%
Urology	54%	68%	69%	70%	71%	69%	70%	72%	73%	75%	70%	75%	75%
Grand Total	**62%**	**68%**	**69%**	**70%**	**71%**	**69%**	**70%**	**72%**	**73%**	**75%**	**70%**	**75%**	**75%**

5.5.2 England average & Trust 62 day backlog PTL %

- England position (at 7/3/21): 9.1% of total 62 day PTL
- NLAG position (at 7/3/21): 9.4% of 62 day PTL compared to HUTH (17.4%) and York (11.8%)
- All cancer alliances (at 21st March) reported % of PTL above 62 days – range between 3% and 13%

	Harrogate and District			Hull University Teaching Hosptials			Northern Lincolnshire and Goole			York Teaching Hospitals			Humber, Coast and Vale			England overall		
	Waiting list	Number pastday 62	% past day 62	Waiting list	Number pastday 62	% past day 62	Waiting list	Number pastday 62	% past day 62	Waiting list	Number pastday 62	% past day 62	Waiting list	Number past day 62	% past day 62	Waiting list	Number pastday 62	% past day 62
Brain/Central Nervous System				3	0	0.0%							3	0	0.0%	744	13	1.7%
Breast	95	0	0.0%	159	24	15.1%	155	8	5.2%	34	1	2.9%	443	33	7.4%	27,450	1,144	4.2%
Children's	5	0	0.0%	3	1	33.3%							8	1	12.5%	285	18	6.3%
Gynaecological	71	1	1.4%	159	21	13.2%	68	2	2.9%	67	1	1.5%	365	25	6.8%	18,929	1,562	8.3%
Haematological	4	0	0.0%	8	2	25.0%	4	0	0.0%	11	3	27.3%	27	5	18.5%	2,600	296	11.4%
Head & Neck	46	1	2.2%	60	5	8.3%	152	22	14.5%	113	17	15.0%	371	45	12.1%	16,785	1,230	7.3%
Lower Gastrointestinal	223	17	7.6%	520	112	21.5%	441	53	12.0%	331	49	14.8%	1,515	231	15.2%	44,764	5,712	12.8%
Lung	9	0	0.0%	64	20	31.3%	46	7	15.2%	33	10	30.3%	152	37	24.3%	4,220	545	12.9%
Other							1	1	100.0%	5	0	0.0%	6	1	16.7%	642	110	17.1%
Sarcoma							1	0	0.0%				1	0	0.0%	977	102	10.4%
Skin	151	1	0.7%	210	20	9.5%	47	5	10.6%	194	5	2.6%	602	31	5.1%	30,652	1,402	4.6%
Upper Gastrointestinal	50	3	6.0%	179	19	10.6%	200	11	5.5%	78	19	24.4%	507	52	10.3%	18,008	1,642	9.1%
Urological	55	3	5.5%	140	38	27.1%	123	7	5.7%	114	16	14.0%	432	64	14.8%	21,221	3,232	15.2%
Total	709	26	3.7%	1,505	262	17.4%	1,238	116	9.4%	980	121	12.3%	4,432	525	11.8%	187,277	17,008	9.1%

5.5.3 Cancer Trajectories – 62 day backlog (volumes)

- Feb 20 >62 days PTL size: 129 patients
- March 21 >62 day PTL size = 12.9% of total PTL (123 patients).
- Aim to reduce >62 day backlog to 5% of total PTL by March 22, with a step change of no more than 8% by end sept 21.
- Table above shows max number over 62 days by tumour site each month to achieve a maximum position of 65 over 62 days by end March.

62 Day PTL Backlog												
Plan for 8% of PTL by Sep 21 and 5% by Mar 22												
By Numbers	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Trust Position	123	131	121	113	116	138	115	104	96	83	89	79	65
Breast	8	8	8	8	8	11	8	8	8	8	10	8	8
Colorectal	41	53	50	47	49	55	48	43	38	31	36	32	25
Gynaecology	3	4	4	4	4	6	4	4	4	4	5	4	4
Haematology	4	4	3	3	3	4	3	2	2	1	2	1	1
Head and Neck	24	23	19	17	14	17	12	12	11	9	10	9	7
Lung	14	13	12	10	11	13	10	10	8	8	5	5	2
Skin	3	2	2	2	3	3	3	2	3	2	2	2	2
Upper GI	13	12	12	12	13	17	16	12	13	12	10	10	10
Urology	13	12	11	10	11	12	11	11	9	8	9	8	6

5.5.4 Cancer Trajectories – 62 day backlog = 5% by March 22

The below shows tumour site % of PTL position to reduce from current 62 day backlog position at March 21 to be no more than 5% of PTL by March 22 (8% by end Sept 21).

By % of PTL	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Trust Position	9%	9%	9%	8%	8%	9%	8%	7%	7%	6%	6%	5%	5%
Breast	4%	4%	4%	4%	4%	5%	4%	4%	4%	4%	5%	4%	4%
Colorectal	9%	10%	10%	9%	9%	10%	9%	8%	7%	6%	7%	6%	5%
Gynaecology	4%	4%	4%	4%	4%	5%	4%	4%	4%	4%	5%	4%	4%
Haematology	57%	50%	50%	40%	40%	50%	40%	30%	30%	20%	30%	20%	10%
Head and Neck	16%	15%	13%	11%	9%	11%	8%	8%	7%	6%	7%	6%	5%
Lung	24%	25%	25%	20%	20%	25%	20%	20%	15%	15%	10%	10%	5%
Skin	6%	6%	6%	6%	6%	8%	8%	6%	6%	6%	5%	5%	5%
Upper GI	6%	6%	6%	6%	6%	8%	8%	6%	6%	6%	5%	5%	5%
Urology	9%	9%	9%	8%	8%	9%	8%	8%	7%	6%	7%	6%	5%

5.5.5 Cancer Trajectories – 104+ days

Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
62 Day PTL Backlog - >104 Days	30	29	27	28	24	25

5.6 Overdue Follow-Ups

Assumptions made for the below:

- Elective and out-patient activity plan followed
- Ratio between overdue/non-overdue activity
- Proportional increase in follow-up activity against news in plan, showing a positive impact.

The forecast illustrates a significant decrease in overdue out-patient follow ups.

Work is currently being undertaken with the Independent Sector (Medefer) which may improve this position further. This is being trialled with Endocrinology and Diabetes to prove concept; if successful expectation to roll out to more specialties.

6.0 Workforce

Workforce plans have been produced for the 6 month planning period, with the following assumptions made:

Nursing and midwifery
The Trust is projecting an 86.52 WTE increase in headcount during Q1 & Q2. This is as a result of international recruitment campaigns and newly qualified nursing cohorts.

Medical & Dental
The Trust is projecting a maintained positon based on current headcount. The majority of NLaG's medical pipeline is reliant on international recruitment that has been restricted as a result of covid. As these restrictions ease, NLaG's pipeline will increase but this is likely to impact later in the year.

Health Care Support Workers
The Trust has already achieved an operational zero vacancy level and will maintain this throughout the year.

AHP's
The Trust expects to increase headcount and maintain this position in Q1 & Q2 which is close to achieving the full established position.

6.1 Key considerations and risks

NLAG has an established Talent Acquisition team which casts net wider to provide assurance around recruitment pool, therefore mitigating some of the risk to recruitment seen in other Trusts that do not have this provision.

The recent closure of the Indian pipeline does not affect short term pipeline supply. The risk is being spread by sourcing through different work-streams and different countries in case of future closures. This includes engaging Yeovil Trust for the supply of 20 nurses (countries to be confirmed), and an international pilot with Indeed (Romania, Singapore, UAE, New Zealand, USA), and our own direct sourcing.

The Trust will relaunch its health and well-being offering to staff and has seen a decrease in sickness levels to that of pre-Covid. To support this, a Health and Well-being lead is being appointed within the Trust.

Annual leave carry over has been factored at service level moving into the new leave year – to support operational pressures that increased levels of annual leave creates, a buy back scheme is in consideration. In addition the Trust will produce further guidance surrounding the management of annual leave to ensure leave is taken proportionally throughout the year to stop any large build-up of annual leave towards then end of the financial year.

7.0 Health inequalities and other considerations

Throughout the planning guidance, there is clear direction to address health inequalities highlighted by the pandemic, particularly focussing on deprivation and ethnicity factors. Analysis into the ethnicity and deprivation levels of the patients on our waiting lists has shown no clear discrepancy in waiting times. All waiting times are consistent with the overall mean of the Trust.

8.0 Finance

As part of the ICS financial plan the Trust is required to deliver a deficit of £0.22m for the H1 period in 2021-22.

The Trust will continue to receive block allocations from Commissioners, including the additional top-up funding for its underlying deficit position as per those received in 2020-21, adjusted for inflation at 0.78% less a 0.28% efficiency requirement, a net 0.50% uplift.

Systems have retained additional funding to cover COVID-19 related cost pressures. The Trust will receive the same level of funding it received in H2 of 2020-21 (£6.4m) plus top-up funding for expenditure incurred that falls outside of the system envelope, predominantly covering Testing and Vaccination costs.

The full year and part year effect of the forecast Trust income and expenditure are as follows:

	£000's	
	6 Months PYE	**Full Year**
Income Assumption		
Block as per 20/21 excl COVID	201,906	403,812
Chargeable patient Income	554	1,107
R&D Income	337	673
Education Income	8,026	16,053
Parking Income	421	842
Catering Income	11	23
Accomodation Income	1,088	2,175
Non Patient Care Contracts	7,654	15,308
All Other Income	615	1,230
COVID Funding	6,581	13,161
TOTAL INCOME	**227,193**	**454,385**
Expenditure Assumption		
Opening Expenditure Budgets 20/21	(217,061)	(437,971)
Pay Awards & Incremental Drift	(1,087)	(2,174)
Non Pay Inflation	(415)	(829)
CNST	(184)	(368)
Cost of Captial, PDC & Interest Expenses	(724)	(1,537)
Investment Programme	(5,858)	(11,716)
Efficiency Target	4,501	9,002
COVID Expenditure	(6,581)	(13,161)
TOTAL EXPENDITURE	**(227,409)**	**(458,754)**
Surplus/ (Deficit)	**(216)**	**(4,369)**

Potential Upsides not included in the Forecast Financial Plan:

- Elective Recovery Funding – The Trust can earn additional funding at 120% of National Tariff values if it delivers additional activity above the 85%

threshold outlined in the planning guidance. However, this is dependent on the ICS as a whole achieving activity delivery above the thresholds.

- Included within its investment programme (Appendix 2) the IAAU and Diagnostic business cases were underpinned by additional savings opportunities namely bed closures and mobile van hire reductions. This should be in addition to the base 2% savings target that was required as part of the Trust long term plan and represents an upside if the Trust can deliver its 2% savings requirement without the benefits of these schemes included.

- Car Parking Income – The current plan assumes car parking income will continue at the level witnessed in H2 of 2020-21. This level of income should increase as recovery plans increase patient activity but will be partially offset with the continuation of reduced face to face outpatient attendances.

- The Trust has a significant investment programme proposed. Not all schemes have been finalised and there will undoubtedly be slippage and delays in recruitment and mobilisation.

Potential Risks not included in the Forecast Financial Plan:

- COVID-19 Expenditure – An assessment has been made of the ongoing cost pressures relating to Covid-19, which overall could be circa £13.2m in total with confirmed funding to that level. The total spend incurred in 2020-21 was £20m and whilst the position included material non recurrent items there is a risk a repeat would create additional costs pressures. Therefore, it is imperative that the Trust minimises all additional COVID related expenditure where possible.

- Savings Programme - The Trust five year long term plans required a stretch target over and above the base tariff efficiency at 2%. This forms the basis for the 2% target applied for 2020-21. As it stands, the current 2% target does not have a robust delivery plan constructed and therefore there is inherent delivery risk.

8.1 Elective Recovery Fund

The methodology for the Elective Recovery Fund (ERF) has been implemented but there are some outstanding minor issues relating to the baseline figures and technical issues. This is similar to the other Trusts and therefore there is a working group across the ICS working together to ensure that all stakeholders have a common understanding of the guidance/technical aspects to agree calculation methods and monitoring arrangements.

The table below shows the achievement of the thresholds comparing 2019/20 activity adjusted for working days against 2021/2022 HI plan figures. There are only two months in activity terms were the Trust falls below the threshold activity numbers but due to higher casemix and improvements in depth of coding the income calculations are all above the thresholds from our baseline activity. This means that any recovery activity provides us with additional resilience in case of changing circumstances.

The impact of the activity plan against the ERF is outlined in the below table.

Elective Recover Scheme Calculation H1 - 2021/2022														
	Activity							Tariff Income @100%						
	1	2	3	4	5	6	H1 Total	1	2	3	4	5	6	H1 Total
19/20 Baseline Activity	**33,627**	**35,239**	**34,560**	**39,089**	**33,307**	**37,608**	**213,430**	**7,137,590**	**7,470,776**	**7,346,843**	**8,225,918**	**7,139,878**	**7,566,893**	**44,887,898**
Working Days in 19/20	20	21	20	23	21	21		20	21	20	23	21	21	
Working Days in 21/22	20	19	22	22	21	22		20	19	22	22	21	22	
Revised Baseline	**33,627**	**31,883**	**38,016**	**37,389**	**33,307**	**39,399**	**213,621**	**7,137,590**	**6,759,274**	**8,081,528**	**7,868,269**	**7,139,878**	**7,927,221**	**44,913,760**
21/22 Baseline Core Activity	**27,732**	**26,670**	**30,787**	**30,851**	**29,501**	**30,789**	**176,330**	**5,723,349**	**5,765,561**	**6,753,484**	**6,776,983**	**6,497,069**	**6,755,124**	**38,271,570**
Baseline Achievement	82%	84%	81%	83%	89%	78%		80%	85%	84%	86%	91%	85%	
Threshold Levels	70%	75%	80%	85%	85%	85%		70%	75%	80%	85%	85%	85%	
Over/(under) Achievement)	12%	9%	1%	(2%)	4%	(7%)		10%	10%	4%	1%	6%	0%	
Recovery Activity	**6,048**	**6,759**	**6,624**	**4,473**	**4,465**	**4,377**	**32,745**	**1,057,821**	**1,288,155**	**1,232,282**	**975,674**	**973,797**	**943,883**	**6,471,613**
21/22 Total Plan	**33,779**	**33,429**	**37,411**	**35,324**	**33,965**	**35,166**	**209,075**	**6,781,169**	**7,053,717**	**7,985,766**	**7,752,657**	**7,470,865**	**7,699,008**	**44,743,182**
Baseline Achievement	100%	105%	98%	94%	102%	89%		95%	104%	99%	99%	105%	97%	
Threshold Levels	70%	75%	80%	85%	85%	85%		70%	75%	80%	85%	85%	85%	
Over/(under) Achievement)	30%	30%	18%	9%	17%	4%		25%	29%	19%	14%	20%	12%	

The table below show the calculation of the ERF and the potential margins that might be generated. This needs to be viewed with caution as this is all dependant on achieving our internal activity above the thresholds each month and securing the independent sector activity at pace. Also until the first PbR freeze position and the first ERF calculated figures for the whole ICS there is still a system risk. There are numerous variables within this calculation so it is prudent to be caution on the achievement of this margin. As stated previously, potential additional funding from ERF is not included within the core financial plan for the Trust and represents an upside if it can be delivered.

Potential ERF Calculation on all Activity								
		Tariff Income						
		1	2	3	4	5	6	H1 Total
100% above monthly threshold	100%	1,695,729	2,070,698	1,502,526	1,048,986	1,466,961	933,207	8,718,107
20% additional Tariff (above 85%)	20%	135,711	273,065	220,648	209,797	293,392	186,641	1,319,254
Total		**1,831,439**	**2,343,764**	**1,723,173**	**1,258,783**	**1,760,353**	**1,119,849**	**10,037,361**
Adj to reflect NHSE baseline differences	3%	(50,366)	(64,456)	(47,389)	(34,618)	(48,411)	(30,797)	(276,036)
Revised Additional Income		**1,781,073**	**2,279,308**	**1,675,785**	**1,224,165**	**1,711,942**	**1,089,052**	**9,761,325**
Elective Recovery Margin 2021/20222								
		1	**2**	**3**	**4**	**5**	**6**	**H1Total**
Baseline additional income		760,767	923,267	405,426	185,558	675,525	87,544	3,038,087
Recovery additional income		1,020,307	1,356,041	1,270,359	1,038,608	1,036,416	1,001,508	6,913,361
Total additional income		**1,781,073**	**2,279,308**	**1,675,785**	**1,224,165**	**1,711,942**	**1,089,052**	**9,761,325**
Baseline Additional Expenditure		190,192	230,817	101,356	46,389	168,881	21,886	759,522
Recovery Additional Expenditure		1,017,916	1,171,257	1,171,257	864,511	864,511	864,511	5,953,965
Total Additional Expenditure		**1,208,107**	**1,402,074**	**1,272,614**	**910,901**	**1,033,393**	**886,398**	**6,713,487**
Baseline Margin		570,575	692,451	304,069	139,168	506,644	65,658	2,278,565
Recovery Margin		2,391	184,784	99,101	174,096	171,905	136,996	769,273
Total Margin		**572,966**	**877,234**	**403,171**	**313,264**	**678,549**	**202,655**	**3,047,838**
Baseline Margin		75%	75%	75%	75%	75%	75%	75%
Recovery Margin		0%	14%	8%	17%	17%	14%	11%
Total Margin		**32%**	**38%**	**24%**	**26%**	**40%**	**19%**	**31%**

9.0 Reporting and Sign off

A weekly planning meeting has been implemented within NLAG to progress work against the planning guidance, and provide oversight and escalation as required. A further weekly planning meeting has been in place since end of March 2021 with HCV acute providers to ensure a collaborative approach is taken to the planning round.

There have been updates into the Tuesday Executive Team meeting as required.

An external confirm and challenge meeting was held on 13th May 2021 with the ICS and NHSI to give an oversight of the detail and assumptions behind the plan and work through any risks or issues. Formal feedback is expected to follow, however the initial response was positive, with the plan being viewed as ambitious, with risks to delivery highlighted as diagnostic capacity, workforce and non-elective demand, however mitigation narrative was described.

10.0 Recommendation

For Trust Board to approve the H1 2021/22 operational plan.

NLG(21)109

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board
REPORT FROM	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Kate Wood, Medical Director
CONTACT OFFICER	Helen Harris, Director of Corporate Governance
SUBJECT	Integrated Performance Report (IPR)
BACKGROUND DOCUMENT (if any)	Access and Flow – IPR Quality and Safety – IPR
OTHER GROUPS WHO HAVE CONSIDERED PAPER AND OUTCOME	Quality and Safety Committee (Q&SC) – 21 May 2021 Finance and Performance Committee (F&PC) – 26 May 2021
EXECUTIVE SUMMARY	**1. Introduction** The IPR is to provide the Board with a detailed assessment of the performance against the agreed indicators and measures and describes the specific actions that are under way to deliver the required standards. **2. Quality and Safety** The Q&SC received the IPR at its meeting on 21 May 2021. The Committee discussed concerns about the information not being fully validated and the need for it to be interpreted with caution. The key exceptions to note are: - MSSA Hospital acquired cases are one. The data has been validated since the report was provided due to reporting timings for the committee. - The Structured Judgement Reviews was reported in a way that showed a deterioration in performance, however a SJR can take approximately three months to be reported from the date of the death to the completion of the review. - The deterioration in VTE risk assessment compliance (c75% against a target of 95%). The Committee discussed that this could potentially lead to serious complications for patients. The factors behind the deterioration were in large part as a consequence of COVID. - Sepsis reporting is not currently reported electronically, but a resolution has been found. The Committee agreed to receive SPC for areas which were deemed to be out of the controls, or noted to be an outlier.

	3. Access and Flow The F&PC received the IPR for Access and Flow at its meeting on 26 May 2021. The key areas to note are: - The Emergency Department at both NLaG hospitals are seeing increasing levels of attendances which has impacted upon delivery of the patient flow and A&E 4 hour target. - The Trust's average Length of Stay across the Trust has improved to 3.91 as at end of April 2021 against a target of 4. - The Trust's performance for 21 day + LoS as at week ending 19/05/2*21 reported at 8.12% remains under the national ambition of 12% and is one of the best performing within the North East and Yorkshire region. - Referral to Treatment continues to see an increasing number of patients waiting with 711 patients that have waited in excess of 52 weeks as at 17/05/21. The performance is as a direct result of the reduced elective operating capacity due to the theatre and anaesthetic response to supporting the high acuity of COVID-19 patients and the social distancing and patient choice. - Cancer 2ww standard continues to be achieved at 98.33%. - Cancer 31 day standard achieved at 99.03%. - Cancer 62 day standard was 61.36%. - Diagnostic: the Ultrasound longest wait is approximately 15 weeks for an urgent referral and 36 weeks for a routine. Respiratory diagnostics waiting time is 12 weeks from referral. MRI waiting time is 25 weeks for an urgent referral and 30 weeks for a routine referral. The F&PC agreed to receive SPC for areas which were deemed to be out of the controls, or noted to be an outlier. The Trust Board is asked to: a) receive the IPR for assurance, b) note the performance against the agreed indicators and measures c) note the report describes the specific actions that are under way to deliver the required standards.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	**Strategic Objective 1: To Give Great Care** **a) Description of Strategic Objective 1 - 1.1:** To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. **Risk to Strategic Objective 1 - 1.1:** The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience. **b) Description of Strategic Objective 1 - 1.2:** To provide treatment, care and support which is as safe, clinically effective, and timely as possible. **Risk to Strategic Objective 1 - 1.2:** The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.

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

Access and Flow - Executive Summary
Objective: To give great care
Post wave two COVID19 pandemic, the Emergency Department at both NLaG hospitals are seeing increasing levels of attendances. In the recent weeks, there have been frequent days with high number of attendances more than 450 a day. A record maximum high of 509 was seen on 18/05/21 which not experienced in the previous years. The emergency departments face pressure in moving patients through the system as a result of zoning and swabbing as well as challenges with the workforce in terms of number and skill mix across the Trust which has impacted upon delivery of the patient flow and A&E 4 hour target. In conjunction with the system partners, two audits at the front door are being undertaken, outcome of which will help focus on areas of improvement; retrospective miss opportunities audit and real time point prevalence audit. It is also worth noting that on 12/05/21, alongside external partners including EMAS and SPA and support from ECIST national team, frailty test of change (pilot) went live at DPoW which has already proved an effective measure to further improve the patient flow. The Trust's average LoS across the Trust has improved to 3.91 as at end of April 2021 against target of 4. The Trust's performance for 21 day + LoS as at week ending 19/05/21 reported at 8.12% remains under the national ambition of 12% and is one of the best performing within the North East and Yorkshire region. RTT continues to see an increasing number of patients waiting. There are 711 patients that have waited in excess of 52 weeks as at 17/05/21 and continue to improve. The performance is as a direct result of the reduced elective operating capacity due to the theatre and anaesthetic response to supporting the high acuity of COVID-19 patients and the social distancing and patient choice. Significant progress has been made in creating additional capacity which includes both the use of Goole District Hospital and the Independent sector where the initial focus is on the treatment of urgent and cancer patients. It is also worth mentioning that elective work at SGH was reintroduced from the 15th March 2021 which involves ring fenced beds on ward 19. Cancer 2ww standard continues to be achieved at 98.33%. 31 day standard achieved at 99.03% and the 62 day standard was 61.36%, show improving trend. Regarding diagnostics, CT colon capacity remains an issue as at 17/05/21, Ultrasound longest wait approx. 15 weeks for an urgent referral and 36 weeks for a routine. Respiratory diagnostics waiting time 12 weeks from referral. EEG waiting time is now at 7 weeks from referral. MRI waiting time is now at 25 weeks for an urgent referral and 30 weeks for a routine referral. The service continues to explore additional capacity options which include use of the independent sector and community diagnostic hubs.

Quality & Safety - Executive Summary
Objective: To give great care
The Trust's performance with quality metrics has been impacted upon by the pandemic. Despite this progress has been made as indicated by the performance for the 2020/21 financial year ending in March 2021. The Trust's SHMI remains as expected and has shown statistically significant improvement throughout the year, with the HSMR presented in this report showing the monthly data. A spike is seen on HSMR during the second wave of Covid-19. Linked to this is also the improvement seen in the proportion of deaths screened for quality and learning purposes, exceeding 90% in some months following implementation of improved process from October/November 2020 resulting in the 50% target for the 20/21 period being met and exceeded. Patient observations recorded in line with timescales (with 30mins grace period) has remained above the 85% target set even during the pandemic and the related challenges with donning/doffing PPE and zoning changes. This is a significant achievement. The number of Serious Incidents declared in month has also seen consecutive reductions since the later part of 2020. Alongside the achievements there are some areas of performance that are not meeting agreed targets set for the 20/21 period. There is a gap in assurance for the management of sepsis. No data is currently available to determine the rate of sepsis screening either via e-screening (using WebV) or paper based processes still in use throughout the Trust (as measured through audit). Plans are in place to undertake an audit and improve the process for accessing the e-screening tool, but at present there is a gap in the availability of assurance for sepsis. Priority cases (based on national guidance) or those identified from the quality screening process as requiring more in depth mortality review using SJR are not happening within timescales with a backlog of cases from August 2020. Cases are being completed, but the risk is the time taken to complete these reviews. This is being monitored at MIG and Medicine are reviewing their internal processes to support timely SJR completion. Blood glucose being recorded for paediatric patients with a PEWS of >1 is still not consistently achieving the target set with an average performance of 81%. VTE risk assessments are reported as special cause variation with the last 4 months reporting under the lower control limit. A spike in MSSA is also noted above the upper control limit during March 2021, but no concerns with regard to practice have been identified following this indicator.

Ref	Metrics	Apr 2021	Target	Variance	Assurance Inconsistency	Indicator Status
	RTT waiting times for non-urgent consultant-led treatment					
AF001	Maximum time of 18 weeks from point of Referral To Treatment (RTT) in aggregate - patients on an incomplete pathway. 18 week % - Unvalidated snapshot	65.79%	92.00%			NNS
AF002	Total outpatient follow up waiting list size	101,076	105,474			LSAR
AF003	Total inpatient waiting list	10,613	11,536			LSAR
AF004	Number of incomplete RTT pathways 52 weeks - Unvalidated snapshot	873	0			NNS
AF005	Maximum 6-week wait for diagnostic procedures (Diagnostic Measurement 01)	39.82%	1.00%			NS
	A&E waits					
AF006	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge (4 hour target)	72.34%	92.00%			NS
AF007	Count of Ambulance Handover delays 15-30mins	998	0			NS
AF008	Count of Ambulance Handover delays 30-60mins	368	0			NS
AF009	Count of Ambulance Handover delays 60+ mins	251	0			NS
AF010	Waits in A+E not longer than 12 hours from Decision To Admit	0	0			NS
	Cancer waits					
AF011	Cancer Waiting Times - 2 week wait	98.33%	93.00%			NNS
AF012	Cancer 2 week wait (breast symptoms)	96.00%	93.00%			NNS
AF013	Percentage of Service Users waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer	65.84%	75.00%			NNS
AF014	Cancer Waiting Times - 31 Day First Treatment	99.03%	96.00%			NNS
AF015	Cancer Waiting Times - 31 Day Surgery	86.67%	94.00%			NNS
AF016	Cancer Waiting Times - 31 Day Drugs	94.44%	98.00%			NNS
AF017	Cancer Waiting Times - 62 day GP referral	61.36%	85.00%			NNS
AF018	Cancer Waiting Times - 62 day Screening	77.78%	90.00%			NNS
	Trust Priorities - Improve the Trust's waiting list with a focus on 40 week waits, total list size and out patient follow up					
AF019	The number of patients overdue their follow up for an outpatient review	24,676	9,000			LSAR
AF020	Overall size of the RTT waiting list	30,218	25,227			LSAR
AF021	50% of out-patient summary letters to be with GPs within 7 days	35.02%	50.00%			LTBC
AF022	Reduce the number of face to face follow up appointments by 10% by 31 March 2021.	11,625	15,903			LTBC
	Improve the effectiveness of cancer pathways focussing on time to diagnosis					
AF023	Cancer waiting times - 104+ day backlog	29	0			LSAR
AF024	Care of patients with confirmed diagnosis transferred by day 38 to be at 75%	26.67%	75.00%			LSAR
AF025	100% Cancer request to test report to be no more than 14 days	83.28%	100.00%			LSAR

Ref	Metrics	Apr 2021	Target	Variance	Assurance Inconsistency	Indicator Status
	Trust Priorities - Improve safe flow and dscharge through the hospital focussing on outliers, late night patient transfers and discharges bfore noon					
AF026	Average Length of Stay (all)	*3.91*	4.00			LSAR
AF027	% of patients who were discharged on the same day as admission (excl Daycase)	*29.94%*	32.00%			LSAR
AF028	Non Elective Average Length of Stay	*4.01*	4.10			LSAR
AF029	Elective Average Length of Stay	*2.77*	2.40			LSAR
AF030	30 day emergency re-admission rate	*7.59%*	0.00%			LSAR
AF031	Number of Medical Outliers	2326	No Target		N/A	LTBC
AF032	85% of discharge letters to be completed within 24 hours post discharge	89.70%	85.00%			LTBC
AF033	Progressive improvement in the number of golden discharges from April 2020	*16.95%*	35.00%			LTBC
AF034	Increase in A&E performance to 83.5%	*72.34%*	83.50%			LSAR
AF035	Reduction of non emergency patient transfers at night after 10pm by 10%	*8.51%*	2.80%			LTBC
AF036	Reduction in average ward moves for non elective patients for non clinical reasons by 7%	*13.67%*	4.60%			LTBC
AF037	Risk Stratification Inpatients	99.80%	99.00%			LSAR
AF038	Risk Stratification Outpatients	*26.22%*	99.00%			LSAR
AF039	40-51 week waiters - Unvalidated snapshot	1,170	0			NNS
AF040	Stranded Patients - 7+ days	206	No Target		N/A	LSAR
AF041	Stranded Patients - 21+ days	36	No Target		N/A	LSAR
AF042	COVID patients in ICU beds	2	No Target		N/A	LSAR
AF043	COVID patients in other beds	12	No Target		N/A	LSAR
AF044	COVID staff absences	10.60%	No Target		N/A	LSAR

*** Key for SPC indicators is located at the end of the document***

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

Period	Lower CL
Apr 2021	65.8%

Value	Median
65.8%	71.1%

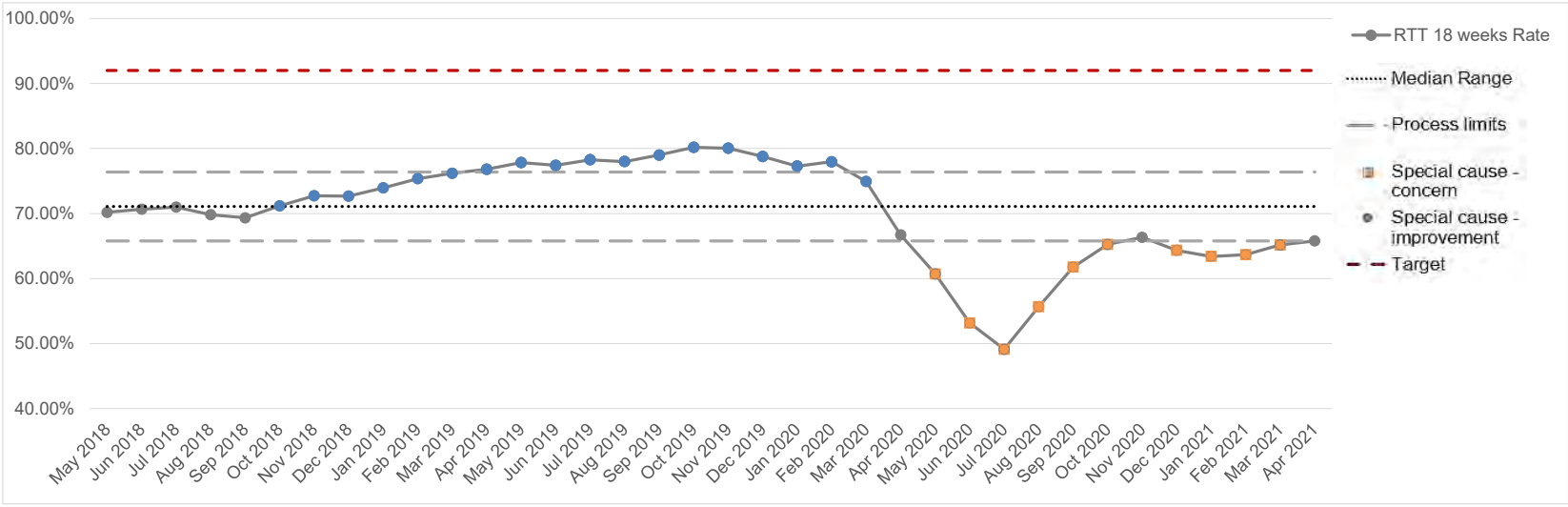
Target	Upper CL
92.0%	76.4%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

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

Period	Lower CL
Apr 2021	0

Value	Median
873	129

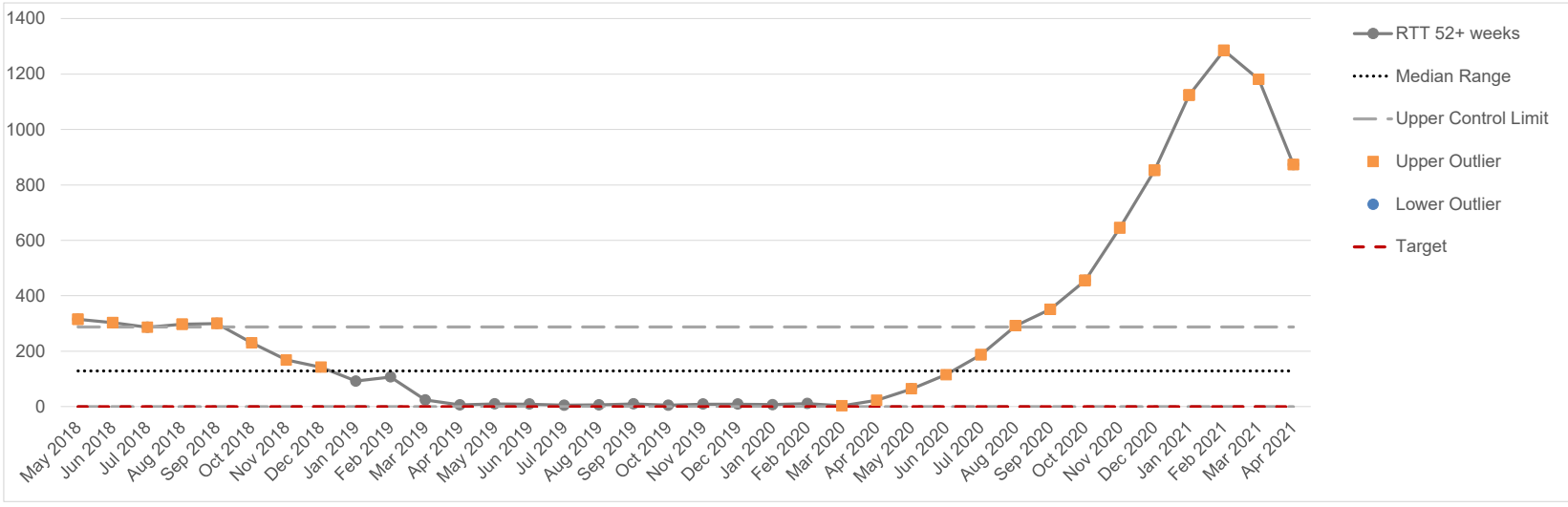
Target	Upper CL
0	288

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
Summary - 52-77 weeks without a plan has decreased significantly from 983 to 584. Significant decrease in numbers due to reduced tip overs as a result of reduced referrals this time last year.	S&CC apply close scrutiny to the over 52 week patients and particular areas to highlight are: ENT have worked closely with Audiology and MRI to reduce the numbers in March at 317 to a current total of 145 in May Oral surgery have reduced from 176 in March to 62 in May through in session efficiencies and additional sessions Ophthalmology have reduced from 190 in March to 104 in May

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

Northern Lincolnshire and Goole NHS Foundation Trust

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

Period	Lower CL
Apr 2021	2.7%

Value	Median
39.8%	14.7%

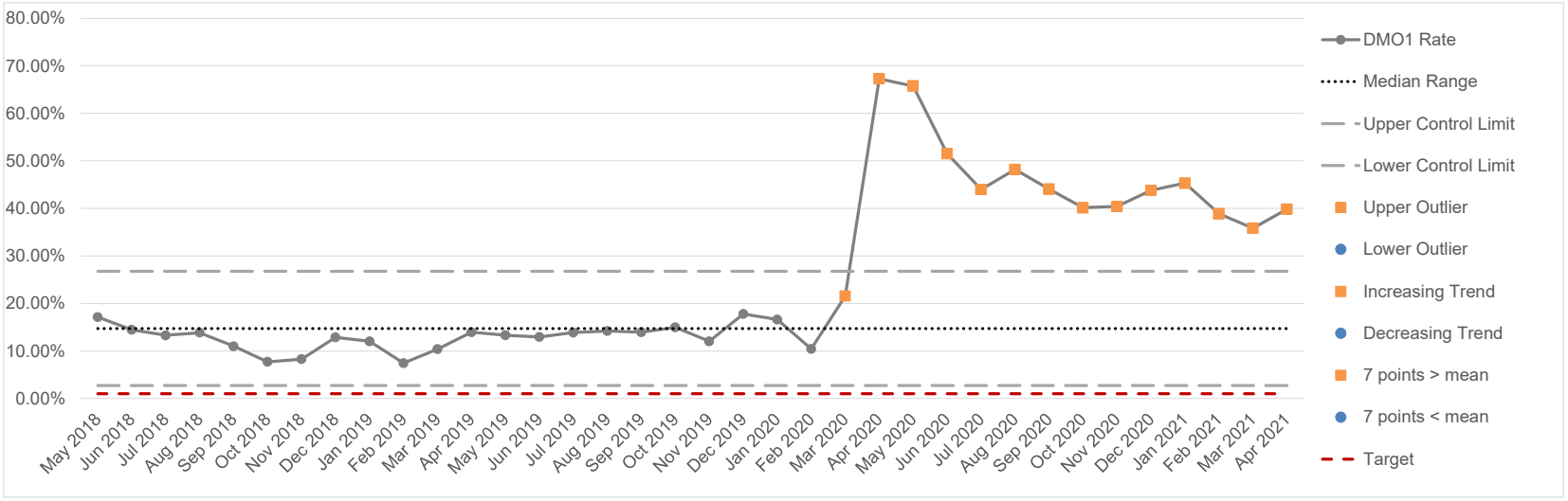
Target	Upper CL
1.0%	26.8%

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
The DM01 was fairly stable and between 10% to 20% of patients were waiting for 6 weeks or more for diagnostic tests between May 2018 and February 2020. Then in the early months of 2020, the UK had the first wave of the COVID pandemic and for approximately two to three months, service provision was significantly reduced and the waiting list increased. Since then capacity has been increased and the DM01 is improving but existing capacity per scanner is less than capacity per scanner pre-COVID due to enhanced infection control measures such as social distancing, segregation and extensive cleaning.	Increase in capacity e.g. access to independent sector capacity (St Hugh's and BMI Lincoln), mobile CT and MRI scanners on site (both at DPOW and SGH), and departments working seven days a week. A new static CT scanner opened at DPOW in January 2021, and two new static MRI scanners commenced operations in May 2021 at DPOW. In addition, a new MRI static scanner will be operational at SGH in October 2021. Radiology reporting - extra sessions by Consultant Radiologists and outsourcing of reports. Radiographer reporting has increased by 43% in the last 12 months and includes chest and abdomen reports as well as upper GI flouroscopy reports.

Issues And Risks	Mitigations
CT colons remain a challenge due to difficulty in recruiting radiographers with CT colon experience. Consultant Radiologists: 50% vacancy rate. Endoscopy: 7-day diagnostics turnaround for suspected cancer patients to meet 28-day faster diagnosis target. Audiology DM01 has deteriorated from 1.6% in January 2021 to 39% in April 2021as a result of the ENT recovery program and the Ultrasound DM01 has grown to 58.8% in April 2021.	CT colons - capsule endoscopy is being implemented on a pilot basis and commenced this month - May 2021. It is envisaged that up to 80% of patients who have capsule endoscopy will not require a CT colon. Ongoing recruitment of Consultant Radiologists both in the UK and abroad. Endoscopy mitigation –Cancer Alliance funding to support additional activity (endoscopy recovery programme). Capacity and demand model being built to better understand the impact on planned and surveillance lists. Funding for Audiology recovery programme and the Ultrasound recovery programme has been approved by the Trust in May 2021 and will be implemented from June 2021 to clear the waiting list backlog. Business cases are being written to appoint more substantive staff in these departments in order to bridge the gap between demand and capacity.

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

Latest Month	Lower CL
Apr 2021	73.0%

Value	Median
72.3%	81.3%

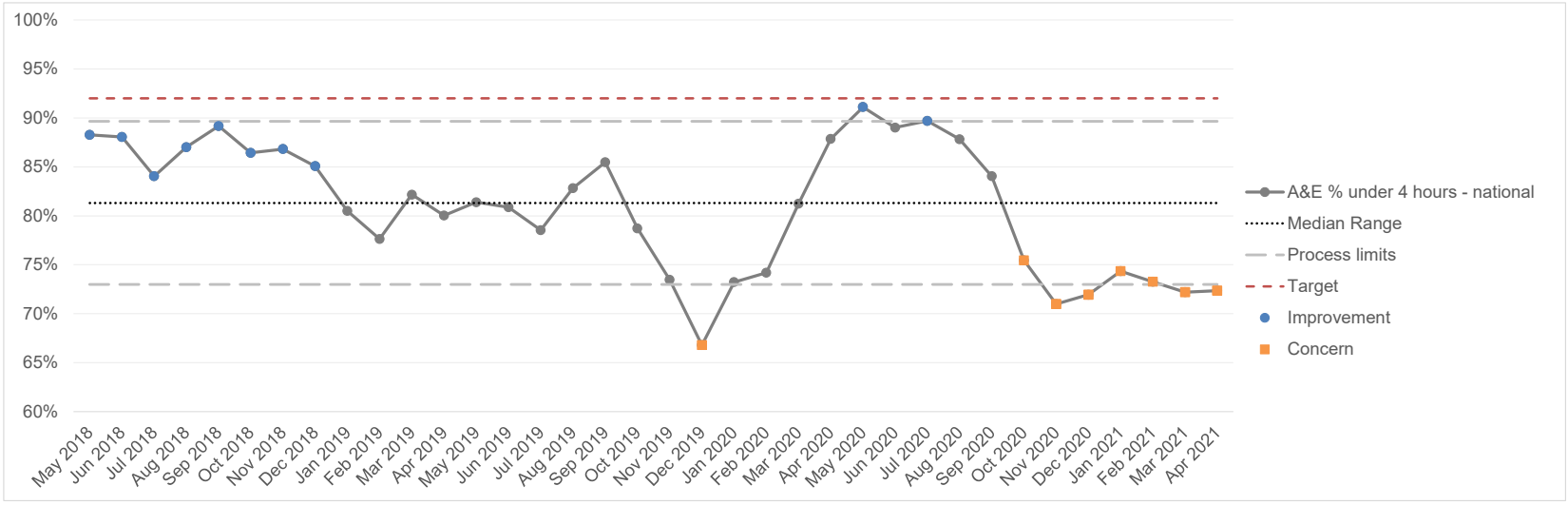
Target	Upper CL
92.0%	89.6%

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
Increased attendances (recent weeks higher than pre-covid) are creating challenges within the emergency departments due to physical capacity within the department, workforce capacity, covid-19 implications and patient flow out of ED into the hospital. The challenges are having a negative effect on the Trust's performance against the four hour target. The performance during March 2021 to August 2021 was an improved position due to the reduced number of attendances and a Trust bed occupancy that allowed for prompt patient flow out of the ED into the hospital.	• ED Performance Task and Finish Group to progress improvement action plans • Discharge to assess initiative to enable prompt discharges and create improved bed occupancy levels • IAAU to enable improved access for incoming admissions • SDEC Task and Finish Group to increase SDEC and avoid admissions • NHS111 First Initiative to reduce avoidable ED attendances • CQC Action Plan • ED Medical Recruitment Strategy • NHSE/I ECIST Support, point of prevelance study and missed opportunities audit • New ED/AAU build in development

Issues And Risks	Mitigations
• Exit block from ED for admission due to lack of patient flow causing long delays for patients in ED • Implications of COVID-19 (zoning segregation, PPE, awaiting swab results, staff sickness and isolation) creating challenges and delays for patient pathway through the ED • Medical staffing vacancies, sickness, and isolation resulting in over reliance on locum/agency doctors and junior skillmix • Nurse staffing vacancies, sickness and isolation resulting in unfilled nursing shifts and over reliance on agency nurses with less ED experience • Delays in diagnostic imaging at times • Delays in specialty in-reach not meeting the less than 30min attendance to review • Lack of clinical cubicle capacity to see incoming patients and hold patients awaiting admission • Delays in mental health input out of hours resulting in long patient delays within ED for vulnerable patients • Inappropriate attendances to ED due to lack of access to alternative, more appropriate services	• Fast track paediatric process in place – January 2021 saw 97% performance for paediatric attendances • Increased staffing in ED • 2 hourly board rounds with EPIC and Clinical Coordinator • Nursing care needs monitored through care round document – risk assess for pressure ulcers, falls, nutrition, hydration, comfort • Alternatives to trolleys – beds, recliner chairs • Choice of meals for patients during prolonged ED stays • Medication and observations as required • Support offered to staff for health and wellbeing

Northern Lincolnshire and Goole NHS Foundation Trust

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

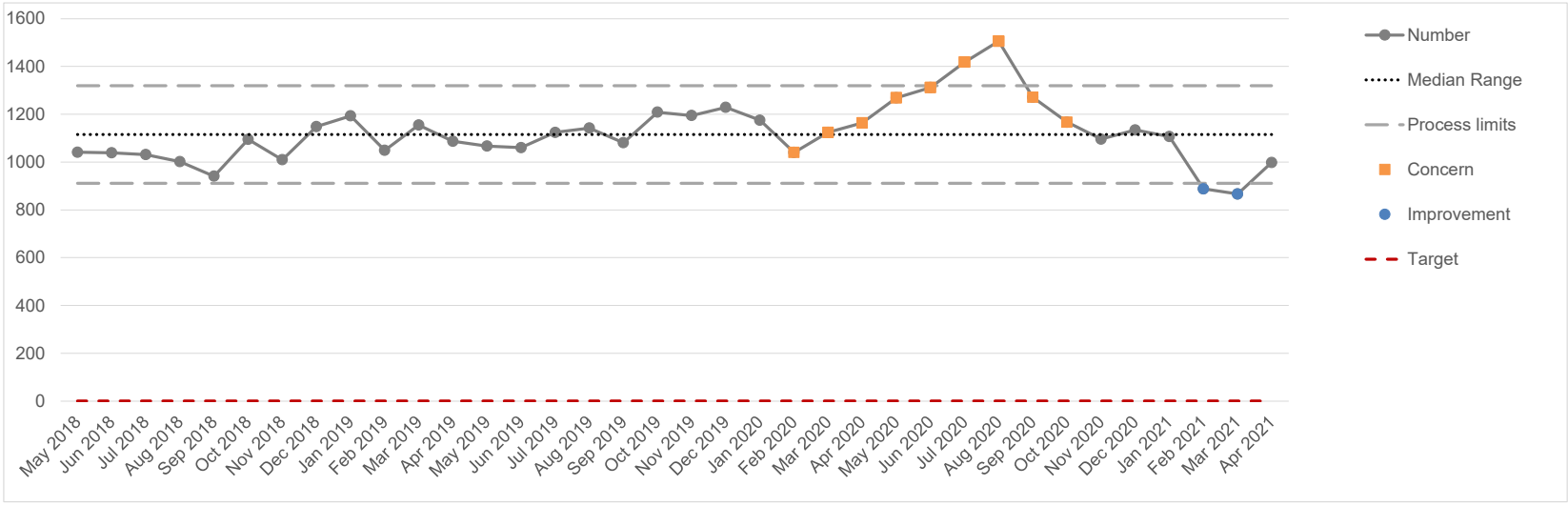
Period	Lower CL
Apr 2021	911.1
Value	**Median**
998	1115.5
Target	**Upper CL**
0	1319.9

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
15-30min handover breaches normally occur when ambulances turn up at the same time resulting in one patient waiting to start their handover once the patient before is completed. Delays in the patient information becoming available on the EMAS siren system for the NLAG team to commence booking the patient in can also lead to several minutes of delay.	• Ambulance Handover Task and Finish Group with system partners to drive improvement plan • UTC at SGH moved out of ED footprint to increase ED physical capacity • System-wide Ambulance Handover Improvement Plan which includes 32 actions including reducing inappropriate conveyances by increasing hear and treat/see and treat; making the actual handover process as efficient and clinically safe as possible; and improving patient flow to reduce the exit block from preventing handovers from commencing due to lack of clinical cubicle availability for incoming patients • New ambulance handover process with digital triage now in place • New ED/AAU build in development • New direct streaming process from EMAS to SDEC now in place • New EMAS patient self-handover SOP now in place

Issues And Risks	Mitigations
• Bed occupancy levels and COVID-19 implications have created challenges in balancing the ward configuration to meet the changing demand of bed requirements • Lack of IT interface ability between EMAS and NLAG systems • Temporary ambualnce drop off locations due to new ED build works creating longer physical journey for ambulance patients • Patients receiving delayed assessment and treatment whilst waiting in ambulances • Long ambulance waits for handover result in reduction of ambulances to attend emergencies in the community • Negative impact on A&E 4hr performance	• Ambulance Handover Improvement Plan • System-wide approach to driving change • Clinical review of patients waiting in ambulances • Prioritisation of patient handovers based on clinical risk/acuity • Fast track option for paediatric patients and recording assessments of patient being held in ambulances

Northern Lincolnshire and Goole NHS Foundation Trust

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

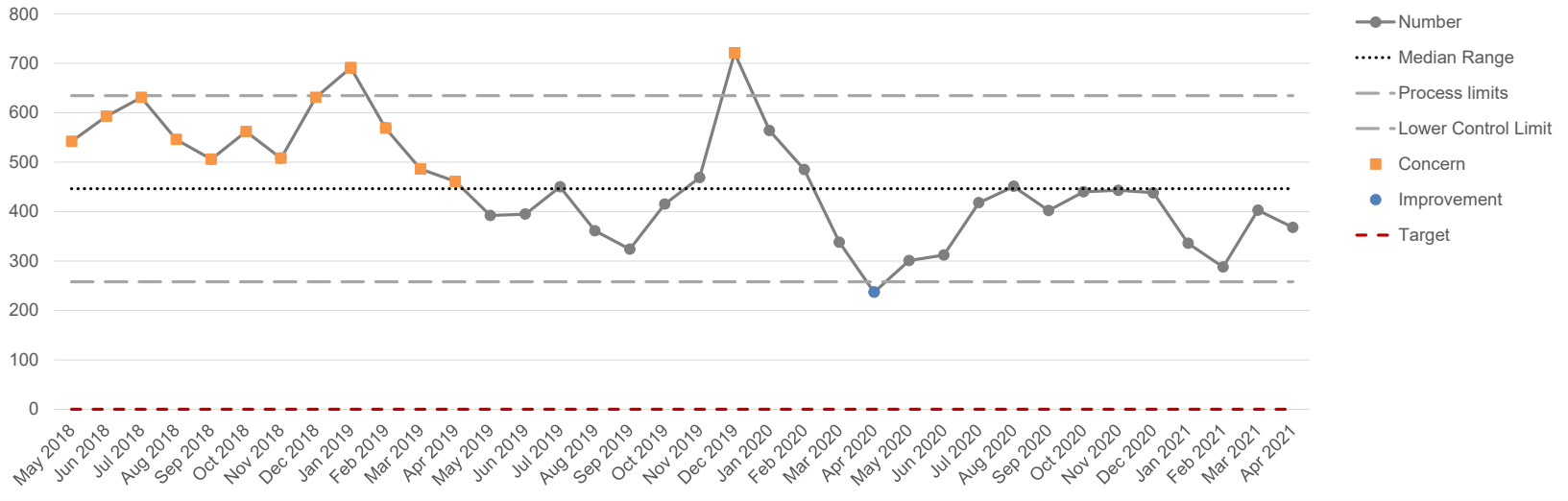
Period	Lower CL
Apr 2021	258.02
Value	**Median**
368	446.5
Target	**Upper CL**
0	635.0

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
30-60min handover breaches occur when the handover area is full and there are no clinical cubicles available to accept incoming patients due to exit block from ED. Increased ED attendances and lack of patient flow out of the ED is resulting in crowding within the department and lack of physical capacity.	• Ambulance Handover Task and Finish Group with system partners to drive improvement plan • UTC at SGH moved out of ED footprint to increase ED physical capacity • System-wide Ambulance Handover Improvement Plan which includes 32 actions including reducing inappropriate conveyances by increasing hear and treat/see and treat; making the actual handover process as efficient and clinically safe as possible; and improving patient flow to reduce the exit block from preventing handovers from commencing due to lack of clinical cubicle availability for incoming patients • New ambulance handover process with digital triage now in place • New ED/AAU build in development • New direct streaming process from EMAS to SDEC now in place • New EMAS patient self-handover SOP now in place

Issues And Risks	Mitigations
• Bed occupancy levels and COVID-19 implications have created challenges in balancing the ward configuration to meet the changing demand of bed requirements • Lack of IT interface ability between EMAS and NLAG systems • Temporary ambualnce drop off locations due to new ED build works creating longer physical journey for ambulance patients • Patients receiving delayed assessment and treatment whilst waiting in ambulances • Long ambulance waits for handover result in reduction of ambulances to attend emergencies in the community • Negative impact on A&E 4hr performance	• Ambulance Handover Improvement Plan • System-wide approach to driving change • Clinical review of patients waiting in ambulances • Prioritisation of patient handovers based on clinical risk/acuity • Fast track option for paediatric patients and recording assessments of patient being held in ambulances

Northern Lincolnshire and Goole NHS Foundation Trust

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

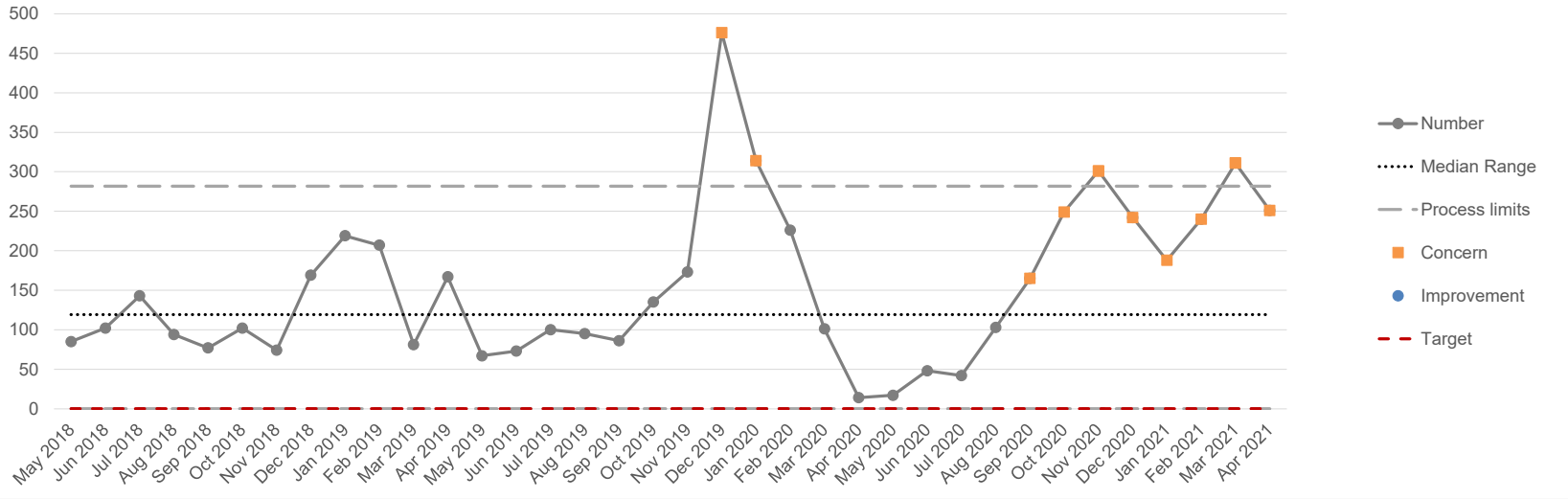
Period	Lower CL
Apr 2021	0.0
Value	**Median**
251	119.0
Target	**Upper CL**
0	281.6

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
60min+ handover breaches occur when the handover area is full and there are no clinical cubicles available to accept incoming patients due to exit block from ED. Increased ED attendances and lack of patient flow out of the ED is resulting in crowding within the department and lack of physical capacity.	• Ambulance Handover Task and Finish Group with system partners to drive improvement plan • UTC at SGH moved out of ED footprint to increase ED physical capacity • System-wide Ambulance Handover Improvement Plan which includes 32 actions including reducing inappropriate conveyances by increasing hear and treat/see and treat; making the actual handover process as efficient and clinically safe as possible; and improving patient flow to reduce the exit block from preventing handovers from commencing due to lack of clinical cubicle availability for incoming patients • New ambulance handover process with digital triage now in place • New ED/AAU build in development • New direct streaming process from EMAS to SDEC now in place • New EMAS patient self-handover SOP now in place

Issues And Risks	Mitigations
• Bed occupancy levels and COVID-19 implications have created challenges in balancing the ward configuration to meet the changing demand of bed requirements • Lack of IT interface ability between EMAS and NLAG systems • Temporary ambualnce drop off locations due to new ED build works creating longer physical journey for ambulance patients • Patients receiving delayed assessment and treatment whilst waiting in ambulances • Long ambulance waits for handover result in reduction of ambulances to attend emergencies in the community • Negative impact on A&E 4hr performance	• Ambulance Handover Improvement Plan • System-wide approach to driving change • Clinical review of patients waiting in ambulances • Prioritisation of patient handovers based on clinical risk/acuity • Fast track option for paediatric patients and recording assessments of patient being held in ambulances

Indicator: AF013 Cancer Diagnosis Within 28 Days — National Indicator

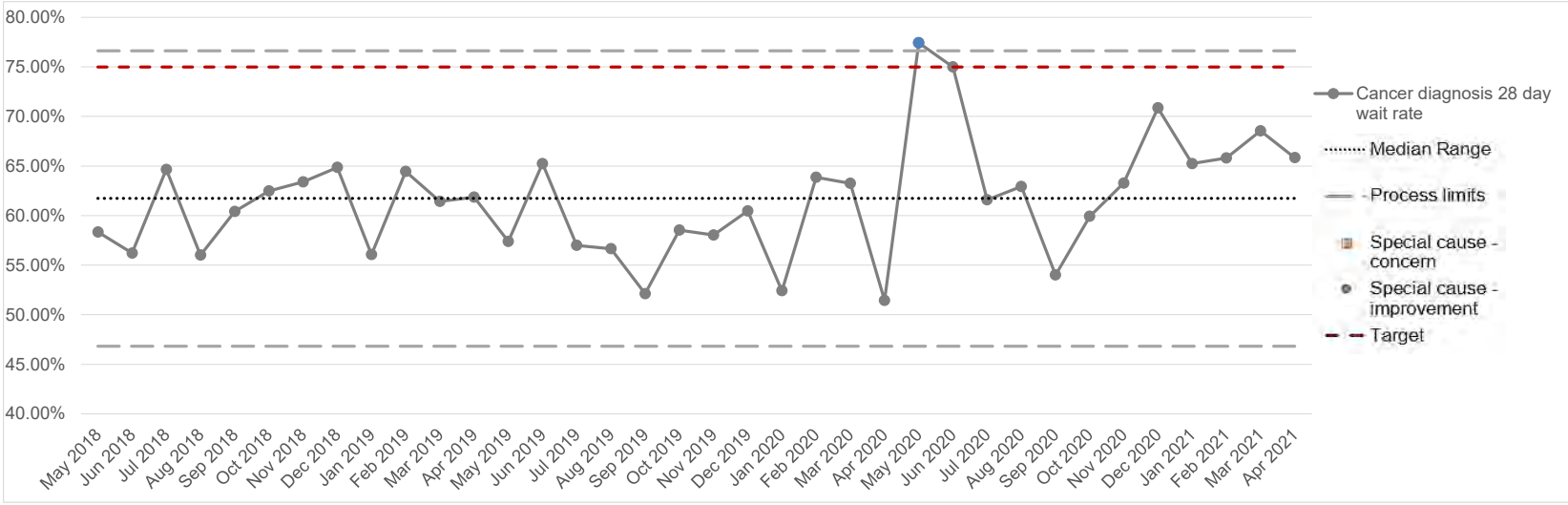
Period	Lower CL
Apr 2021	46.8%
Value	**Median**
65.8%	61.7%
Target	**Upper CL**
75.0%	76.6%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
	S&CC continue to struggle to deliver on this standard due to access to diagnostics and subsequent reporting of results Work is ongoing with all specialties to enable patients to be seen <7 days from referral, enabling diagnostics 3 weeks to turnaround patients

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

Indicator: AF015 Cancer 31 Days Surgery — National Indicator

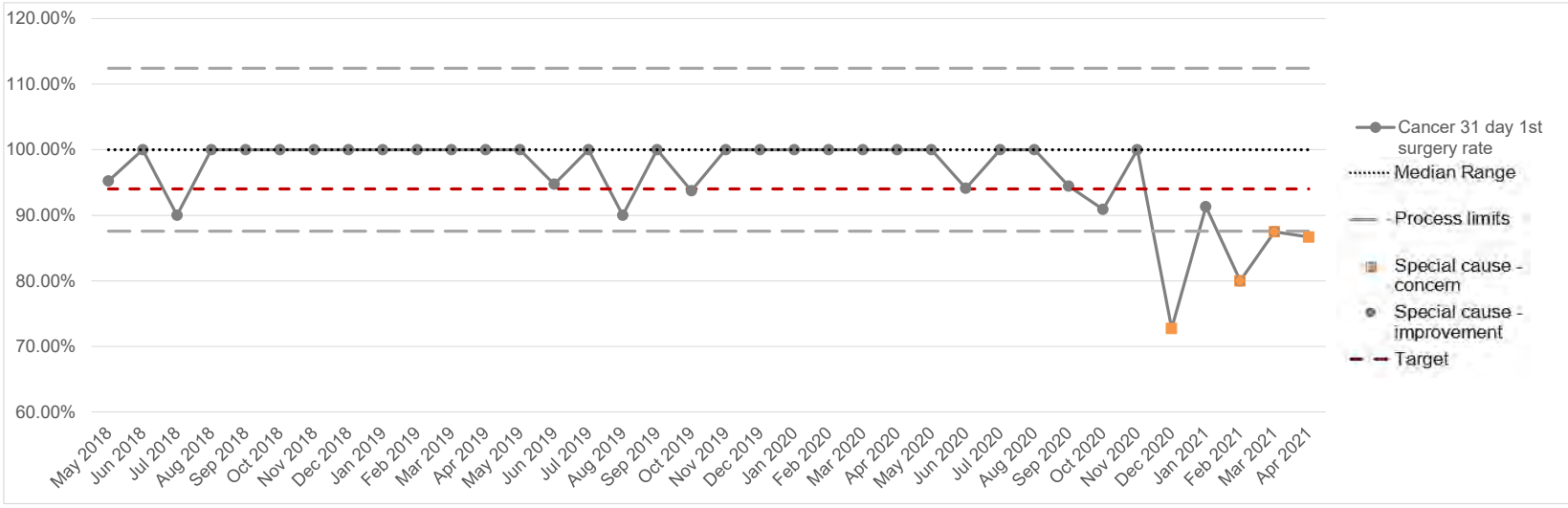
Period	Lower CL
Apr 2021	87.6%
Value	**Median**
86.7%	100.0%
Target	**Upper CL**
94.0%	112.4%

Variance

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

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
	The majority of our specialties are able to deliver this standard with the exception of Colorectal due to capacity constraints within theatre

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

Indicator: AF016 Cancer 31 Days Drugs — National Indicator

Period	Lower CL
Apr 2021	97.8%
Value	**Median**
94.4%	100.0%
Target	**Upper CL**
98.0%	102.2%

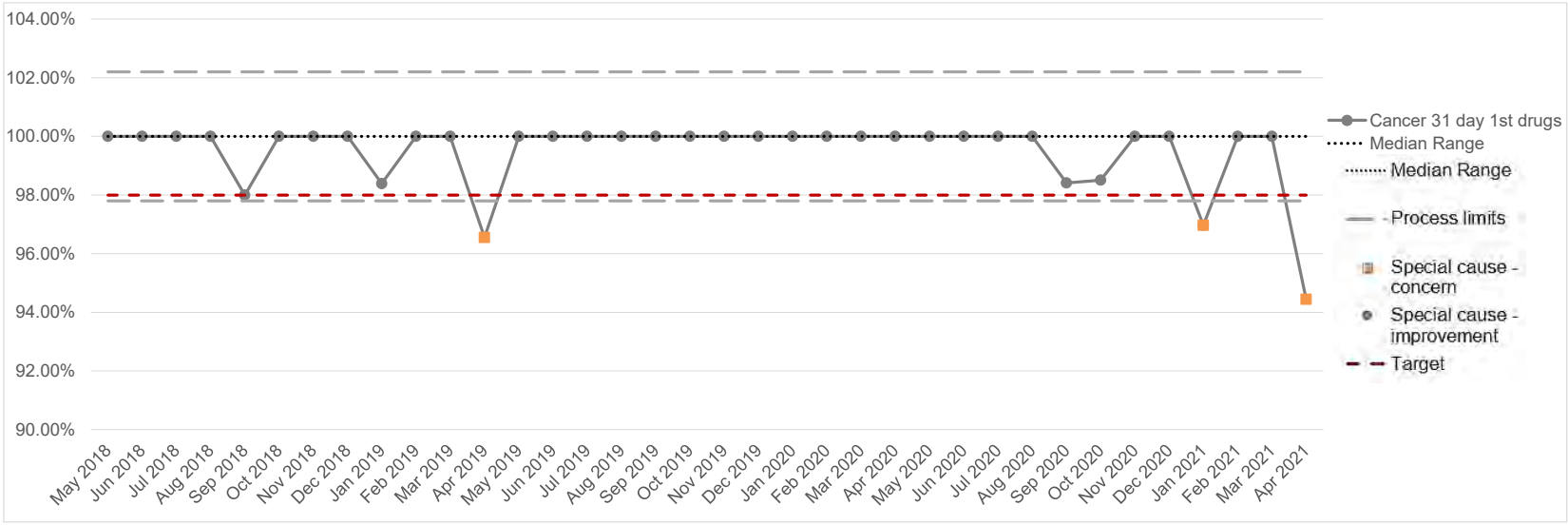
Variance

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

Assurance Inconsistency

SPCPassing

Variation indicates consistently passing the target



Background And What Is The Chart Telling Us?	Actions
	All our specialties achieve this standard the majority of the time, even during the height of COVID

Issues And Risks	Mitigations

Indicator: AF017 Cancer 62 Day GP Referral — National Indicator

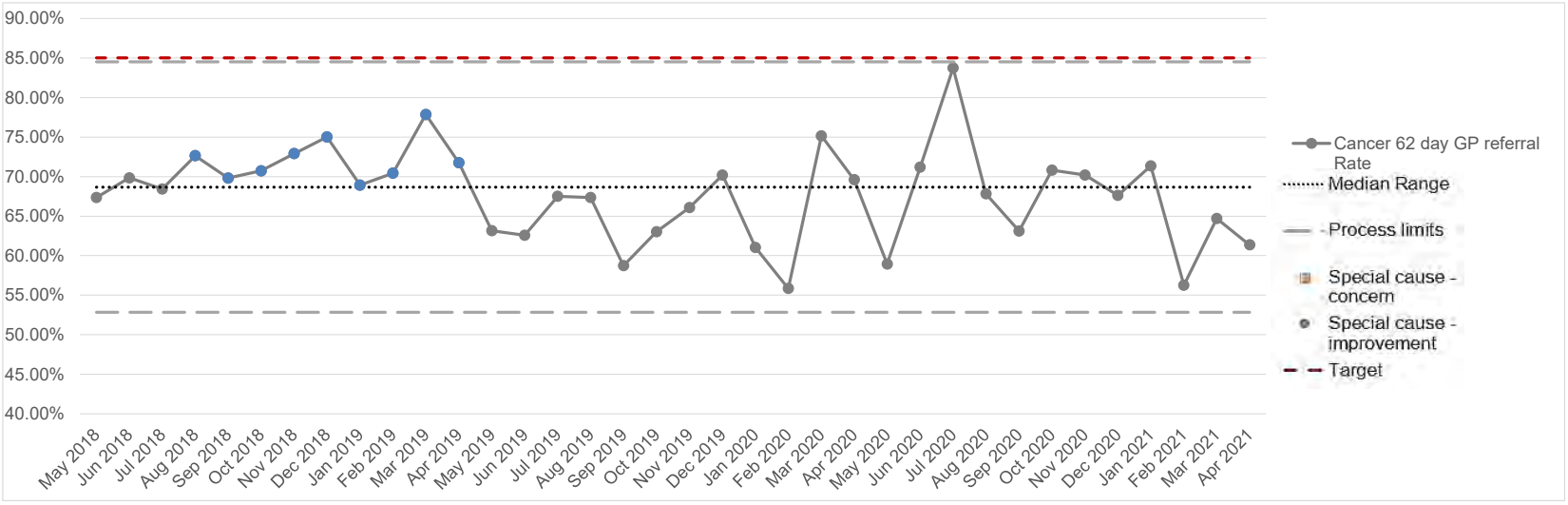
Period	Lower CL
Apr 2021	52.8%
Value	**Median**
61.4%	68.7%
Target	**Upper CL**
85.0%	84.5%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
	Colorectal: significant improvement in delivery of this standard but still averaging 70% - lack of theatre capacity during November resulted in significant backlog of patients to date H&N: historically struggle to achieve this standard due to complex diagnostic pathways and referral to HUTH for treatment. Currently averaging about 30% achievement UGI: historically struggle to achieve this standard due to complex diagnostic pathways and referral to HUTH for treatment. Currently averaging about 60% achievement Urology: historically struggle to achieve this standard due to complex diagnostic pathways and referral to HUTH for treatment. Currently averaging about 70% achievement

Issues And Risks	Mitigations
Impact of another surge in COVID Inability to deliver agreed interventions within a timely manner - diagnostics, surgery, oncology	Daily monitoring to ensure patients are booked timely, appropriate escalation when unable to date

Indicator: AF018 Cancer 62 Day Screening — National Indicator

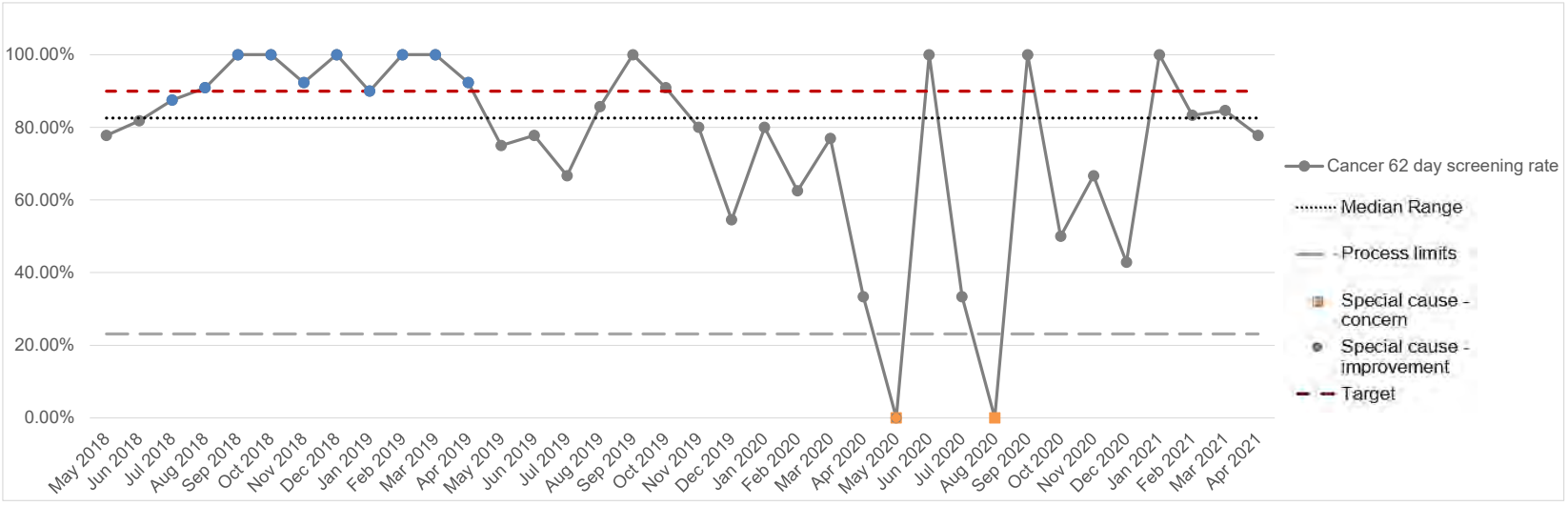
Period	Lower CL
Apr 2021	23.1%
Value	**Median**
77.8%	82.6%
Target	**Upper CL**
90.0%	142.0%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

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

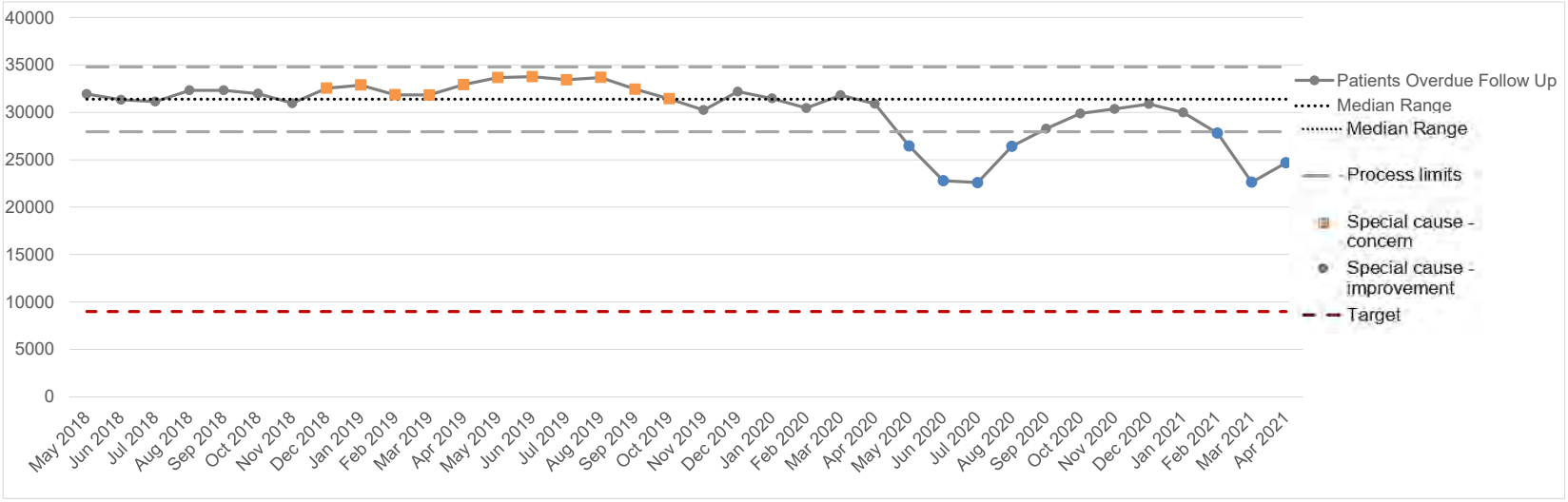
Period	Lower CL
Apr 2021	27,954
Value	**Median**
24,676	31,384
Target	**Upper CL**
9,000	34,813

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



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

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

Northern Lincolnshire and Goole NHS Foundation Trust

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

Local Indicator - Specification Agreed and Reviewed

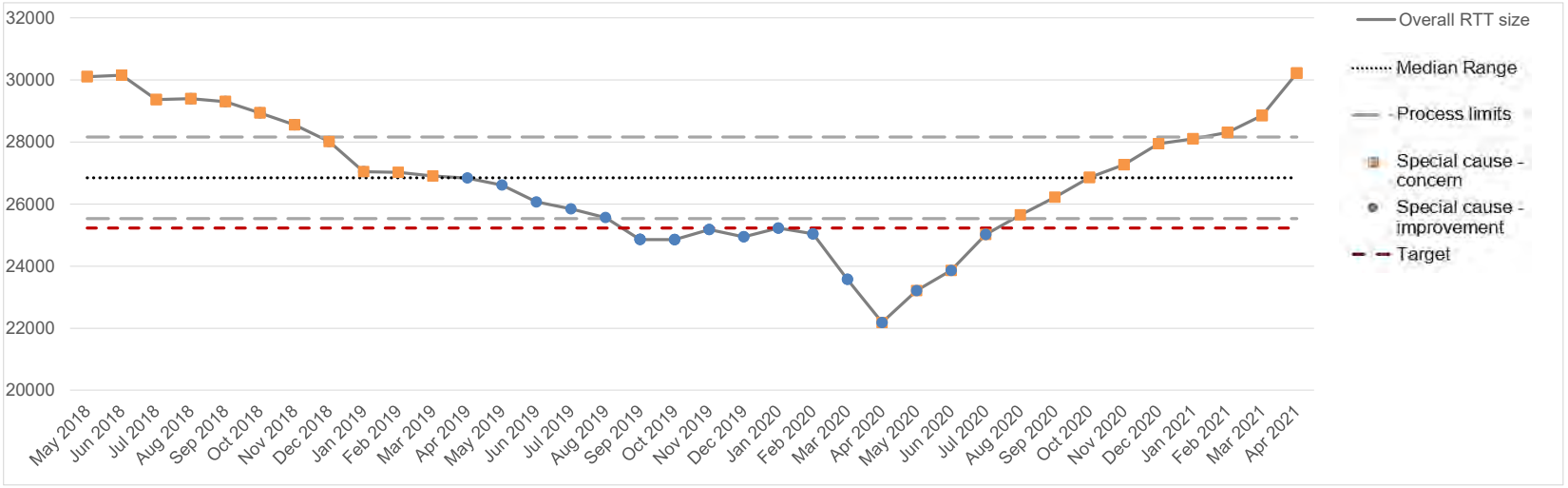
Period	Lower CL
Apr 2021	25,533
Value	**Median**
30,218	26,849
Target	**Upper CL**
25,227	28,164

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
	S&CC apply close scrutiny to the incomplete patients

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

Northern Lincolnshire and Goole NHS Foundation Trust

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

Period	Lower CL
Apr 2021	14,410

Value	Median
11,625	19,905

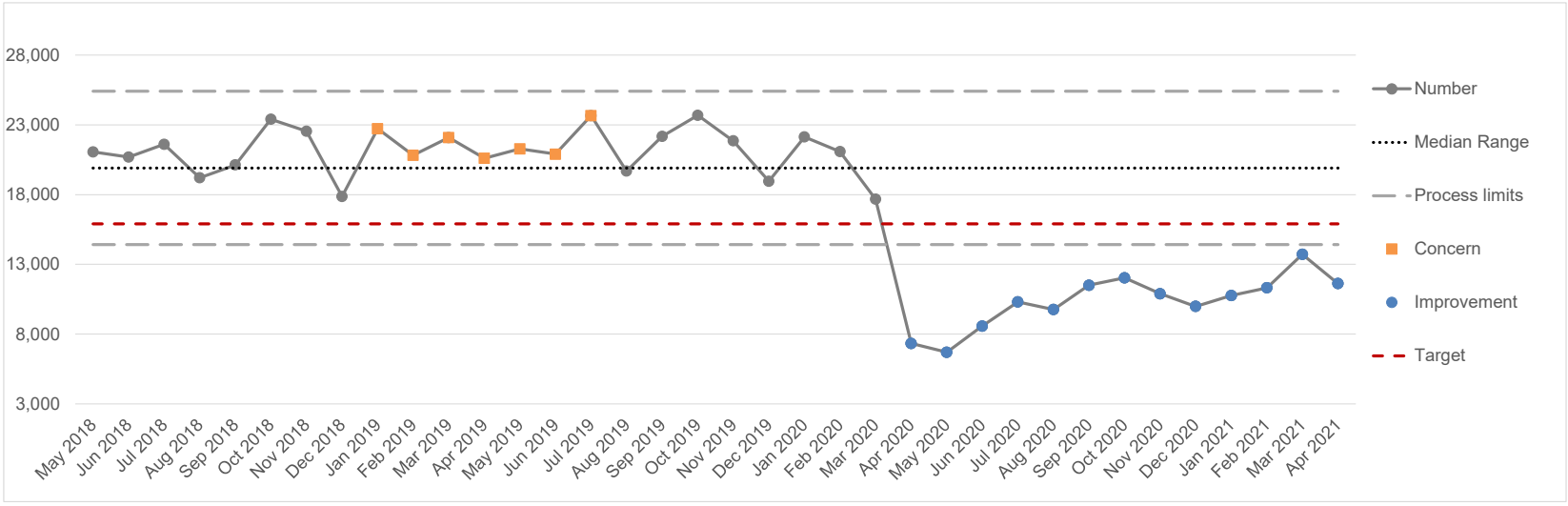
Target	Upper CL
15,903	25,400

Variance

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

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
	Pilot scheme implemented in Paeds SGH to support increase in discharges and PIFU and reduce the number of follow up appointments.

Issues And Risks	Mitigations

Indicator: AF023 Cancer 104+ Days

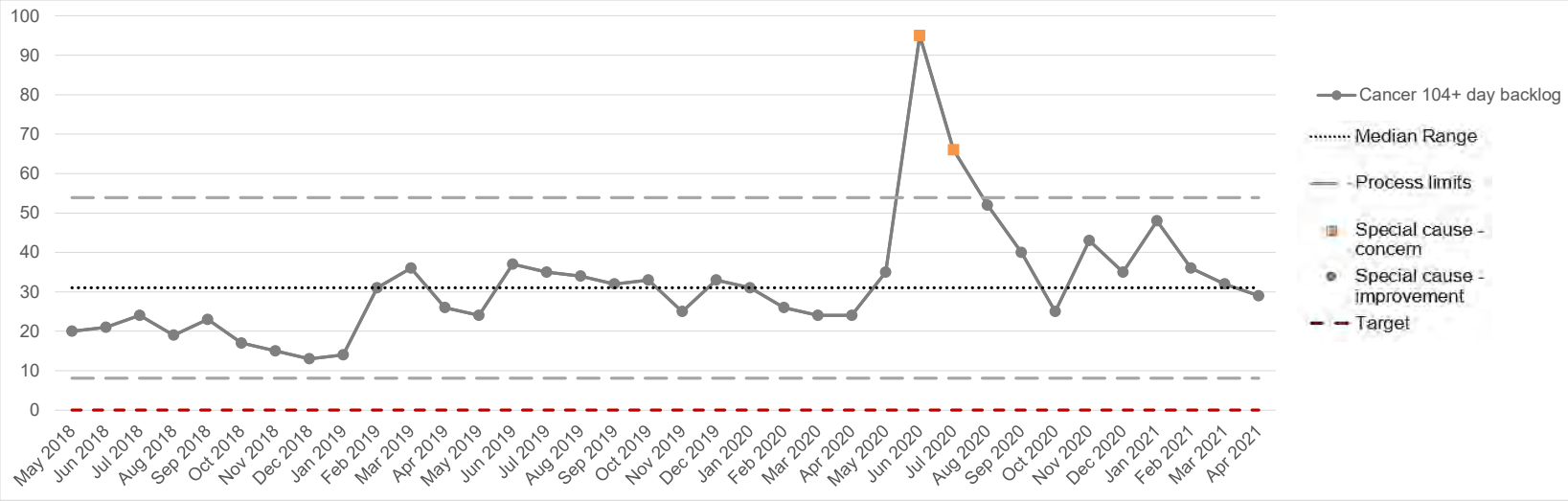
Period	Lower CL
Apr 2021	8.1
Value	**Median**
29	31.0
Target	**Upper CL**
0	53.9

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

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

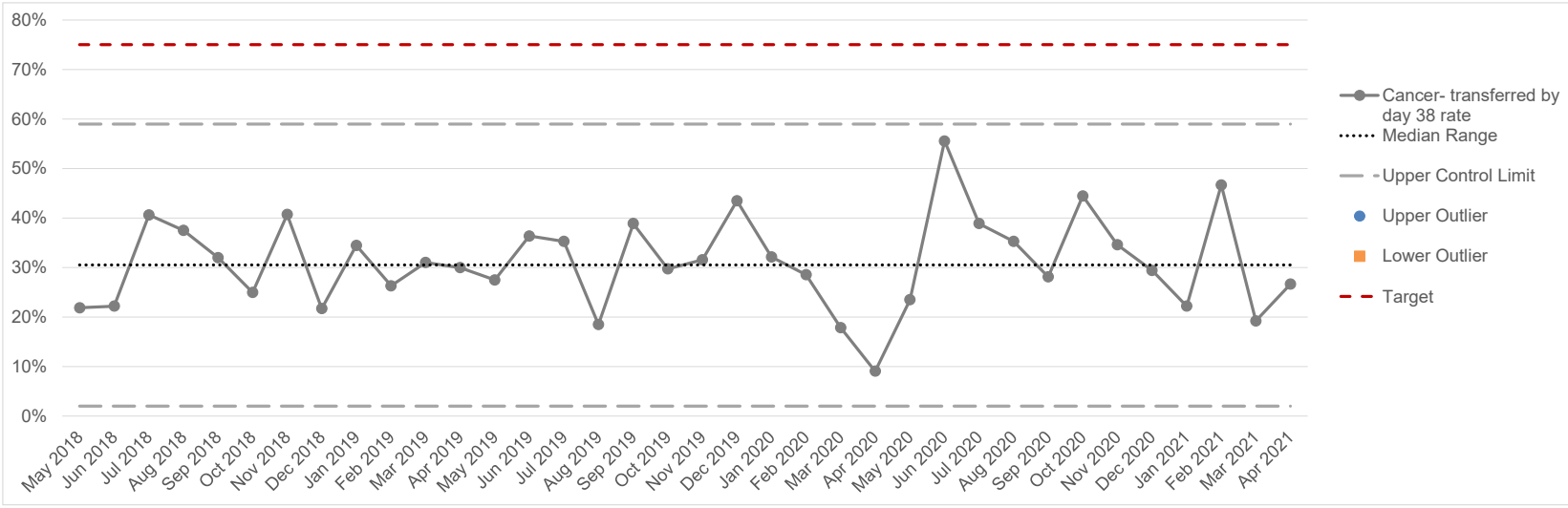
Period	Lower CL
Apr 2021	2.1%
Value	**Median**
26.7%	30.5%
Target	**Upper CL**
75.0%	59.0%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: AF025 Cancer Request To Test In 14 Days

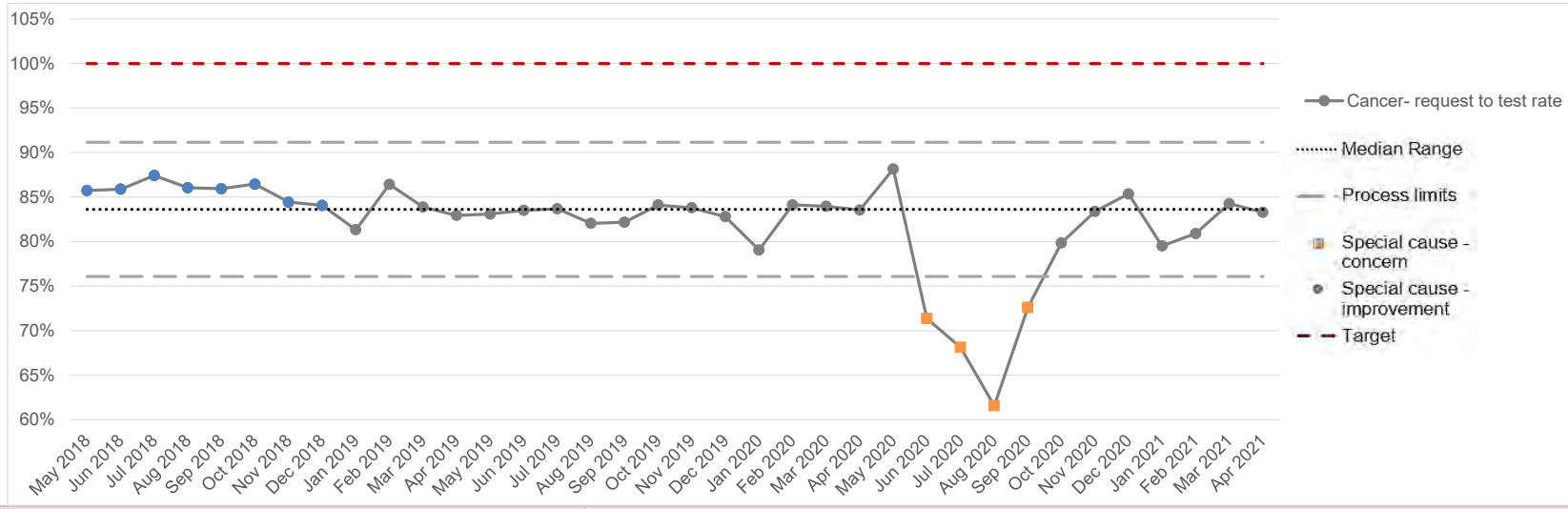
Period	Lower CL
Apr 2021	76.1%
Value	**Median**
83.3%	83.6%
Target	**Upper CL**
100.0%	91.1%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

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

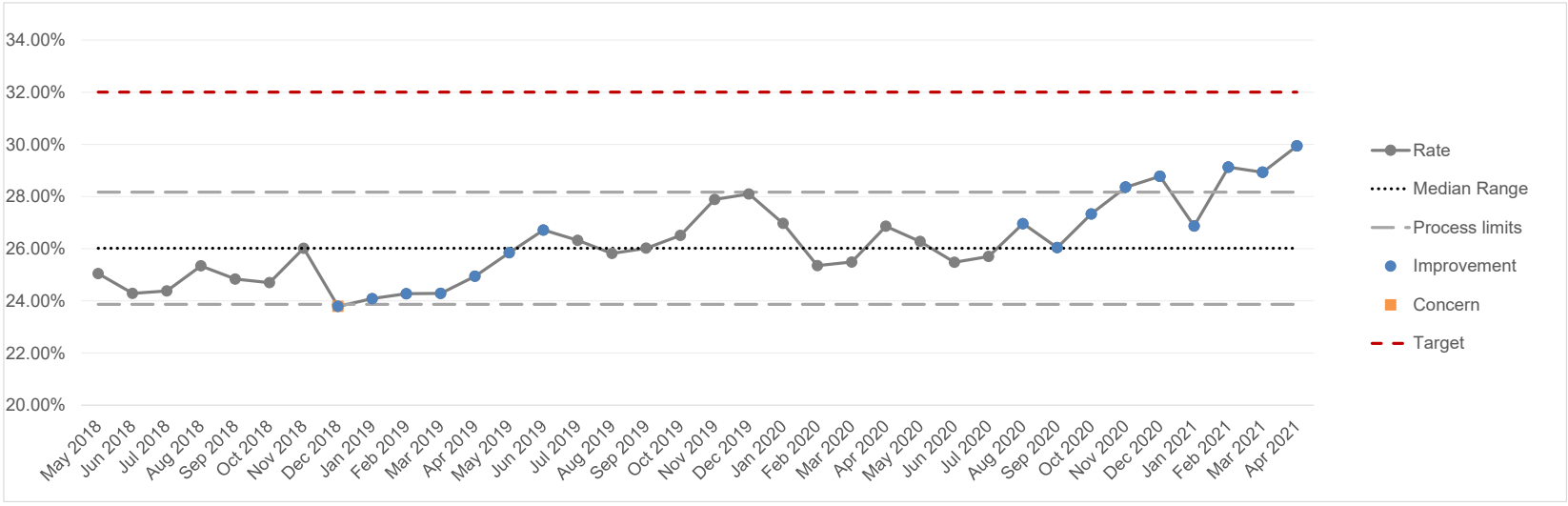
Period	Lower CL
Apr 2021	23.9%
Value	**Median**
29.9%	26.0%
Target	**Upper CL**
32.0%	28.2%

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

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

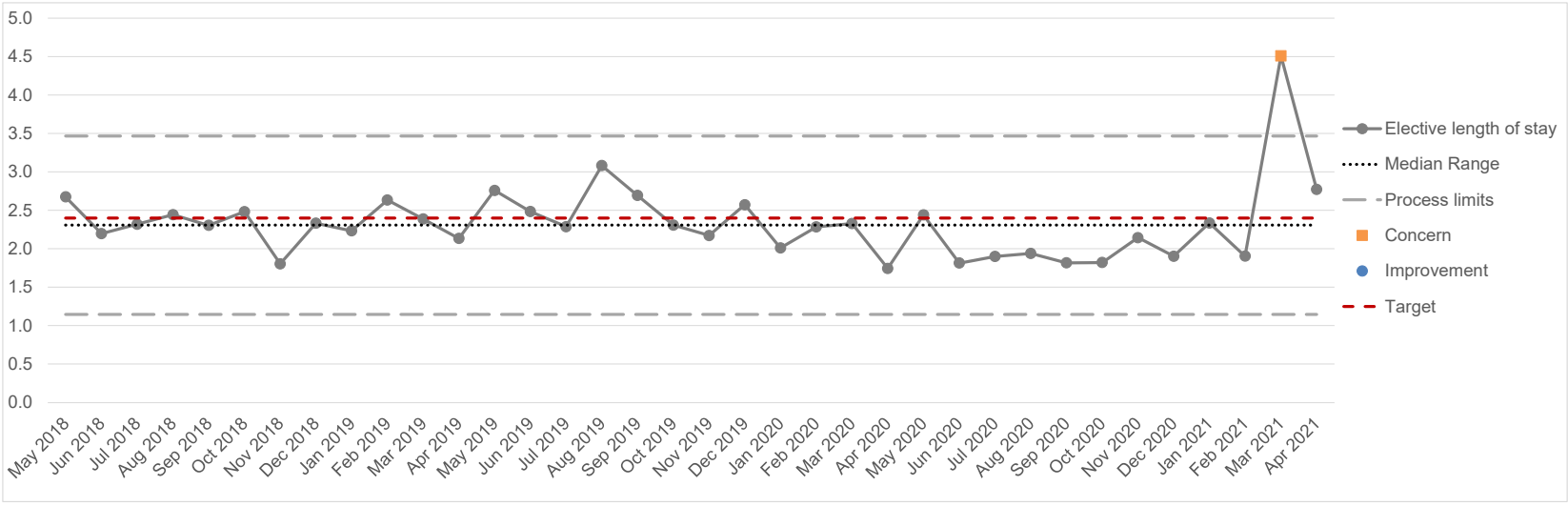
Period	Lower CL
Apr 2021	1.1
Value	**Median**
2.8	2.3
Target	**Upper CL**
2.4	3.5

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Indicator: AF034 Percentage Of A&E Under Four Hours Local Target (Trust Priority)

Local Indicator - Specification Agreed and Reviewed

Period	Lower CL
Apr 2021	73.0%

Value	Median
72.3%	81.3%

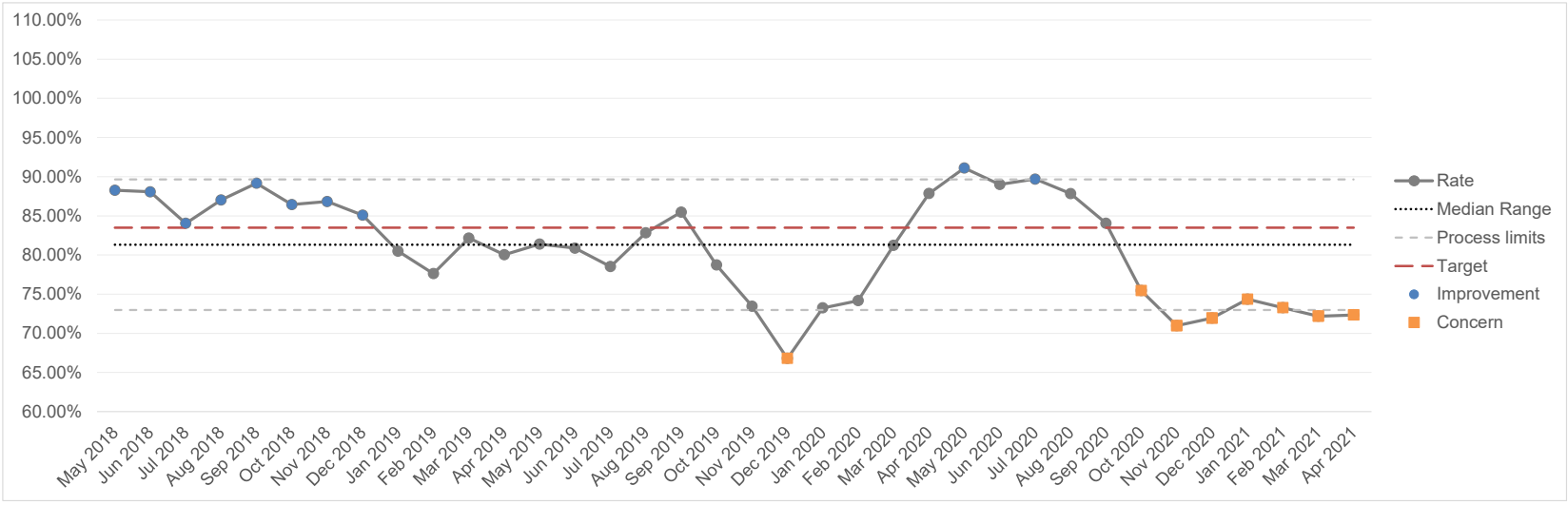
Target	Upper CL
83.5%	89.6%

Variance

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

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

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

Period	Lower CL
Apr 2021	2.0%

Value	Median
8.5%	4.6%

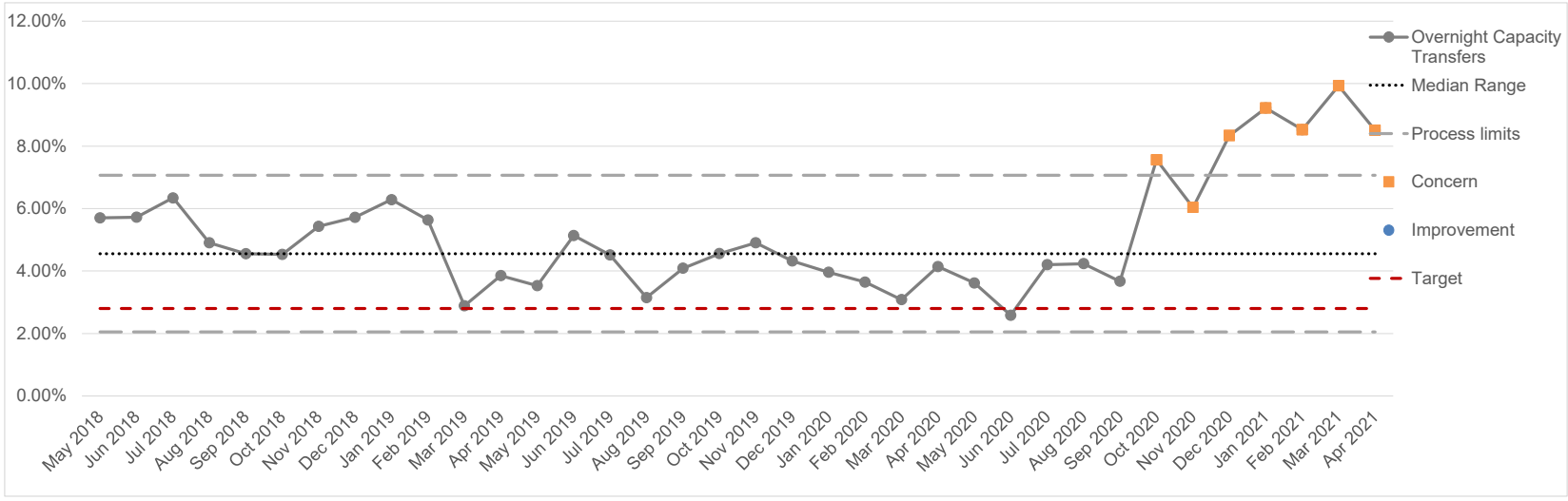
Target	Upper CL
2.8%	7.1%

Variance

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

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
	In light of the changes to ward designations within Medicine (IAAU) there is a need to review the business rules which determine 'overnight transfers' within the data as this may be affecting the trends.

Issues And Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: AF039 Number of 40-51 Week Waits - Latest month represents the unvalidated snapshot

Period	Lower CL
Apr 2021	302

Value	Median
1,170	838

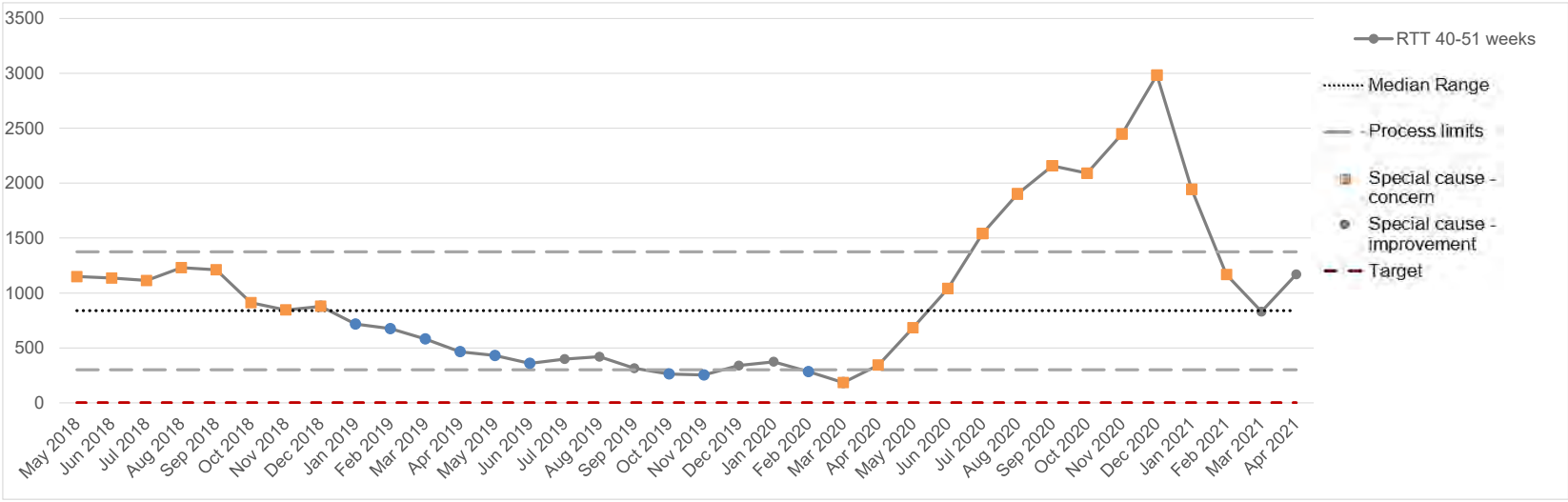
Target	Upper CL
0	1,374

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
	S&CC apply close scrutiny to the over 40 week patients and ensure valid pre assessments are in place to maximise capacity for theatres

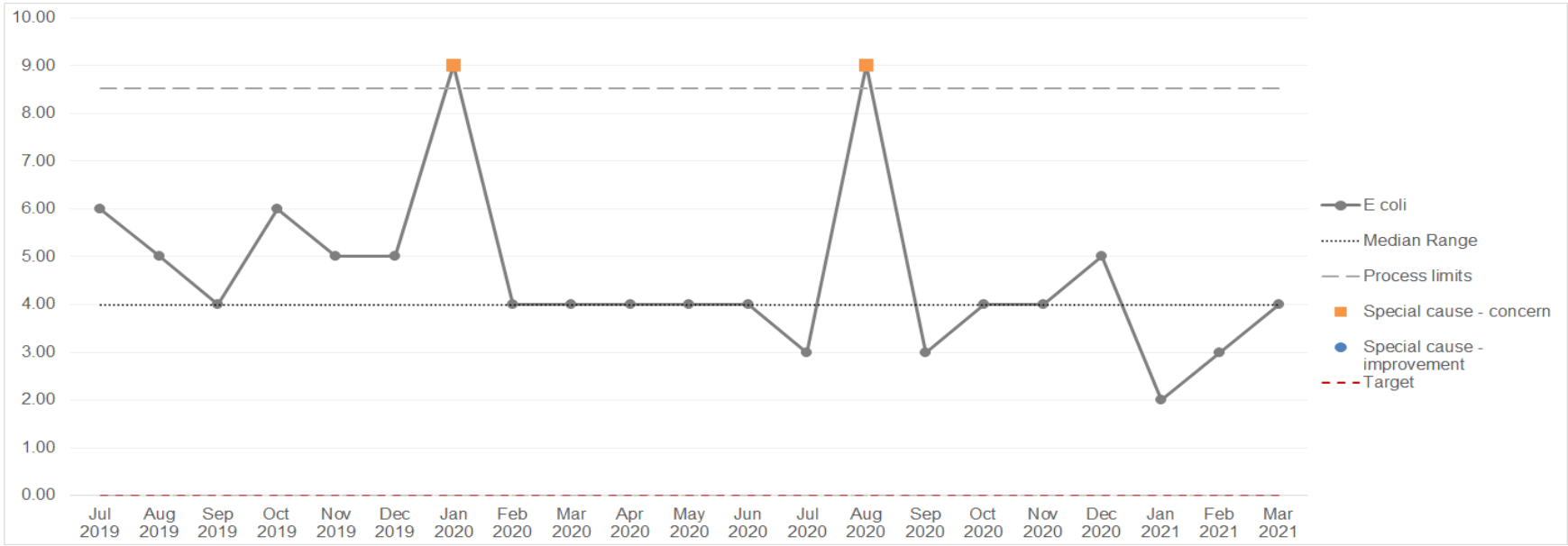
Issues And Risks	Mitigations
Potential further COVID waves	Locum staff in place
Carry over of annual leave - clinician availability	Blocking booking of agency and bank
Inability to resource additional sessions as lockdown lifts	Theatre productivity programme has commenced

Ref	Metrics	Mar 2021 unless otherwise stated	Target / Trajectory	Variation	Assurance
	National Requirements				
QS001	Mixed-sex accommodation breaches	Deprecated	0		
QS002	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0		
QS003	Methicillin - susceptible Staphylococcus aureus (MSSA) bacteraemias	6	0		
QS004	Escherichia coli (E.coli) bacteraemia bloodstream infection (BSI)	4	0		
QS005	Trust attributed C-Diff	2	No target		
QS006	Number of gram-negative bloodstream infections	5	No target		
QS007	Venous Thromboembolism (VTE) risk assessment	77.58%	95%		
QS008	Duty of candour	100.00%	No target		
QS009	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		
QS010	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%		
QS011	Emergency C-section rate	13.40%	<=15.2%		
QS012	Patient Safety Alerts to be actioned by specified deadlines	100.00%	No target		
QS013	Serious incidents - Raised in month	1	No target		
QS014	Occurrence of any Never Event	0	0		
QS015	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%		
QS016	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%		
QS017	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%		
QS018	Inpatient scores from Friends and Family test - % positive	No data this month	No target		
QS019	A&E scores from Friends and Family test - % positive	No data this month	No target		
QS020	Maternity Scores from Friends and Family Test - % positive	No data this month	No target		
QS021	Community Services Score from Friends and Family Test - % positive	No data this month	No target		
QS022	Staff Friends and Family Test %	No data this month	No target		
QS023	Hospital Standardised Mortality Ratio (HSMR) - **Data is for February 2021**	90	100		
QS024	Summary Hospital level Mortality Indicator (SHMI) - **Data is for November 2020**	107	100		
QS025	Written Complaints Rate	5.9	No target	Not an SPC	Not an SPC
	Trust Priorities				
QS026	Mortality Screen of 50% of deaths	81.0%	50%		
QS027	Structured judgment review (SJR) in 100% of those requiring a review	11.0%	100%		
QS028	Adults: Timeliness of observations within 30 minutes of due time	90.66%	>85%		
QS029	Children: Timeliness of observations within 30 minutes of due time	100.00%	>85%		
QS030	Improve frequency of sepsis screening and robustness of reporting	In development	Improvement		
QS031	5% reduction in insulin errors causing significant harm in 20/21	0	0		
QS032	Diabetes role specific training compliance	85.7%	>85%		
QS033	Blood glucose taken in ECC if NEWS over 1 for adults	92.5%	100%		
QS034	Blood glucose taken in ECC if PEWS over 1 for children	80.00%	100%		

*** Key for SPC indicators is located at the end of the document***

Indicator: **QS004 Escherichia coli (E.coli) bacteraemia bloodstream infection**

Period	Value	Target	Trajectory	Variance	Assurance
Mar 2021	4	0			

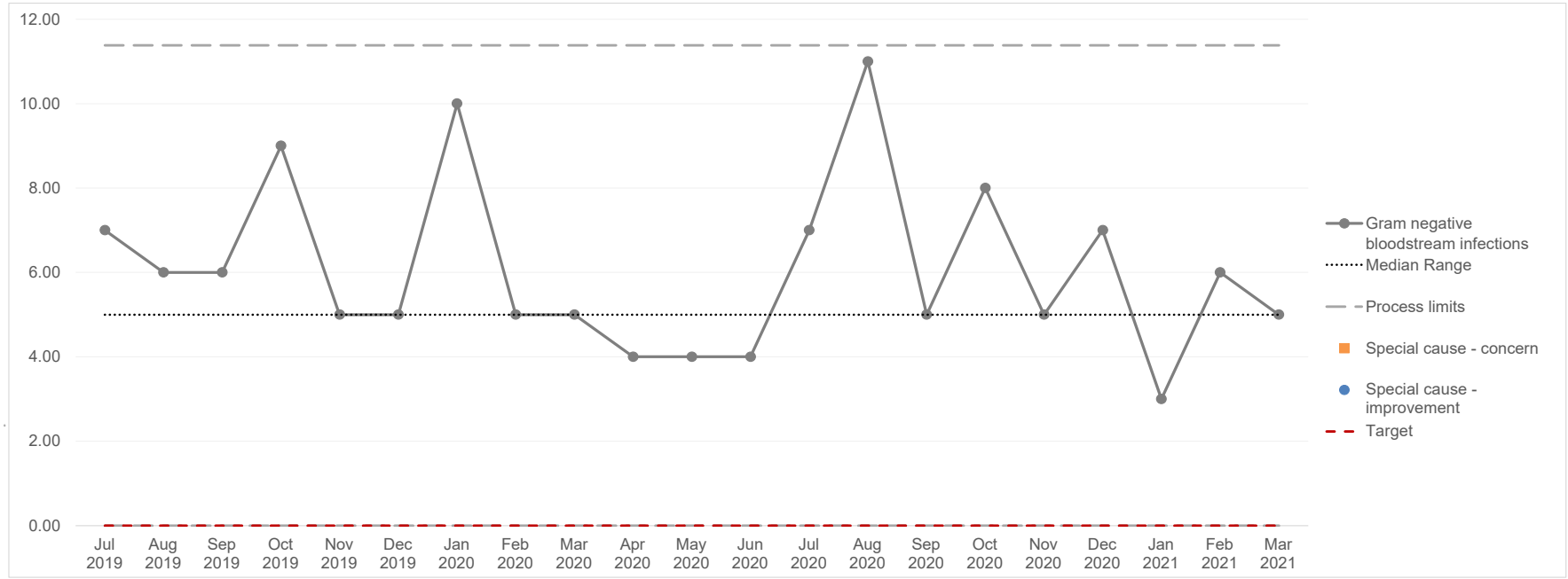


What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling us that the median number of E.coli bloodstream infections is 4 per month. During March, 4 were reported. There is no discernable trends from the SPC and no assurance outcome can be derived.	Cases where the patient has been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

Risks	Mitigations
None	N/A

Indicator: **QS006 Gram negative bloodstream infections**

Period	Total Value	Target	Trajectory	Variance	Assurance
Mar 2021	5	0			



Breakdown of gram negative infections

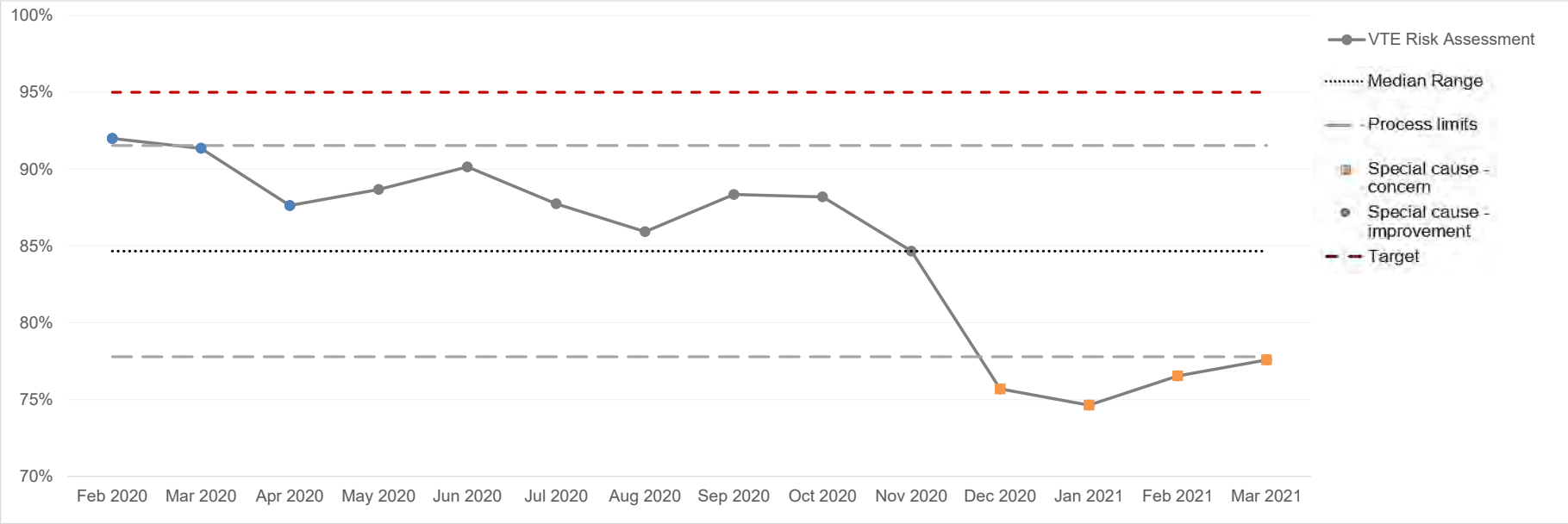
E Coli	Klebsiella	Pseudom
4	1	0

What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
The chart tells us that during March 2021 the Trust reported 5 Gram negative bloodstream infections. There is no target or ambition set by Public Health England for this area. The Trust continues to monitor.	The data is produced by taking a rolling 12-month count of trust-apportioned gram-negative bloodstream infections in patients aged 2 years and over out of a rolling 12-month average occupied bed days per 100,000 beds. The organism data comes through into the IPC module (in WebV) from PathLinks as the results are available. The Infection Control Team submits the all the organisms and not just the trust assigned cases PHE England via the HCAI DCS Mandatory Surveillance website. The cases are trust assigned based on compled rules determined by PHE which vary by organism. This is a monthly submission and is a is a national requirement.	No target or ambition set by PHE.	The Trust continues to monitor this area.

Risks	Mitigations
None.	N/A.

Indicator: **QS007 Venous Thromboembolism (VTE) risk assessment**

Period	Value	Target	Trajectory	Variance	Assurance
Mar 2021	**77.6%**	**95.0%**			

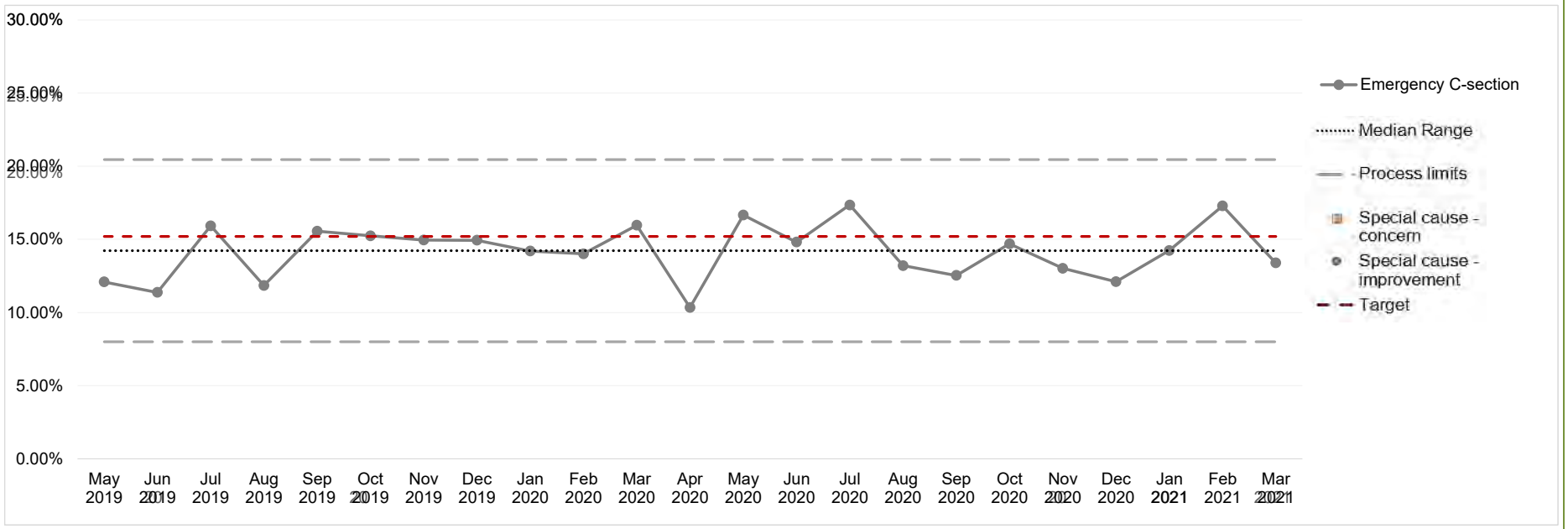


What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling us that we are outside the control limit causing a special cause concern.	The data looks at the number of patients admitted who have a VTE risk assessment out of the number of patients admitted in most recently published quarter. Data is produced from (TBC) and is submitted by Information Servics. This a national Requirement.	VTE risk assessment performance has reduced during the Trust's response to the 2nd wave of Covid-19 during November and December and the ongoing management of patients with or at risk of Covid-19. Changes in operational procedures such as re-zoning wards rapidly on both the DPOW and SGH sites required to create Red / Yellow A / Yellow B CoViD areas to cope with the increasing demand of CoViD-related (or CoViD-suspected) acute admissions have likely impacted on performance.	Medicine have appointed 2 Clincial Leads to support compliance and an operational focus on VTE. An electronic VTE screening tool has been launched on WebV. Clinical Leads / DCD / Deputy Medical Directors / Senior Nursing Staff to continue to attend medical & nursing handovers on ward areas in both DPOW and SGH to reinforce the importance of timely recording of VTE risk assessments.

Risks	Mitigations

Indicator: **QS011 Emergency C-Section**

Period	Value	Target	Trajectory	Variance	Assurance
Mar 2021	**13.4%**	**15.2%**			

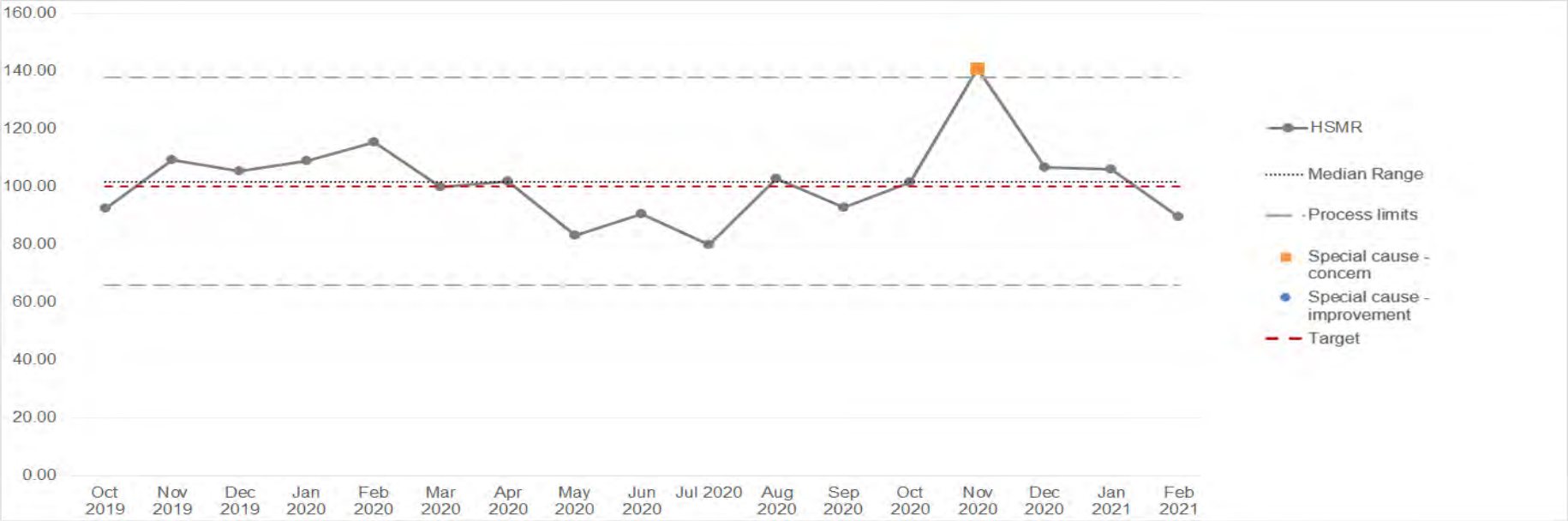


What Is The Chart Telling Us?	Background	Issues	Actions
The chart tells us that for the month of March 2021 13.4% of patients had an emergency C-section against a target of 15.25%. The median average for the period covered is less than the target.	This indicator looks at the percentage of deliveries where the mother had an emergency C-section as a proportion of all deliveries in the reported month. This is submitted as part of the Maternity Services Dataset (MSDS) and the rates are also published on the Yorkshire and Humber Maternity Dashboard. The data comes from the Trust Maternity Information System (CMIS). Indicator from the Single Oversight Framework (SOF)	None identified.	Ongoing monitoring.

Risks	Mitigations
None.	N/A.

Indicator: **QS023 Hospital Standardised Mortality Ratio (HSMR)**

Period	Value	Target	Trajectory	Variance	Assurance
Feb 2021	**89.7**	**100**			

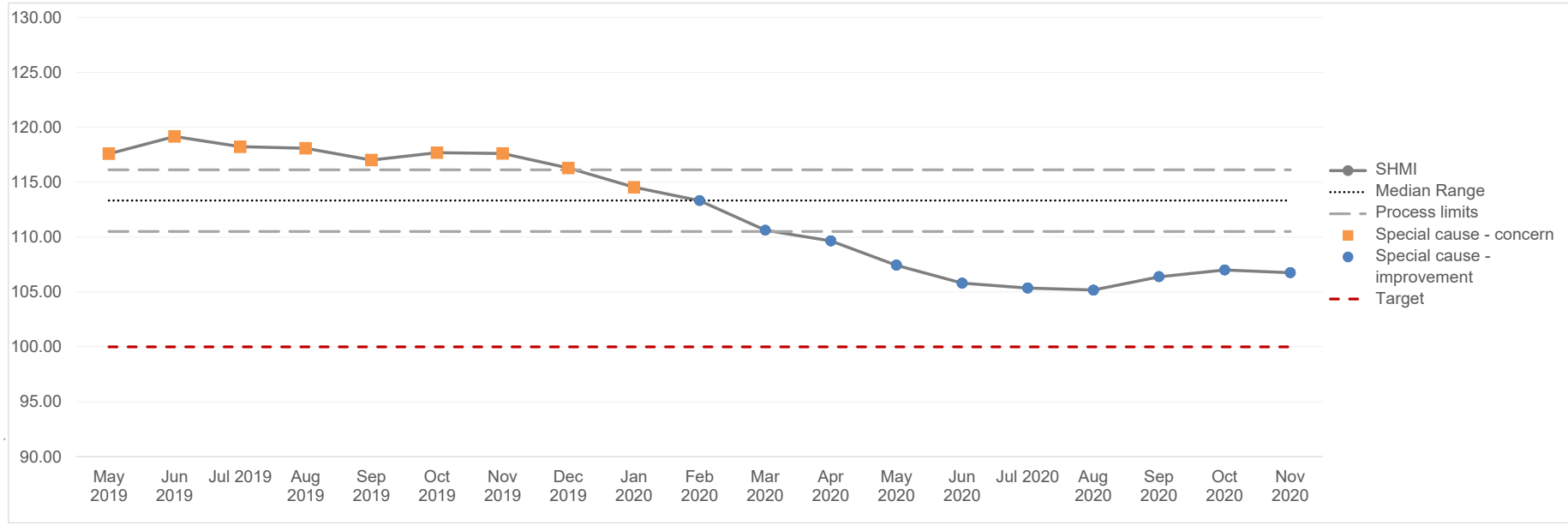


What Is The Chart Telling Us?	Background	Issues	Actions
The chart tells us that the HSMR for the Trust has performed under or just above the national average for the financial year with a spike seen I November throughJanuary which is linked to the second wave of Covid-19.	HSMR is a ratio between the number of actual deaths (in hospital) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. This is reported on a rolling 12 month basis and is a national indicator. Originally the data on deaths comes from the Trust PAS system, and the scores themselves are calculated and then provided back by NHS Digital and HED so ensure these balanced across the country usingn data from all hospitals. NHS Digital Provide the Official SHMI, and the HED system provide a slight variation on that SHMI and the HSMR information.	None.	The HSMR along with other mortality indices are overseen by the Trust's Mortality Improvement Group (MIG). Significant progress has been seen with SHMI and HSMR during 2020/21.

Risks	Mitigations
None.	N/A.

Indicator: **QS024 Summary Hospital Level Mortality Indicator (SHMI)**

Period	Value	Target	Trajectory	Variance	Assurance
Nov-20	106.8	100			

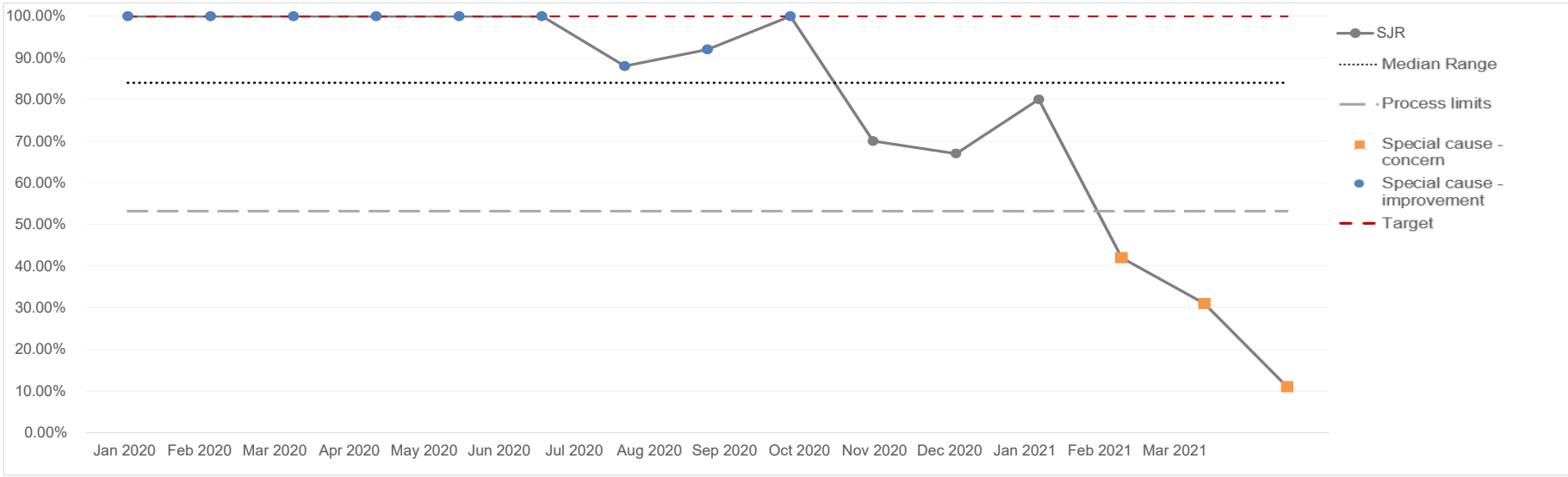


What Is The Chart Telling Us?	Background	Issues	Actions
The chart tells us that the Trust's SHMI performance has improved to a statistically significant reduction. The Trust's SHMI is still above the national average (100) but is statistically described as being 'as expected'. The SHMI includes out of hospital deaths as well as in-hospital deaths. when breaking the indicator down into its component parts, the in-hospital SHMI is beneath 100, but the out of hospital component, which measures deaths within 30 days of discharge, is higher than 100.	SHMI is a ratio between the number of actual deaths (in hospital and within 30 days of discharge from hospital) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. This is reported on a rolling 12 month basis and is a national indicator. Originally the data on deaths comes from the Trust PAS system, and the scores themselves are calculated and then provided back by NHS Digital and HED so ensure these balanced across the country usingn data from all hospitals. NHS Digital Provide the Official SHMI, and the HED system provide a slight variation on that SHMI and the HSMR information.	None.	SHMI performance as well as the Trust's performance against other mortality indices is overseen by the Trust's Mortality Improvement Group (MIG). The out of hospital SHMI is subject to being a Trust Quality Priority for 21/22 and the Trust is working with NHSE/I to undertake a review of recent deaths and EOL care.

Risks	Mitigations
None.	N/A.

Indicator: **QS027 Structured Judgement Review, 100% of those required**

Period	Value	Target	Trajectory	Variance	Assurance
Mar 2021	**11.0%**	**100.0%**			

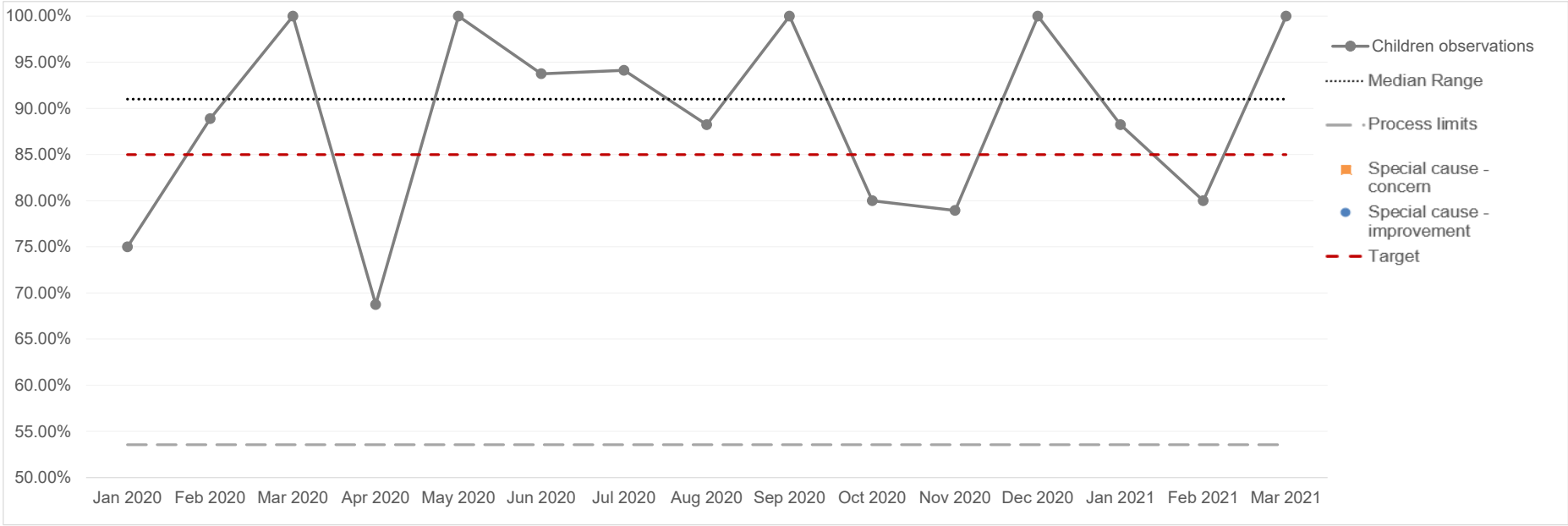


What Is The Chart Telling Us?	Background	Issues	Actions
The chart tells us that cases requiring more detailed review using SJR are currently not being completed in a timely manner which has resulted in a backlog back to August 2020. The Trust is ensuring these cases are reviewed, but at present this is not within agreed timescales. It should be noted that the most recent months reported data should be interpreted with caution as reviewers are provided with 6-weeks to undertake a review so the latest available data may not reflect cases still being reviewed in line with these timescales.	Structured Judgment Review (SJR) in 100% of cases for those meeting full SJR Criteria (Per Month). Methodology is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is consistently reproducible. SJR relies upon trained reviewers looking at the medical record in a critical manner and commenting on specific phases of clinical care. The data looks at the number of SJR Reviews Completed out of the Number of SJR priority cases raised (Per Month) and the data comes from the central mortality database. This is a local indicator which is monitored on a monthly basis by the Mortality Improvement Group [MIG], reporting to the Quality Governance Group.	There is a backlog in the review of priority mortality reviews.	The Trust's Mortality Improvement Group oversees this alongside other mortality performance indicators. Work is underway within Medicine to review the number of staff who have been trained in SJR reviews and determine if additional reviewers can be identified to support ensuring more timely review of cases.

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

Indicator: **QS029 Children, timeliness of observations**

Period	Value	Target	Trajectory	Variance	Assurance
Mar 2021	**100.0%**	**85.0%**			

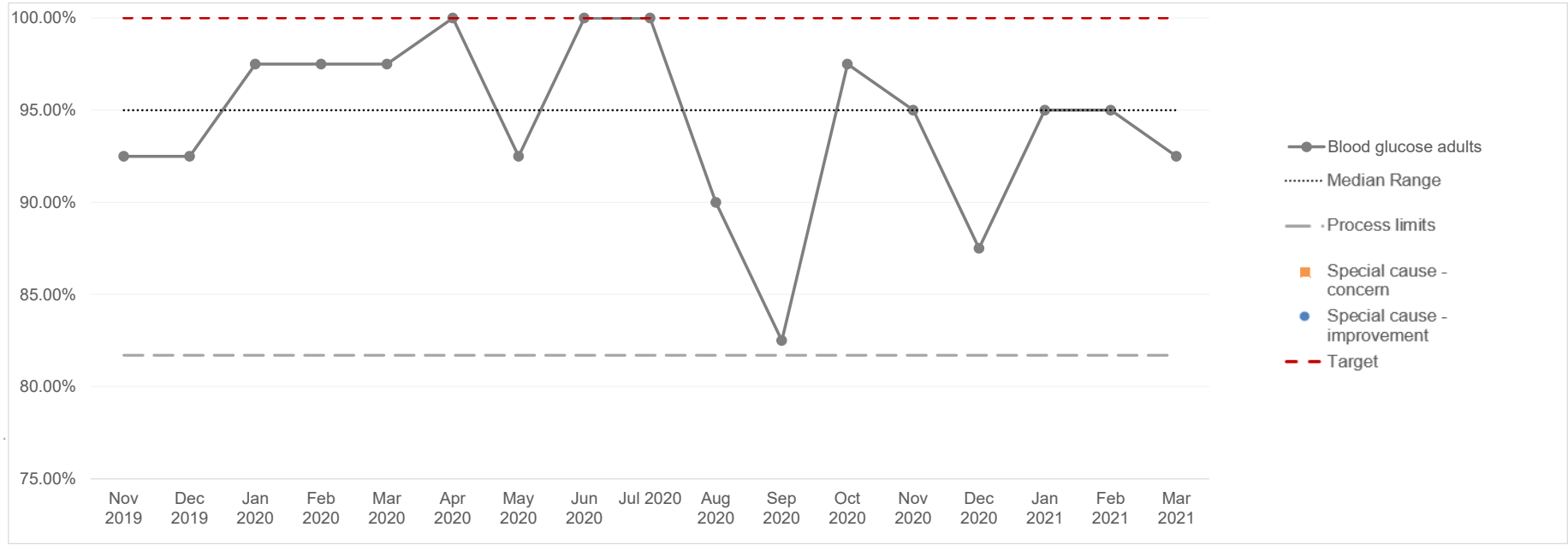


What Is The Chart Telling Us?	Background	Issues	Actions
The chart shows for the most part from this snapshot audit that performance has exceeded the 85% target.	The spot checks are undertaken on the paediatric wards at each site (Disney at SGH and Rainforest at DPOW) by the ward managers. 10 children per site are identified randomly based on those on each ward at the time of data collection on a monthly basis (if fewer than 10 on the ward, all patients will be audited). The source of the information is the Trust's WebV system.	None.	This is an area of continuous audit data collection within the Division and is overseen regularly.

Risks	Mitigations
None.	N/A.

Indicator: **QS033 Blood Glucose Adults**

Period	Value	Target	Trajectory	Variance	Assurance
Mar 2021	**92.5%**	**100.0%**			

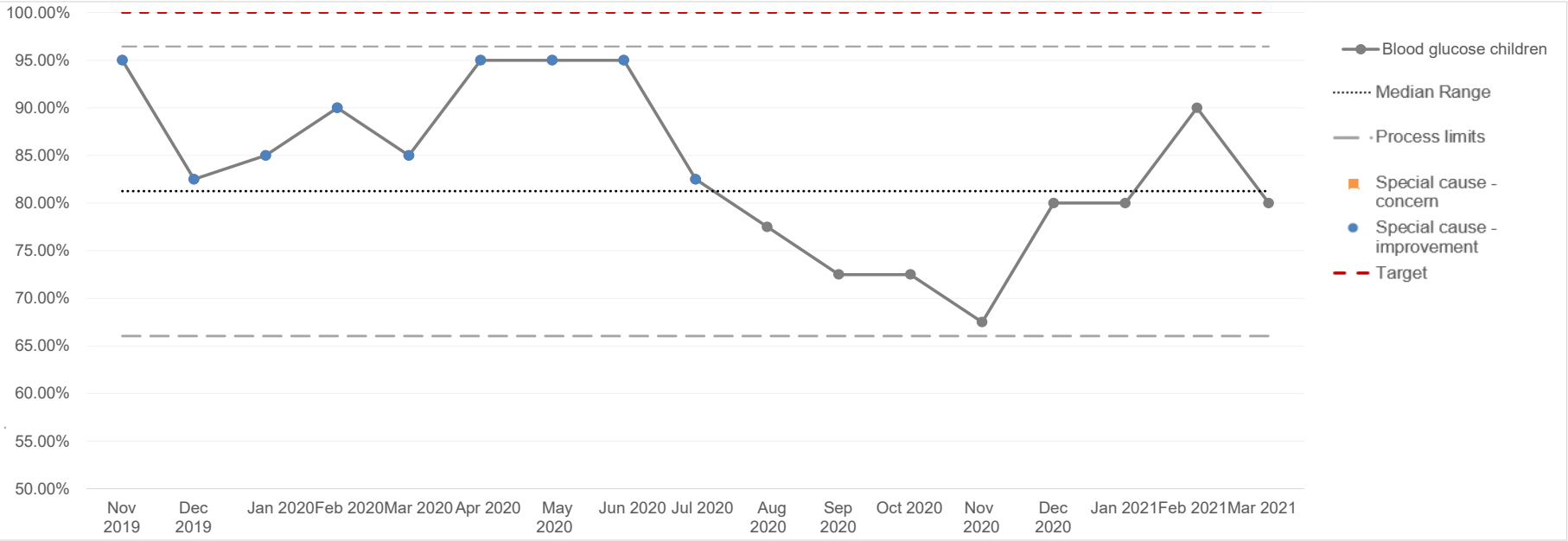


What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling us that for adults, on average for this period, 95% of patients with a NEWS score indicating the need for blood glucose to be recorded have had this recorded within the Trust's Emergency Department.	A random sample of patients (Adult and Paediatric) presenting to the ED were extracted from Symphony (A&E Record) in each time period with abnormal vital signs with the parameters listed below. Symphony, Web V and ECC documentation reviewed to test compliance.	None.	Ongoing oversight by the Diabetes Task and Finish group.

Risks	Mitigations
None.	N/A.

Indicator: **QS034 Blood glucose taken in ECC if PEWS over 1 for children**

Period	Value	Target	Trajectory	Variance	Assurance
Mar 2021	80.0%	100.0%			



What Is The Chart Telling Us?	Background	Issues	Actions
The chart tells us that for children with a PEWS score that indicates a blood glucose recording this is being taken on average in 81% of cases.	A random sample of patients (Adult and Paediatric) presenting to the ED were extracted from Symphony (A&E Record) in each time period with abnormal vital signs with the parameters listed below. Symphony, Web V and ECC documentation reviewed to test compliance.	Blood glucose recording in ED linked to PEWS has fallen below 78% for 4 consecutive months. From an investigation into this it appears that the Paediatric Emergency Nursing Team has been working to PEWS of 6 or more to trigger blood glucose monitoring. Education has been provided demonstrating the need to do this for children with PEWS of 1 or more and progress since this intervention will be monitored. Performance remains variable.	The BM taken in ECC has fluctuated. The addition of the PEN team has led to a change to be set down in protocol, to allow for clinical judgement from a Paediatric expert.

Risks	Mitigations
There is a risk we are not consistently achieving this target within ED.	Ongoing monitoring and oversight by the Emergency Department and Paediatric teams. A paper has gone to QGG to outline an amendment to the approach which will then need to be reflected in the audit standards. This new approach acknowledges the paediatric expertise and clinical judgement from the PEN team.

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

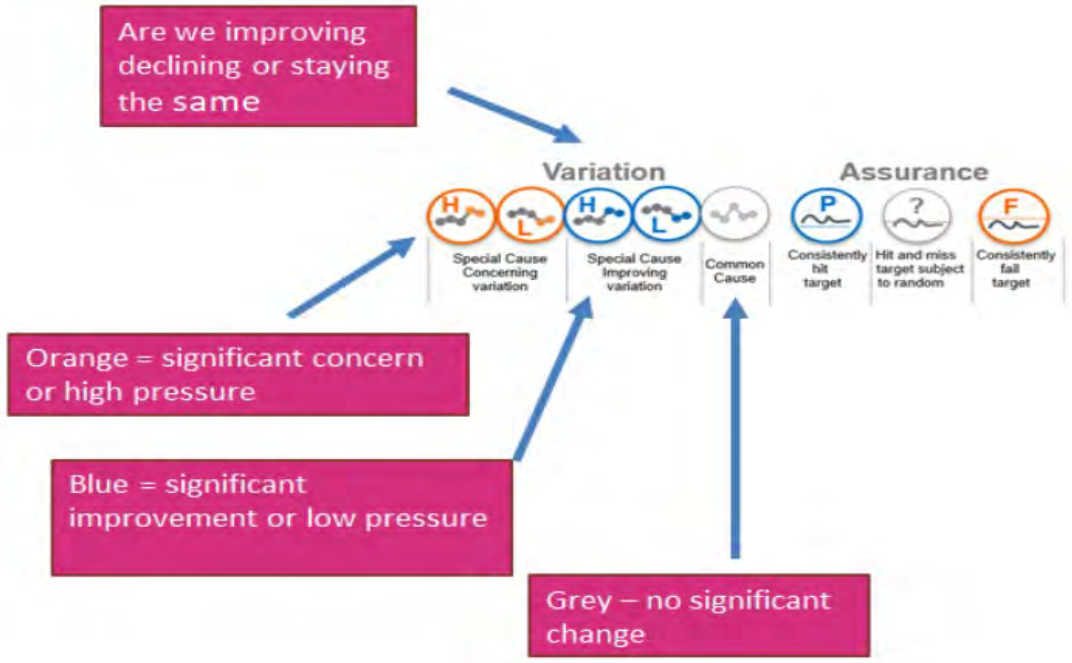
The purpose of this key is to specify whether each indicator is a nationally agreed indicator.
For national indicators, the key indicates whether the data has been validated and submitted at the point this report is refreshed.
For local indicators, the key indicates whether a specification and agreed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

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

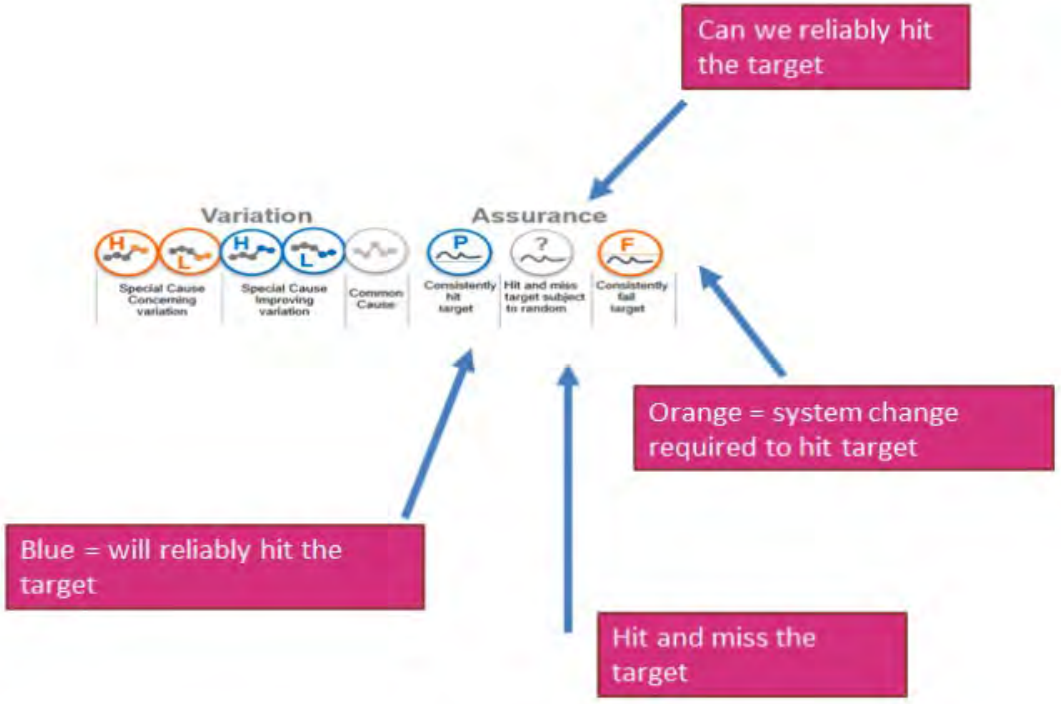
SPC Images

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

High level key - Variation



High level key - Assurance



Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)110

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Dr Kate Wood, Medical Director Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Angie Legge, Associate Director for Quality Governance
SUBJECT	Executive Governance Report
BACKGROUND DOCUMENT (if any)	None
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None
EXECUTIVE SUMMARY	The report this month has added Patient Experience. Work continues to address staffing, and further international nurses were welcomed to the Trust in the last month. However the fill rate for the past 7 months has remained below 95% and community nurse staffing remains of concern. The Trust SHMI remains in the 'as expected' range, but there continues to be a disparity with the Out of Hospital SHMI, and a project with NHSE/I has been launched to look at that.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	1. To give great care				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	

Executive Governance Report

Dr Kate Wood, MD

Ellie Monkhouse, CN

Safe Staffing

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

Current Position	Risk	Mitigation
Combined fill rate last 7 months below 95% for in-patient wards. Substantive staff fill rate below 50% on 19 wards on nights in March (increase from 13 in Feb). 6 wards had CHPPD below 8.0 in March. RN vacancy 10.07%, 168.73 wte. Highest rate Medicine division at 88.06 wte. HCSW vacancy 7.18%, 60.77 wte	There is a risk to the quality and safety of care of patients on the wards due to availability of staff	Safecare Live data reviewed daily at 10am 3 x daily staffing reviews in place Accelerated recruitment and on boarding of HCSWs, will meet operational zero target in April International nurse recruitment accelerated with enhanced training and support Virtual open days to attract student nurses who will qualify in September 20% Bank incentive scheme in place SNCT data collection commenced 26.04.21 to inform ward establishment reviews
	Increased Complaints / PALS due to staffing levels	The patient contact helpline and family liaison assistants are supporting communication with families which is supporting frontline staff to prioritise bedside care.
	Staff stress due to pressures of Covid-19	Trust wellbeing offer Professional Voice email address Leadership training is being offered to equip staff with skills to lead through this challenging period
Community nurse staffing remains under pressure with 19 red flag incidents reported in March - 7 regarding staffing levels and 6 relating to task saturation/ workload volume	There is a risk to the quality and safety of patient care due to demand exceeding capacity, particular risk on evenings and nights	Business case following establishment review to BCRG Electronic allocation system being installed and will assist with capacity and demand modelling Use of bank staff to increase staffing on an evening and overnight Participating in national project to develop safe staffing tool for community nursing
Midwife: Birth ratio 1:25 (below 1:28 & in line with national guidance)		Continue to monitor monthly and review midwifery red flags.

IPC

Aim: To minimise cross infection to maintain patient safety

Current Position	Risk	Mitigation
During April the Trust reported zero Hospital Onset COVID cases. There have been 2 variants under investigation detected recently (B1617) and managed appropriately. This does raise the question if variants increase does this affect how positive patients can be managed within healthcare – awaiting national guidance.	The risk of COVID outbreaks is rapidly diminishing due to reduced community prevalence, high patient / staff vaccination rates, LFD testing and better access to rapid testing and reswab list. Risk 2794 (ECC cross infection) Risk 2697 (Risk of staff contracting Covid)	National guidance 30 Redirooms for isolation Cubiscreen (shielding curtain) Architectural walls on B3, Ward 23, Ward 28, IAAU SGH Lateral flow testing Capital projects to look at replicating A1 at SGH site to enhance isolation winter capacity.
Currently the reported HCAI rate for COVID patients is 0% which is a substantial improvement from >20% a few week prior.	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 and expose unvaccinated patients.	Redirooms All ECC patients to be rapid tested if due for admission Utilise single rooms if result unavailable or other containment method.

Patient Experience

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

Current Position	Risk	Mitigation
Improving position of complaints responded to within timescale. Complaint responses now all describe learning Appropriate person now investigating complaint	• Culture of responding to feedback as an opportunty is slow to shift • Capacity of Lead investigators to undertake timely investigations • Engagement from medical teams in new process	• Complaints improvement plan • New process demonstrating success in pockets • Training across divisions for new lead investigators • Close oversight and tracking of complaints by week.
PaLs and complaints mostly related to lack of communication with In-patient wards. Patient Contact helpline receiving calls from distressed relatives Family liaison roles only short term	• Increased in PALS/complaints • Reputation as caring • Staff morale in the face of dissatisfied families	• Family liaison Assistants on some wards 6 months • 3 Pt experience officer across 3 sites • Patient Contact helpline • Leadership development for frontline staff • Staff well being initiatives/resilience • Sage & Thyme training programme
Impact of capital builds on DpOW patient experience	• More challenging to park, way find and mobilise to appointments	• Starting to bring volunteers back onto site • Working with estates project team to reduce risks

CQC Action Progress

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

Current Position	Risk	Mitigation
Signed off: 32% (46 actions) Complete: 37% (52 actions) In Progress: 21% (30 actions) On Hold : 2% (3 actions)	There is a risk that actions may not be fully embedded	Monitoring is a part of each action A review will take place of all blue actions when the new Head of Compliance starts to ensure the monitoring is robust.
Off track actions (Red): 6.4% (9 actions)	The Trust will not be compliant with mandatory training by the CQC visit	Prioritisation of individuals who have not done the training at all, or who are longer out of date. Factoring in mandatory training into staffing rotas Focused push on areas of low compliance
	The Trust does not have sufficient capacity to meet the diagnostics action	Risk Stratification & Clinical harm reviews Additional capacity where feasible through mobile diagnostics Agreed referral priority
	Additional resources are needed to meet staffing levels	See Slide 1 for wider view on staffing Staffing review complete, business case in progress. Daily monitoring to ensure safe service.

Maternity & CNST

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

Current Position	Risk	Mitigation
	Safety in maternity units	Implementing Local Maternity System SOP with sharing of Serious Incidents. Establishing submission to Trust Board of Serious Incidents
	Safety in maternity units	Provision of independent senior advocate role (awaiting further detail). Further develop of Safety Champions
Compliance 83%	Staff training and working together	Comply with MDT training compliance across all staff cohorts – need to meet 90% To establish National Antenatal Risk Assessment process once guidance released
	Managing complex pregnancy	To develop a pathway and SOP for referral to Regional Maternal Medicine Centres once national guidance released.
Multiple criteria required to be met – on-going work on CO monitoring, pre-term birth clinic, uterine artery Doppler scanning.	Monitoring fetal wellbeing	To comply with Saving Babies Lives Care Bundle v2,
	Compliance with CNST safety actions	Work on-going with Standard 4 Clinical Workforce, 6 Saving Babies Lives v2 (as above), 8 MDT training (as above), 9 Safety Champions
	24/7 theatre access, maternity SGH	24/7 theatre (SGH) access commenced 1/1/2021for caesarean sections and trial of instrumental births.

Mortality

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

Current Position	Risk	Mitigation
Aim: 90% of all deaths screened by July 2021 **Q4: 87%** (Jan 21: 94%; Feb 21: 84%; Mar 21: 82%)	None identified, last years target was 50% - so significant improvement in reviewing higher proportion of deaths has been made. Latest data tends to be an under-reporting due to timescales involved in undertaking reviews (i.e. Apr 21: 66%).	Ongoing work. Linked to clinical coding validation work led on by divisional lead mortality/coding leads. Assurance reporting on process from Coding report to MIG and quality screening reported to MIG in monthly mortality report.
Aim: 100% of those where a concern is identified have an SJR within 6 weeks **2020/21: 70%**	There is a backlog of cases not yet reviewed going back to August 2020. [Risk 2797; risk rating 8] There is the risk that some older cases may require escalation for further investigation and consideration of duty of candour on the back of the SJR review.	Revising SOP to reduce the number of priority NQB criteria requiring NLAG clinician review: (1) implement amendments to SOP in line with NHSE/I guidance and (2) Share cases with community concerns with CCGs via incident reporting instead of NLAG internal review. Review of SJR trained staff in divisions and determination if the pool of reviewers can be expanded.
Aim: SHMI 'as expected'	Out of hospital SHMI significant disparity of 37 points.	NHSE/I audit underway looking at the management of patients at EOL. CCG/out of hospital improvement action plan, reporting to MIG. Reviewing with information team any local peers to determine the difference between in and out of hospital SHMI.

Serious Incidents

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

Current Position	Risk	Mitigation
14 out of 19 investigations in progress are within timescale	There is a risk of delay in investigation due to staffing pressures or complexity of the case	Key dates initiated at commencement of investigation Early booking of interviews and RCA meeting Weekly timeliness monitoring Escalation of delays to SI Panel / division Family Liaison keeping the family up to date Liaison with CCG in respect of reasons for delay
85% assurance rate by CCGs	There is a risk that the quality of the investigation will not be enough to identify the key concerns and root cause	Regular training on investigation skills Review process on Serious Incidents through divisional sign off to dental Governance challenge and Executive sign off.
No measurement	There is a risk that actions will not be SMART and thereby not increase safety	Challenge to recommendations and actions at SI Panel
Currently 9 off track within Medicine but less than 3 months over due date and verbal assurance on safety received	There is a risk that actions will not be delivered in a timely way	Action plan monitoring monthly at SI Panel Action plan delivery part of PRIM Action change process for when the context changes and action no longer applies
	Insufficient learning from a Serious Incident	Learning on a Page to all wards and departments Learning Strategy Serious Incident Review Group to look at any further action needed Learning Strategy Learning Group commenced to devise key themes for sharing

NLG(21)111

DATE OF MEETING	1st June 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Shaun Stacey, Chief Operating Officer
CONTACT OFFICER	Richard Peasgood, Executive Assistant
SUBJECT	Executive Update - Performance
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The Operational Update details the current position with ED and ambulance waits, as well as the Discharge to Assess program and Elective and Cancer position.

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

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

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

Emergency Department Waits and Ambulance Handovers

Highlights	Lowlights	Risks
• Zero 12 hour DTA breaches during April 2021 • Reduction in number of ambulance 60min+ handover breaches during April 2021 compared to March 2021 • New patient pathway – EMAS direct streaming to SDEC services at both sites now in place • New patient pathway – Ambulance protocol for patient self-handover now in place at both sites • The new ED builds are progressing well with construction ongoing at DPOWH and the final decanting and enabling works ongoing at SGH. Detailed room specifications and digital strategy being developed • NLAG are early adopters for the region to go live with direct bookable arrival slots in ED at DPOWH for the SPA using the new Any2Any interfacing as part of the NHS111 First initiative programme • Good progress is being made on recruitment due to the launch of a new ED medical staffing recruitment strategy and nurse training and development plans • Additional medical staff have been injected into ED to improve patient safety throughout the department	• 78% increase in ED attendances in April and May 2021 compared to April 2020. Average daily attendances during May 2021 is 429 per day, up from 419 per day during April 2021. Maximum number of arrivals of 509 experienced. • Trust performance against the 4hr target for April 2021 was 72.35% (DPOWH 69.9%, SGH 74.3%) • In conjunction with the system partners, two audits at the front door are being undertaken, outcome of which will help focus on areas of improvement; retrospective missed opportunities audit and real time point prevalence audit. • The Trust has included a 3 tier oversight arrangement in the both EDs to address fragility due to an increasing number of attendances. • The impacts of covid-19 on ED are still providing additional challenge for waiting room capacity due to social distancing, delays in diagnostics due to increased cleaning regimes, additional PPE requirements, and delays to admission • Staffing numbers remain a challenge as covid-19 heavily impacted the appointed recruitment pipeline • Ambulance handovers have been a targeted focus throughout 2020/21, with a direct correlation between high bed occupancy levels and 60 min+ ambulance handovers • Staffing experience, skill mix and reliance on agency staff is continuing to be a challenge in ED especially on overnight shifts	• Risk of overcrowding in and fragility in both EDs due to increase in attendances and reduced capacity from both physical and workforce perspectives. • High bed occupancy levels leading to a lack of patient flow and exit block in ED will result in delays for patients in ED and drop in 4hr performance and delays in off loading patients from ambulances and risk 60min+ handover breaches • Reliance on locum bank and agency specialty doctors in ED due to delayed recruitment pipeline

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

Highlights	Lowlights	Risks
• In May 2021 the SDEC activity improved to 37.65% compared to 33.08% in April 2021. This is compared to 30% good national average. The 3+ days LoS in May 2021 improved to 41.02% from 44.8% in April 2021. • A frailty service pilot at DPOWH commenced on 12 May 2021 for 4 weeks providing improved patient experience for frail patients on SDEC instead of ED. Pathways for EMAS to access advice and guidance through SPA to avoid acute attendances where possible • Additional investment into the medical staffing for IAAU has been made during the year, allowing an increase in the service provision out of hours to support SDEC services • New EMAS pathways went live during March 2021 that enables EMAS crews to speak directly with a Consultant Acute Care Physician for clinical advice and a decision on whether to directly stream patients to SDEC services • Advice and guidance services for Medicine Acute SDEC is now in place that allows primary care to speak directly with a Consultant Acute Care Physician for clinical advice and guidance • The final phase of the IAAU will be the move into the newly refurbished units located next to the new ED builds and the additional workforce required to increase the service hours	• Although significant recruitment has taken place, demands on the workforce remain high and work is ongoing to fill all posts required to deliver the service • The Acute Medicine team has taken on significant increases in workload during the year, with an increased number of beds coming under their remit and the introduction of covid/non-covid acute assessment wards • Continued embedding to improve specialty input times and remove traditional barriers from quick access to SDEC services	• Reliance on sufficient daily discharges to enable flow out of IAAU is required • Turnaround times for covid-19 swab results impacts on ability to move patients on from IAAU into green/red wards • Workforce and skillmix

Discharge to Assess (D2A)

Highlights	Lowlights	Risks
• The Trust's performance for 21 day+ currently reported at 7.27% (as at 23rd May) remains under the national average of 12% and is the second lowest within the North east and Yorkshire region. • Improvement work at rapid pace has taken place to enable the whole northern Lincolnshire system implement and embed the Hospital Discharge Service: Policy & Operating Model. • All wards now have senior consultant presence at board rounds before 10am • All wards are now able to report if and when a patient no longer has a criteria to reside in an acute hospital bed by completing web v • A vast amount of work has been carried out on the Web V System to enable wards to record which patients no longer meet the criteria to reside this enables national daily reporting • Working with our system partners daily to ensure patients who require care when leaving the acute trust receive this within 24 hours of identification with a full escalation plan for delays in place • Reduction in long length of stay continues to be recognised at a national level with further recognition by the beneficial change programme • The trust are carrying out a frailty pilot on the Grimsby site this has already seen significant improvements in the patient pathway with over 85% of patients assessed by the frailty team discharged on the same day • The trust have been accepted onto the ward/board round collaborative with NHS E/I a medical ward from the Scunthorpe & Grimsby site have been nominated	• Medical and Nurse staffing numbers remain a challenge and this impacts on the overall flow on all sites • Although there have been significant improvements for senior presence on all wards before 10am there is a vast amount of work that now needs to take place to improve the effectiveness of board rounds to ensure every patient has a plan • Work needs to be carried out on ensuring the identification of patients being placed on an end of life pathway is carried out in a timely manner to ensure the appropriate ongoing care can be put in place dependant on the patient and relative needs and wishes	• Turnaround times for covid-19 swab results impacts on ability to move patients to community beds and placements • Continued pressures on the acute workforce resulting in delay in decision making and timely discharge • Continued IT system & reporting improvements required to ensure all data is captured and reported accurately

Electives and Cancer

Highlights	Lowlights	Risks
• Volume of patients waiting longer than 104 days in Cancer is improving since July 2020. • The number of RTT 52 week plus waiters continues to decrease • Delivery of 101% of the agreed 2020/21 phase 3 recovery plan for out-patient attendances, with both Surgery and Family Services exceeding the plan and Medicine delivering 87% • The out-patient follow up backlog position continues to reduce with significant improvements in Medical specialties with the support of the Independent Sector • The Independent Sector continues to support the Trust with additional capacity within CT, MRI, Gynaecology, Orthopaedics and General Surgery. This capacity is targeted to support long waiter backlog patients. • Processes in place to record, track and monitor risk stratification for all patients at all points in the pathway • Inpatients Live Risk Stratification at 99.8%	• Volume of patients waiting longer than 104 days in Cancer is 30 (trust wide – all tumour sites except Breast & Gynaecology (25th May 2021)) • RTT Performance continues to be low • Due to reduced theatre capacity, particularly during the peak of Covid waves, this has resulted in delivering below plan for elective recovery. The Trust has delivered 83% of the plan for elective and 71% of the plan for daycases within the agreed 2020/21 phase 3 recovery plan. • Plans are being put in place to risk stratify all open Outpatient episodes • Risk stratification in ophthalmology at SGH.	• Workforce risk around significant vacancy gap • Workforce risk around carried over annual leave • Potential wave 3 of COVID-19 • Capacity to deliver risk stratification for Outpatients • Challenges to delivery of the elective recovery plan

NLG(21)112

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Mike Proctor, Non Executive Director
CONTACT OFFICER	Mike Proctor, Non Executive Director
SUBJECT	Part 1 Quality & Safety Committee Highlight Report Part 2 Maternity SI's
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The report in this summary of the discussions at the QSC meetings in April and May. Maternity SI's are reported separately to comply with Ockenden requirements.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	1.1 – for information				
BOARD / COMMITTEE ACTION REQUIRED	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	

(please tick ✓)					

Quality and Safety Committee Highlight Report
Part 1 – Committee Meeting taking place in April and May 2021

Highlights	Lowlights	Risks
Ophthalmology follow up waiting lists - patient harm risk. Following a cross referral from the Finance and Performance Committee on concerns regard long waits in the speciality, the Quality and Safety Committee at its March meeting commissioned a report from the Ophthalmology team specifically focussing on the approximately 9,000 patients who were due an outpatient review and had no date set. The report, received in May, revealed that there was no effective system of risk stratification in the speciality as it was impossible to filter patients by diagnostic sub-speciality and, as a result, it was not possible to assess or identify potential or actual patient harms. The speciality team had implemented a plan to manually add diagnostic codes to the patient record and then implement the Moorfields Eye Hospital risk stratification process. This work would be completed in October and the findings would then be reported to QSC. **Cancer** The Committee received a cross referral from ARG. They had noted the longstanding problem of failing to achieve the 62-day constitutional standard for cancer treatments. Whilst acknowledging the responsibility of the Finance and Performance Committee for monitoring actions and improvement trajectories on this and other performance standards they requested further examination of potential harms to patients experiencing long waits for treatment. **Following a discussion, the QSC commissioned a focussed report in this area, led by the Medical Director will be presented to the June Quality and Safety Committee meeting.**	•	The Board to note that the current status on Ophthalmology follow up waiters should be regarded as a significant gap in assurance.

Integrated Performance Report The Committee noted a significant deterioration in VTE risk assessment compliance (c75% against a target of 95%). This could potentially lead to serious complications for patients. The factors behind the deterioration were understood and were in large part a consequence of COVID. **Workforce** Ensuring adequate and safe Nurse staffing levels continues to be challenging. The recent international recruitment of nurses was welcomed and applauded by the Committee as a positive step to help address the issue. **BAF** It was agreed that the Committee would receive and review the BAF every four months **Maternity** The submission on CNST standard was due in July. Significant progress has been made and there is confidence that sufficient progress will be made on the outstanding areas (actions 6 and 8) to ensure that all standards will be met within the required timescale. **Nursing, Midwifery and AHP Strategy** The Committee commended the strategy and recommended that the Board approve.		The Medical Director provided assurance that actions were in place to address and the Committee would continue to monitor.

Quality and Safety Committee Highlight Report
Part 2 - Maternity Serious Untoward Incidents

April Meeting
STEIS – 2020 20635 – Hypoxic Ischaemic Encephalopathy

Improvement Actions include:

- Paediatrician attendance for all births where thick meconium liquor is evident.
- Improved awareness of contraindications of administering Syntometrine to women with raised blood pressure.

May Meeting

STEIS – 2021 327 – Interuterine Death

Improvement Actions include:

- Improved use of Growth Assessment Protocol and software.
- Improved oversight of DNA Policy and subsequent escalations.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)113

DATE	1 June 2021
REPORT FOR	**Trust Board of Directors**
REPORT FROM	Gill Ponder, NED / Chair of Finance & Performance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**F&P Committee Highlight Report – April & May 2021 – PERFORMANCE ONLY**
BACKGROUND DOCUMENT (if any)	-
PURPOSE OF THE REPORT	Issues from the Finance & Performance Committee meetings requiring escalation by exception to the Trust Board
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The attached highlight report summarises the key issues presented to, and discussed by the Finance & Performance Committee at its meetings on 28 April and 26 May 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 good 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 SO1-1.2; SO1-1.3; SO1-1.4; SO1-1.5; SO1-1.6; SO4.
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:	1 June 2021
Report From:	Finance & Performance Committee held on 28 April & 26 May 2021

Highlight Report:

Performance Report – 28 April 2021

Board Assurance Framework (BAF)

- Committee received verbal and paper update on work in progress to develop revised BAF.
- Committee needs to consider further how it will undertake deep dives to provide assurance to Trust Board, coherent with BAF reporting cycle.
- Concern was noted that greater clarity was required to differentiate between risks and issues.

Final Operational Plan 2021/22

- COO briefed verbally on 27 Apr 21 submission of Final Ops Plan to ICS for H1, first half of year.
- Further development required to enhance efficiency.
- Concerns remain over impact on performance of staff shielding; staff sickness; staff leave and rest needs and financial requirements.
- It was noted that plan met Gateway Guidance Letter in part, with aspects such as ethnicity and indices of multiple deprivation able to be documented.
- Overall ICS financial position is challenging. NLAG Plan achieves income targets for H1 but second half of 2021/22 is less robust.

Performance

- Committee agreed that revised IPR, its commentary and COO verbal brief were clearer, easier to comprehend and provided appropriate evidence for consideration.
- NLAG comparable regional performance in cancer pathways is very good.
- Pandemic continues to impact operational performance through ED zoning and swabbing requirements; reduced theatre capacity and anaesthetic response; lack of diagnostic capacity and workforce limitations as described above.
- Evidence provided showing recovery planning is accelerating and moving in right direction.
    - Additional elective capacity created using GDH and Independent Sector.
    - Despite continuing increase in 52 week waits, plan is to reduce numbers to zero by end FY 2021/22.
    - Diagnostic hub planned to open later this year with ICS linked bids in planning for additional mobile MRI scanning capacity.

    - Outpatient Risk Stratification slowly gathering pace, with emphasis on patient review rather than simple administrative procedure.
- Committee were assured that Recovery Planning is well underway and asked to see clear trajectories in future reports to allow them to monitor planned versus achieved.

Community Services – Community Response Team GP

- Committee received very positive report by Ant Rosevear, DGM C & T on the Community Response Team GP service.
- Introduced, North Lincolnshire only, in April 2020, in response to DHSC Covid-19 Hospital Discharge Service Requirement, since superseded by Hospital Discharge Service: Policy & Operating Model in August 2020.
- Commissioned by NL CCG with Discharge to Assess funding, Safecare Ltd provides GP senior decision making support 0800 – 2000, every day.
- Evaluation has demonstrated key outcomes including better patient support at end of life, covering symptom control and preferred place of dying; admission and readmission avoidance and supporting complex discharge.
- ICS need to make decision re future funding post 30 June 2020, in light of evidence gathered.
- Desire to emulate in NE Lincs; subject of potential future work.

Digital Strategy Update

- CIO provided an update on Digital Strategy and agreed to produce a quarterly report to F & P Committee for assurance purposes.

Estates & Facilities

- NLAG has secured grant funding of £46.64m from Salix and BEIS relating to energy performance schemes, largest award in the country. Request submitted to seek realism deferral of spending deadline from September 2021 to March 2022.

Performance Report – 26 May 2021

Board Assurance Framework

- Further refinement of BAF continues. Committee agreed some strategic risk review periodicities to populate F & P Work Plan, with 'Performance' ones to be confirmed, ensuring that correlation is maintained between F & P deep dives and BAF reporting frequency to Trust Board.

Performance

- Considerable ED pressure with 500+ attendances trust-wide on several days. Patient flow affected by IPC actions, workforce numbers and skill mix. Two ED front door audits undertaken; results to F & P in July, including outcome of work with partners across ambulance and MH providers to improve position.
- Unlikely to see dramatic improvement in overall diagnostic capacity over next few months.

- The 52 week wait position continues to improve as does Cancer 64 day measure.
- The 2 week wait standard continues to be met as does 31 day measure.
- View held that Statistical Process Control charts are not being best used, with call for further education at senior level and below to enhance their effectiveness.

Operational Plan H1 2021/22

- Operational Plan reviewed, checked and challenged by Committee. Plan acknowledged as ambitious with risks highlighted as diagnostic capacity, workforce and non-elective demand.

Estates & Facilities

- The 2020/21 Premises Assurance Model report (embedded below) was received and approved. Several good practices were noted, along with a few areas for improvement. NLAG is well placed, as result of engagement with PAM over past five years, to comply with the now mandatory requirement of NHSE/I to have a PAM programme as part of 2020 NHS Standard Contract.

Confirm or Challenge of the Board Assurance Framework:

No specific BAF challenge undertaken however review, scrutiny and discussion of multiple reports provided assurance that current risks are understood and being addressed appropriately.

Action Required by the Trust Board:

The Trust Board is asked to note the issues highlighted, the key points made and support suggestion of further development of SPC Chart use including wider education of workforce to enable greater utilization of this facility.

In addition, consider whether any further action is required.

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

NLG(21)114

DATE OF MEETING	Tuesday 1 June 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Ellie Monkhouse, Chief Nurse
SUBJECT	Nursing, Midwifery & AHP Strategy The Future 5 and Beyond 2021 - 2024
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Nursing, Midwifery & AHP Board Senior Nurse Forum Ward Manager, Matrons and HCSW Clinical Away Days Senior Nurse Time Out sessions TMB on 12/04/21 Quality & Safety Committee on 16/04/21
EXECUTIVE SUMMARY	This is our first joint Nursing, Midwifery and Allied Health Care Professionals (AHP) Strategy. This has been done in consultation with our Clinical teams across the trust through various engagement events over several months. It takes into account themes and trends identified through complaints, nursing metrics, the nursing dashboard, national incentives and good practice. The original launch of this was delayed due to the pandemic, however, this also gave us the opportunity to review the strategy based on our experiences of working through the pandemic and include some other priorities. Whilst this is a formalised document with a formal launch scheduled for May 2021, work and developments within this strategy have continued throughout the pandemic, so some of this work is already visible across the organisation. The NLaG Professional framework will become the basis of our practice development team and education teams work, this transition has already started. The strategy was launched on International nurses day on May 12th as part of a week of celebrating Nursing, Midwifery and AHP's. The clip below shows highlights from this our celebrations. https://youtu.be/IkZUJCXjVL4

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

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

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Nursing, Midwifery and AHP Strategy

Future 5 and Beyond

2021 -2024

Kindness • Courage • Respect

INTRODUCTION

The first joint Nursing, Midwifery and AHP Strategy will build on our priorities so we can focus what matters to all of us and our patients. It will help us to keep improving the care we provide and continue on our improvement journey. Future 5 and Beyond, 2021-2024 will guide us in developing a practice of continuous learning and a valued and respected workforce, using our resources effectively to make sustainable changes, embedding and raising our professional standards and providing high quality, innovative safe care.

All photography included in this document was taken pre-Covid.

TABLE OF CONTENTS

FOREWORD

We are delighted to present our Nursing, Midwifery and AHP Strategy 2021-2024 which sets out our priorities for the coming years.

Every year brings more challenges but also more opportunities. Demand for healthcare continues to increase but so too does our understanding of how to prevent ill health and treat those in need of our care.

This strategy builds on your feedback sought through a number of engagement events, including conversations with our Chief Nurse team, our 15 Steps Programme, a survey and walkarounds in clinical areas to discuss key priorities with individuals and teams. From this we have identified areas that you are proud of, what is most important to you and also some key challenges.

We are proud of our nursing, midwifery and AHP workforce because of the professionalism, dedication and consistent desire to improve quality you display. We champion this strategy and its aims to support you in the vital work that you do and to further enhance and develop our workforce.

Peter Reading
Chief Executive

Terry Moran CB
Chair

A MESSAGE FROM THE CHIEF NURSE

Welcome to the Future 5 and Beyond 2021-2024, the first joint Nursing, Midwifery and AHP Strategy for Northern Lincolnshire and Goole NHS Foundation Trust.

Future 5 and Beyond 2021 to 2024, builds on the priorities you identified in the original Future 5 which you helped develop in January 2019. Over the last 18 months we have introduced the 15 Steps Programme which has enabled us to really focus on what matters to all of us and our patients, and we have seen some great successes from all the teams involved with this. This has given us a great baseline that we can build on, allowing us to keep improving the care that we provide and continue on our improvement journey.

We have also seen investment in our nursing and midwifery establishments to focus on high quality care and we have introduced a recruitment and retention strategy to continue to attract high calibre health care professionals to the organisation. You are all part of building our reputation through our investment in our professional standards, investment in our workforce and the delivery of high quality of care. Visitors to the trust always comment on the warm welcome they get from our teams and we are also seeing more interest in our posts externally, attracting people from around the region, so we need to continue to build on this.

We will continue to work with our local colleges and universities to attract people to our professions, give people a great experience and develop new roles and career pathways. We are working on developing new opportunities to invest in our workforce and help with your career aspirations. We will be welcoming more students to support the sustainability of our professions and the important role they play in the experience of our patients.

It now seems a good time move to our new Nursing, Midwifery and AHP Strategy, as we take a step back and look to what is next for us and our professions and move forward with our next Future 5 and Beyond!

This year we will strengthen our collaborative working with our AHP colleagues and work through the leadership and development strategy with senior AHP professionals. This joint strategy is the first part of this, and the first step in this journey. We will be doing more joined up working, and looking for our future AHP leaders! This will start with our AHP Forum, which will run alongside our current Nursing and Midwifery Forum with the forums coming together at least twice a year.

This Future 5 and Beyond 2021-2024 builds on the original priorities identified and was co-designed over several months through engagement events, speaking with external colleagues, national priorities, inpatient surveys, incidents, as well as ongoing feedback from the Nursing Dashboard, Nursing Metrics meetings and the 15 Steps Programme. As part of the new (post-COVID) 15 Steps, we will develop our Star awards, for those who have demonstrated consistent high standards over a period of time.

Particular areas of improvement we will focus on over the next three years will be through our developing community of Quality Improvement, these are areas we will be able to demonstrate real change across the trust, where everyone will be able to contribute and will work across our multidisciplinary teams.

The Future 5 and Beyond aligns with the trusts strategic vision and quality priorities to support the organisation on its continuous journey of improvement. We will do this through the NLaG Professional Framework from which we will be able to build on our strategy, professional practice and professional voice.

We have several strategies that we are developing that will support some of the work described in this strategy. These include:

- Maternity Strategy
- Children and Young Peoples Strategy
- Vulnerabilities Strategy
- Patient Experience Strategy
- Volunteers' Strategy
- Carers Strategy.

The Future 5 and Beyond is our strategy, which has been built with you. You have told me what the key themes are, and what matters to you as health care professionals. 2020/2021 has been challenging for the NHS during the Year of the Nurse and Midwife and I am incredibly proud of the response to the pandemic from nursing, maternity and allied health care professionals and how you all responded and adapted to daily changes that were taking place. It is a pleasure to work with you all as your Chief Nurse.

In the two years I have been working at the trust, I have seen a real difference in the care you are providing and the professional standards you continue to display. You should all be proud of these achievements, but I know we can all do so much more, and I will work with you all to continue to promote and grow our professions.

Thank you for your ongoing commitment and support to providing excellent care to our patients, I look forward to working with you all as we deliver the Future 5 and Beyond, 2021-2024.

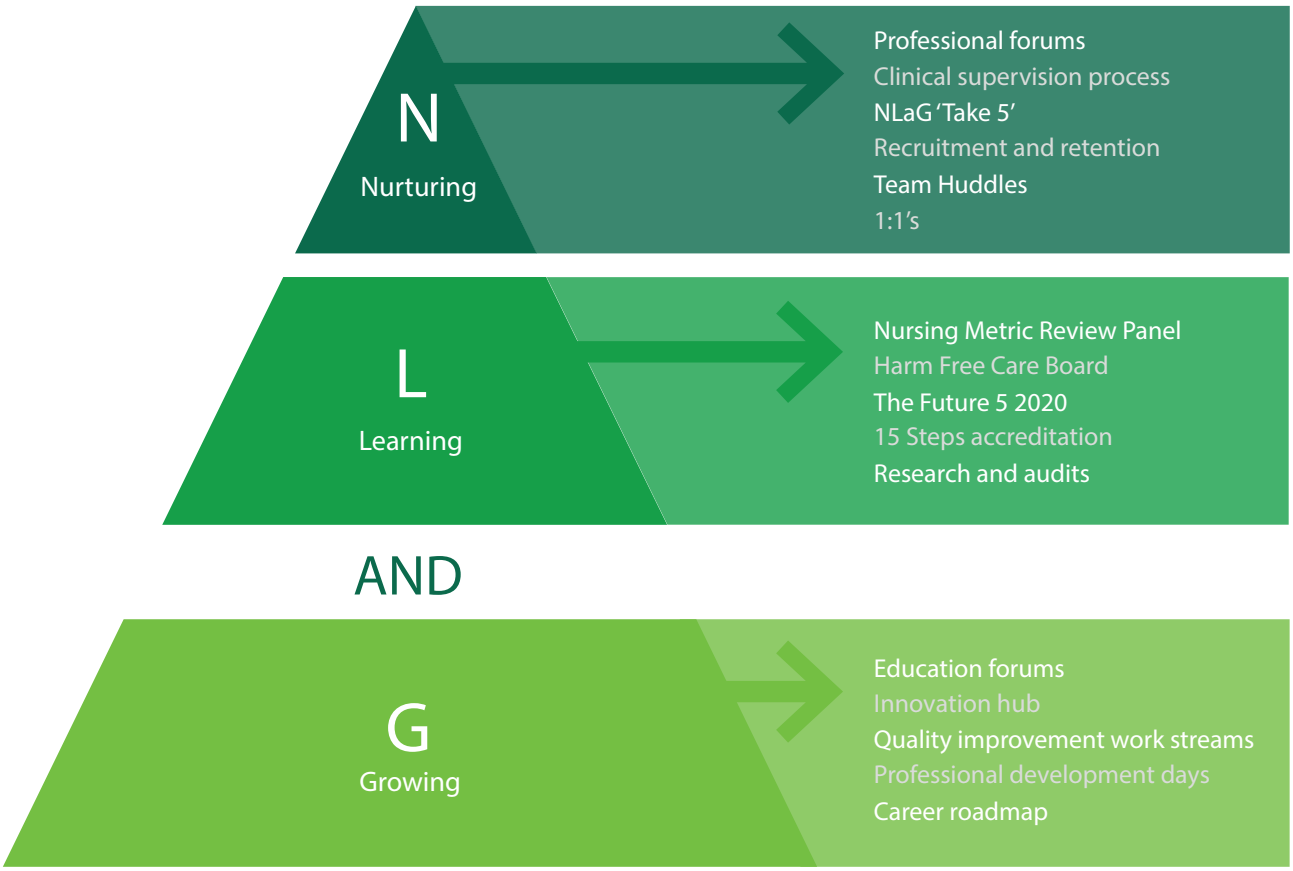
Ellie Monkhouse
Chief Nurse

THE NLAG PROFESSIONAL FRAMEWORK

The NLaG Professional Framework has been developed as a way of continuing to develop our teams and individuals to embed, drive and deliver the Future 5 and Beyond 2021-2024.

This will be our underpinning framework to continue to improve the quality of care and patient experience whilst supporting the knowledge and skills of our teams.

The framework will also help us to continue on our journey to make changes to practice and continue to build on our professional standards and contribution to the strategic development of the trust.



THE FUTURE 5, TAKE 5, TEAM TIME

The Future 5, Take 5, Team Time is to provide a structure to the introduction of weekly team huddles, led by local leaders.

This was co-designed with our clinical teams across the organisation to capture the things that are important to you and what needs sharing in the absence of the traditional ward/team meetings on a regular basis. It also allows the opportunity to share information from the senior nursing teams, whether that is any learning from incidents or events, or to update on new processes or ask for information.

It's also important we take the time to reflect on the care we have been able to provide and check on each other, this should include the whole team who work together.

This will be developed as one of our quality improvement innovations to help ensure messages are cascaded and shared through teams in a more real time.

This innovation will be embedded into the normal working routine as part of this strategy to help us take time to reflect on our work, our roles and our practices.

THE FUTURE 5 AND BEYOND, 2021-2024

The Future 5 and Beyond will:

- Develop a practice of continuous learning and development
- Develop a valued and respected workforce
- Use our resources effectively to make sustainable changes
- Continue to embed and raise our professional standards
- Provide high quality, innovative safe care.

FUTURE 5 AND BEYOND PRIORITIES

The Future 5 and Beyond 2021 - 2024 priorities are:

1. Develop our leaders now and for the future
2. Improve recruitment and retention
3. Continue to build on our professional standards
4. Aim to provide harm free care
5. Focus on patient centred care.

KEY ACTIONS

1 We will develop our leaders at all levels

- Ongoing professional development days across different roles and investment in leadership through opportunities to work with the senior nursing team and development programmes
- Embed the NLaG (Nuturing, Learning and Growing) professional framework
- Develop our community of quality improvement by starting to use use a shared governance approach
- Start to develop criteria led discharge by developing clinical skills and knowledge
- Celebrate success through our innovation hub and encourage our teams to present their ideas internally and externally.

KEY ACTIONS

2 We will improve recruitment and retention

- Continue to review our safe staffing levels and ward/team reviews on a bi-annual basis using recognised tools
- Embed 'Take 5, Team Time' and 'Time to Shine' across nursing, midwifery and AHP teams and support the trusts people plan with recognised health and well-being incentives
- Continue to work and develop our recruitment and retention strategy, to include career pathways and new roles and recognising any national incentives, including investing in international recruitment and our non-registered workforce
- Continue to invest in training, development and educational roles to support continuous professional development, skills and competencies
- Explore opportunities for rotational and development programmes that could be developed and offered across the organisation.

KEY ACTIONS

3 We will continue to build on our professional standards

- Improve our written and digital documentation
- Develop a continuous audit cycle and embed learning from these into practice
- Develop the next stage of the 15 steps accreditation programme, working towards our star teams and star accreditation
- Continue to work towards a professional supervisory model, including our Patient Safety and Professional Practice Days
- Continue to develop our Nursing and Midwifery Dashboard by including more quality metrics and making it more user friendly and visible to everyone across the trust.

KEY ACTIONS

4 We will aim to provide harm free care

- Provide consistant team and falls huddles across organisation
- Roll out supportive observation and AFLOAT model across the trust
- Provide safer medication management, focusing on omission of doses and securing of medicines in our clinical areas.
- Continue to provide 'gold standard' on our infection, prevention and control practices.
- Embed the use of safe staffing red flags across the organisation.

KEY ACTIONS

5 We will focus on patient centred care

- Enhance how we can support patients and carers experiences at the end of life
- Develop a Carers and Volunteers Strategy
- Refresh and embed our Patient Experience, Learning Disabilities and Vulnerabilities Strategies and continue to focus on our Vulnerability Walk rounds
- Educate, train and develop strategies for preventing deconditioning whilst in hospital
- Review and improve the quality and timeliness of our patient discharges.

OUR IMPROVEMENT JOURNEY

Our Quality Improvement Community

We will continue to grow our quality improvement community with quality improvement developments to embed across the organisation during 2021–2024.

1. Learning and understanding patient experience from complaints

2. Criteria led discharge

3. Supportive observation

4. Reduction of out of hours transfers

5. Quality and experience of discharge

These developments have been identified from our last CQC inspection, 15 Steps Programme, key themes from the Nursing Metrics Panel, Nursing dashboard and the Inpatient Experience Survey. These key areas will make the experience of our patients better, and will involve empowerment and development of our teams. These will be embedded into the Trust Quality Improvement Strategy.

These will be multidisciplinary developments and support the experience of patients, carers and our clinical teams. As well as using quality improvement methods to help us make these changes, we will also use the NLaG Professional Framework to support any new innovations and help provide support.

Our Innovation Hub

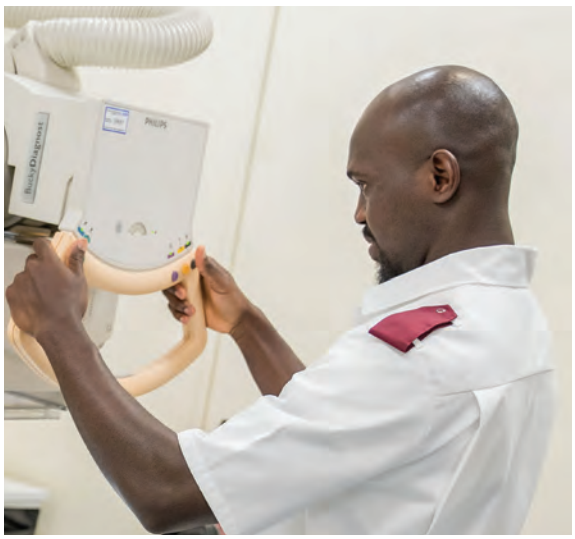
We will continue to develop and grow our Innovation Hub as part of the Quality Improvement Strategy, to be able to support new ideas or suggestions from teams or individuals.

We will establish our innovation panels, which will help provide sponsorship, mentorship and coaching from senior nursing and AHP leads to help deliver changes to professional practice, and patient experience.

The Professional Voice

The professional voice is an inbox specifically for you to raise any professional concerns or share ideas. It was originally set up during the Coronavirus pandemic for professionals from the nursing, midwifery and AHP community and will remain open as it generated some good ideas, including the Safe Spaces for Listening events created in February 2021.

nlg-tr.twprofessionalvoice@nhs.net



HOW WILL WE DELIVER THIS?

- The Future 5 and Beyond 2021-2024 will be achieved by identified workstreams and action plans overseen by the Deputy Chief Nurses and Assistant Chief Nurses alongside the senior nursing and AHP teams.
- Progress within each division will be monitored by the Divisional Heads of Nursing supported by the Deputy Heads of Nursing and AHP leads.
- The Chief Nurse will review progress on a bi-monthly basis with the Deputy Chief Nurses and quarterly through strategy review challenge meetings with the Divisional Heads of Nursing, Midwifery and AHP leads.
- An update for each work stream will be reported at the bi-monthly nursing, midwifery and AHP Board, and through other professional forums, this will include any associated risks to delivery.
- An annual review will take place, with a refresh of our action plans to ensure continuous improvement.
- We will continue to provide an annual Nursing, Midwifery and AHP Conference to showcase our work and improvements.
- We will provide an annual report on our outcomes, developments and to celebrate good practice.
- We will work hard to ensure we promote the work of the trust, individuals and professionals working within the organisation across local, regional and national forums.
- We will work to support improvements and innovation by embedding a culture of QI across our all of our developments and innovations.
- We will keep our teams updated via our Patient Safety and Professional Practice Days, forums and Nursing Midwifery and AHP Community Leadership Sessions.


Clinical Decision Unit
Ambulatory Care Unit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Contact Us:

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

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NLG(21)115

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Christine Brereton, Director of People
CONTACT OFFICER	Christine Brereton, Director of People
SUBJECT	Executive Report - Workforce
BACKGROUND DOCUMENT (if any)	Not Applicable
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Not Applicable
EXECUTIVE SUMMARY	The people report outlines highlights, low lights and risks in month. The risks are aligned to the People Risk Register and are consistently triangulated. Good progress continues to be made with recruitment of staff into the People Directorate however it is worth noting that there is a 'time lag' to these recruited staff starting with the Trust.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Actions and outcomes outlined in this paper are triangulated with the BAF Strategic Objective 2 – To Be A Good Employer

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

People Directorate June 2021

Highlights	Lowlights	Risks
Workforce Committee The Workforce Committee has now resumed full business with effect from 27th April 2021. To support delivery of the NLAG's People Strategy an implementation plan has been produced which outlines key objectives for the People Directorate for 21/22. This was approved by the Executive Team and the Workforce Committee. Delivery against the objectives will be monitored through the Workforce Committee. **People Directorate Restructure** Proposals for the restructure of the People Directorate were approved by the Executive Team. It will be formally signed off by TMB and then formal consultation will commence with affected staff and the Trade unions. **NHS People Plan** Expectations are now growing to deliver against the NHS People Plan as we begin the slow recovery from Covid. It is envisaged that a People Performance Framework will be developed and the Trust will be expected to demonstrate how it is delivering against the specific targets. **NLAG People Strategy (Workforce, Culture and Leadership):** **<u>WORKFORCE:</u>** ***Appointments*** made to Head of HR Systems and Governance role, Nico Batinica due to start August 2021 and to the Associate Director – Workforce, Paul Bunyan, an internal candidate. The new lead for occupational health, Helen Mumby has commenced in post and is currently undertaking a service review.	**Travel and Sourcing of international recruits** Covid is making international recruitment difficult due to the closure of borders. Travel restrictions will make international travel complicated for staff wanting to travel abroad on holidays. The Trust is producing guidance for staff and managers. **AFC Panel Process** **The** AfC panel process is currently under review which is causing delays to the assessment of job descriptions – the review process is happening at pace and in partnership with union colleagues but will require an element of external training to take place **Vacancy Position** The vacancy position has increased for Medics and Nursing in month 1. However this is as a result of establishment increases, not a result of increased turnover or recruitment issues. Medics increased by 27.37 WTE and registered nurses increased by 15.17 WTE. ***Turnover*** has gradually deteriorated over time since the start of the pandemic in April 2020 to present**.** The latest turnover data point is 9.6% which is just over the Trust target of 9.4% which indicates that the turnover position is not improving or	As per the People Risk Register **Staff Personnel Records –** There is no central system for the management of staff personnel files meaning lots of different systems exist at a divisional level – potential to not be compliant with GDPR prompting the risk of potential interest from the ICO. A business case of how this could be addressed is being developed for consideration at TMB. **Recruitment -** Failure to recruit to clinical hard to fill posts could result in an increased vacancy rate with increased agency cost and compromised service delivery

International Nurse Recruitment Project - A project board led by the Chief Nurses Office with support from other departments is undertaking an international nurse recruitment project. This has been successful with cohorts of international nurses starting over recent months. Funding has been received from NHSI/E to support with further recruitment with a target of 80 international nurses to commence by December 2021. The risk of covid remains an issue so work is underway to identify methods of how this can be reduced, including working in partnership with Yeovil District Hospital NHS Foundation Trust who are supporting our recruitment efforts as a centre of excellence, a recruitment pilot with Indeed, and continued sourcing via the Talent Acquisition Team. ***Health Care Support Worker /Health Care Assistant Recruitment Project -***The project to recruit Healthcare Assistants has resulted in achieving an operational zero vacancy rates. In addition, a pool of appointed HCAs ready for redeployment has been established with 35 WTE in this pool to cover turnover. A regular recruitment schedule will be set up to maintain an appropriate number of staff in this pool. ***Medical Support Workers (MSW) -*** The Trust has worked with the Lincolnshire Refugee Doctor Project to source candidates for the MSW role which was implemented in 2020 to provide additional support to wards during the pandemic. Funding to extend these contracts to September 2021 has been received and existing MSWs have been extended for this period. ***Newly Qualified Nurses (NQN) -*** A good response to newly qualified nurse recruitment following virtual engagement sessions which started in 2020. This has resulted in 80 NQN appointments to date. Further engagement is underway with third year students on placement to attempt to increase this number further, and the recruitment team are currently working with Divisions to finalise allocations to wards. ***NHS Employers International Recruitment Masterclass -*** NHS Employers are running a series of masterclasses nationwide to support Trusts in international recruitment. The NLAG Recruitment Team were invited to present at a masterclass on 25th May to share our practice relating to the on boarding and pastoral care of international recruits. ***Workforce reporting*** - A new reporting process is now in place to report and provide oversight of workforce data via the workforce committee mainly via a Statistical Process Control (SPC) chart. This will continue to be developed. This will form part of the overall IPR report for the Board. We will review our targets for workforce data to ensure that this is comparable with our comparable NHS partners and other Trusts both regionally and nationally.	seeing signs of recovery in relation to pre-pandemic levels of turnover of 9%. Work to improve the flexible working offer linked to culture and engagement, retire and return options and education of managers to enable flexible requests to be considered to be started within our culture work streams. We will also link in with NHSI/E on this area.	

In addition a new online real-time Operational Dashboard is being designed. This dashboard is being designed to provide the user with intelligence around the profile of their area's workforce, this will include PADR, Mandatory Training, Turnover, Absences and Vacancy data altogether in a dashboard view.

Sickness Absence - Over the last 3 months the sickness rates have decreased and are now close to pre-Covid levels for this time of year.

The main reason for absence in terms of **overall days lost** is anxiety/ stress/ depression/ other psychiatric illnesses. The relaunched Health and Wellbeing offer combined with the appointment of a Health and Well-being lead is expected to have a positive impact.

The main reasons for absence in terms of **number of sickness episodes** within the period were Cold, Cough, Flu – Influenza which is linked with Covid Related absences. These were all shorter term.

Overall Nursing and Midwifery and Additional Clinical Services staffing groups had the highest levels of sickness within the period of May 2021 and have continued to have the highest levels since January 2021.

Trade Union Partnership
Engagement with the trade unions to improve working relationship and a partnership approach has now commenced. This includes a review of facilities time to help support our trade union colleagues to fulfil their duties. In addition, staff ***c***onsultations have now recommenced following a partnership agreement with union colleagues via the launch of a consultation subcommittee to review all pending and live consultations. This has enabled the Trust to launch some longstanding consultations with significant positive clinical impact.

CULTURE:

Appointment made to Associate Director of Culture and Leadership, Alison Dubbins due to start beginning of August.

OD Support - Working in ward areas for staff to discuss Health and Wellbeing. Currently holding drop-in sessions with Amethyst ward at DPOW. Uptake is slower than desired but an awareness area created on the poster board next to staff room.

Risk Assessments - Work continues with risk assessments and those that need re-reviewing in line with recent government guidelines, incorporated into the risk assessment conversation is the health and well-being conversations 6943 staff have now completed both elements. Risk assessments are now part of the on-boarding

Long Service Awards
Due to the pandemic and redeployed People Staff we have over 300+ staff that now require recognition.

Staffing
Low number of staff in culture team Culture due to turnover of staff and lag into recruitment. This is impacting on our ability to support divisions with OD intervention and take forward some of the plans outlined in our People Strategy and NHS Plan, Recruitment to address is underway.

Culture - There is a risk that organisational culture adversely affects the Trust's ability to continuously focus on quality improvement adversely affecting patient care and the Trust's reputation and relationship with regulatory bodies.

process for new starters and are managed by recruitment and work continues to finalise those outstanding 594 which are primarily bank only staff.
Current EAP (Vivup) is due for renewal shortly and looking at how other trusts use their EAP and uptake of this.

NLaG Menopause Staff Network has tripled its membership numbers to 190. Staff are using the network to help one another and intelligence is emerging in areas the Trust can improve working conditions for our menopausal staff

Coaching and mentoring network is now starting to gain traction with more requesting coaching conversations as a development tool. ICS Funding has secured another two coaches to be trained from our Trust. Planning sessions and coaching supervision for the current coaches to be organised to ensure all are equipped to meet

Culture Task and Finish Group In line with the People Strategy implementation plan for 21/22, we will put in place a Culture Task and Finish group which will bring together all of our workstreams on culture, i.e. Pride and Respect. We will undertake a self-assessment culture diagnostic so that we can focus our attention on the right things over the next 12 months. This will take place on the appointment of the new AD – Culture and Leadership.

Mandatory training and appraisal – an update was presented to the board development session highlighting the progress made, and the risks to achieving compliance. Core mandatory training is currently 91% for the Trust, role specific 80% and PADR 81%, there has a been a steady increase in compliance. New targets for 21/22 were approved at TMB.

Leadership development is in place for clinical leads and new consultants. This is being well received by the participants. A Leadership Development Programme for all leaders will be scoped out this year

Executive Development is planned for June and July and 360 feedback for the team is underway.

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NLG(21)116

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Michael Whitworth, NED & Chair of Workforce Committee
CONTACT OFFICER	Michael Whitworth, NED & Chair of Workforce Committee
SUBJECT	Workforce Committee Highlight Report and Board Challenge
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The Committee held its first full meeting on 27th April 2021 since October 2020. The focus was on the re-introduction of the full assurance agenda of the committee. • Review of terms of reference – the existing terms of reference were shared, however, in light of the long enforced period of inactivity it was agreed to revisit this later in the year as part of the annual self-assessment review. • The Draft Annual Work Plan was presented and approved, covering: o Strategy, deep dives and statutory reporting o Operational workforce performance reporting o Oversight of education and training The draft plan was presented in a way that aligned the planned activities against Committee's Board Assurance Framework, CQC and legal requirements. • The Draft People Strategy – Annual Delivery Implementation Plan was presented and approved. • The Committee also reviewed and discussed the revised Workforce Performance Report.

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

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	✓

Quality and Safety		**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and long term. Ineffective staff engagement and ownership of the Trust agenda affects morale and failure to change and improve the culture.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	1 June 2021
Report From:	Michael Whitworth, NED & Chair of Workforce Committee
Highlight Report: Workforce Committee – April 2021	

1 Introduction

1.1 The aim of this report is to provide an update and prompt discussion and scrutiny of the work of the Committee and Board Assurance.

2 Background

2.1 The Committee held its first full meeting on 27th April 2021 since October 2020.

2.2 The focus was on the re-introduction of the full assurance agenda of the Committee.

2.3 The Committee had been scheduled to review the Terms of Reference, however, following a discussion the Committee agreed that it should be undertaken as part of the annual self-assessment review and a sustained period of Committee work.

3 Items Highlighted by the Committee for the Attention of the Board

3.1 No matters were highlighted for escalation to the Board.

4 Items for Committee Ratification and Assurance

4.1 The Draft Annual Work Plan was presented and covered strategic assurance, operational workforce performance assurance, as well as the employee relations and education and training functions of the Committee.

4.1.1 There was considerable discussion about the function of deep dives and the ability of the Committee to look at workforce issues in a wider context. The importance of the Trust pro-actively reviewing new staff roles and workforce innovation was highlighted.

4.1.2 The Work Plan and timeline was approved.

4.2 The Draft People Strategy – Annual Delivery Implementation Plan was presented to the Committee.

4.2.1 The key elements of the Strategy are Workforce, Culture and Leadership.

4.2.2 The Committee approved the Plan in principle, however:

- It was noted that progress would be linked to the planned expansion and development of the People directorate, and that some changes to the

timeline had been suggested by the Executive team to reflect this.

- The Committee felt that the "retention" agenda should be more prominently presented within the plan. The work on nurse retention was noted by the Committee.
- It was acknowledged that ICS developments, particularly around new and enhanced staff roles, may play an increasingly important role in workforce development and be an important opportunity for the Trust.

5 Other Matters

5.1 The Committee received and reviewed the workforce performance report.

5.2 The Committee recognised the development and validation work that had been undertaken to produce the new draft report which was well received.

5.3 It was noted that some aspects of the previous reporting regime had resulted in erroneous or misleading information being presented. The Committee is keen to assure the data quality of workforce information for the Board on an on-going basis.

Confirm or Challenge of the Board Assurance Framework:

The Board assurance framework was not reviewed at the April Committee meeting.

Action Required by the Trust Board:

The Board are asked to receive and note the content of this highlight report.

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NLG(21)117

DATE OF MEETING	1 June 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 Q4 (Jan-March 2021) and Annual Report 2020-21
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The FTSU Guardian Q4 Report and Annual 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.

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Q4 –Jan– March 2021 & Annual report for 2020-2021

Liz Houchin 19th May 2021

Contents

1. Executive Summary

1.1 This paper provides an update regarding NLaG activity for Q4 2020-21 (which covers the period January to March 2021) and also the annual report for the year 2020-2021. Within this paper the results of the National Guardians Office publications are presented alongside NLaG information to provide national and regional comparison and context.

2. Strategic Objectives, Strategic Plan and Trust Priorities

This paper satisfies the Trust Strategic Objective of 'Being a good employer', and is aligned to the Trust priorities of: Leadership and Culture, Workforce and Quality and Safety.

3. Introduction / Background

3.1 The paper is presented in a structured format to ensure compliance with the ''Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts'' published by the National Freedom to Speak Up Guardians Office and NHS Improvement (updated July 2019). The presentation of this information is structured in such a way that enables the FTSU Guardian to describe arrangements by which Trust staff may raise any issues, in confidence, concerning a range of different matters and to enable the Board to be assured that arrangements are in place for the proportionate and independent investigation of such matters and that appropriate follow-up action is taken.

Assessment of FTSU Concerns Raised

4.1 In Q4 2020-21 the number of concerns received were 35. There were no concerns reported anonymously in Q4. The main theme was 'behaviour' with nurses and midwives raising the most concerns.

- The total number of concerns in 2020-21 was 143. Of these 5 concerns were raised anonymously which is lower than the national average and may indicate that staff feel safe to raise concerns openly or confidentially.

- National figures show that the average number of concerns for a NHS Trust was 16. Data also shows that the rolling 12 month average of 55 would put the Trust in the high position with both the national and peer median being 23.

- The rolling 12 month average figure for concerns which involved an element of patient safety is 13 which places the Trust in the top quartile nationally, with both national and peer median being 2.

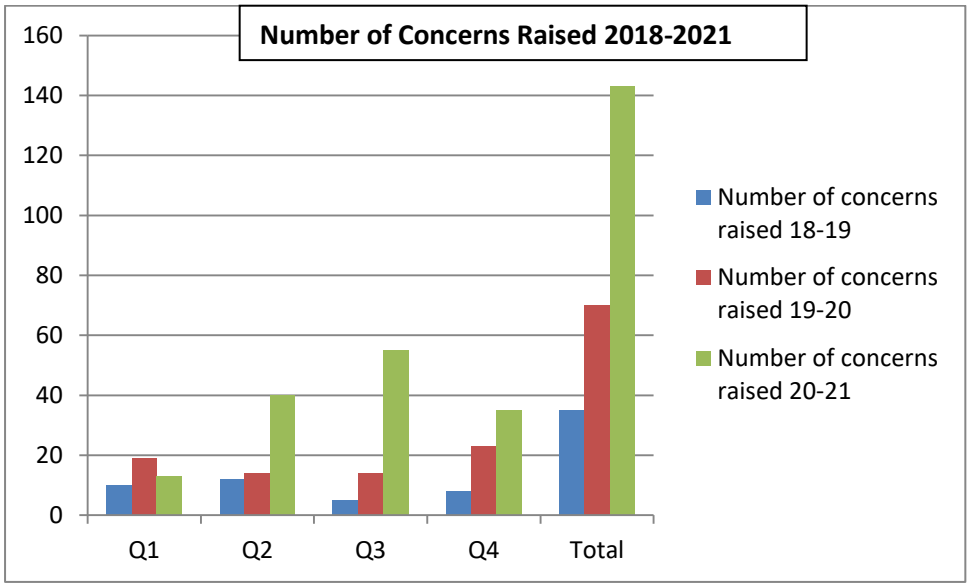
- The rolling 12 month average figure for concerns which involved an element of bullying and harassment was 10, which puts the Trust in the highest quartile nationally, the national and peer median being 4.

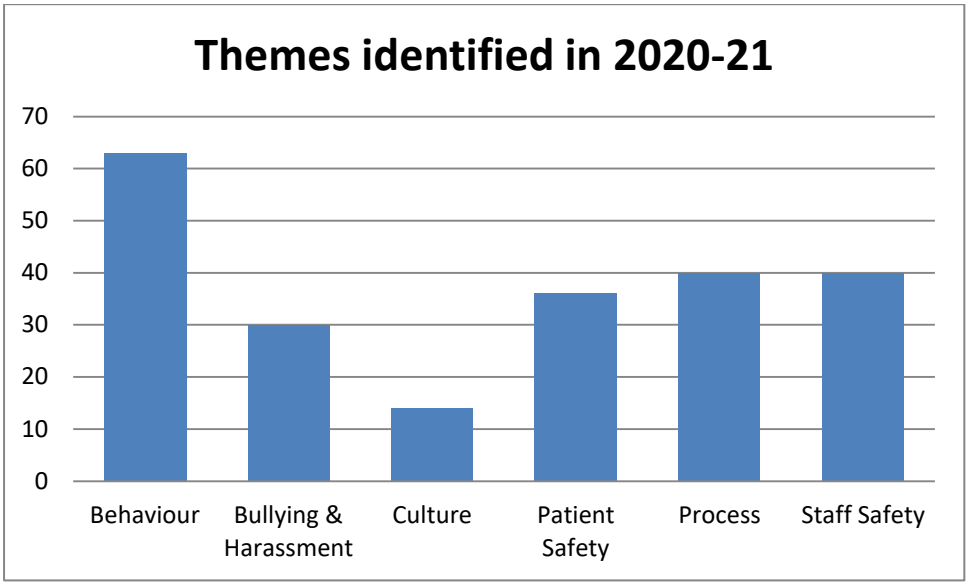
4.2 The number of concerns coming to the Guardian has risen for the past three years and may be due to a number of factors, the appointment of a permanent and dedicated Guardian, and the increased confidence of staff feeling able to raise concerns. In addition there has been considerable promotion through the year including Freedom to Speak up Month and social media presence.

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

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

4.5 FTSU Guardian is now producing quarterly reports for all divisions to ensure that the FTSU information is used to triangulate with other data ie HR information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified and OD interventions put in place where needed.

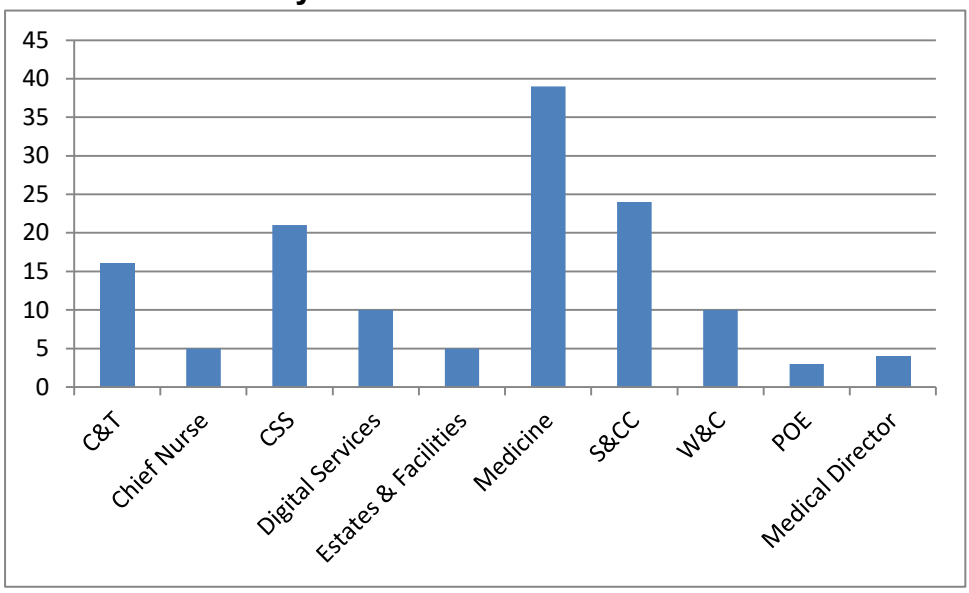




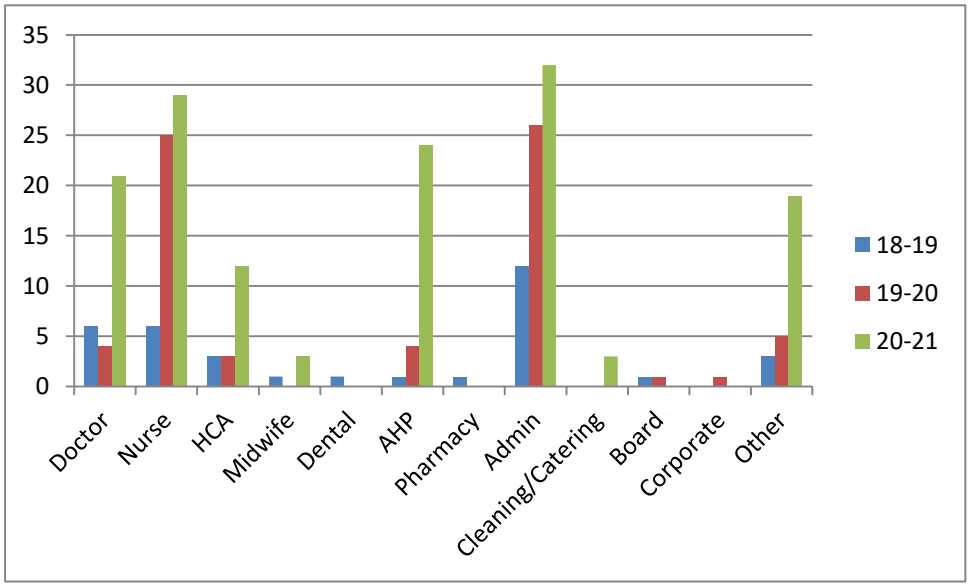
Please note that each concern may have more than 1 element.

Area of Concern	No.	Themes and Lessons Learnt
Behaviour	63	Most of these relate to behaviours that are not in line with Trust values or behaviour that is unprofessional. The increase in reporting may be related to an increase in awareness of the Guardian role and also as staff became tired and burnt out from working during the pandemic. Each Division has access to FTSU data which can be used in conjunction with other HR data to identify areas of concern.
Process	40	These are cases where staff were either unsure of how to proceed with a concern and needed help signposting/support to the appropriate services. Most relate to HR policies and procedures but some related to clinical issues ie discharge policy not being followed.
Staff Safety	40	Various issues including staff levels, training and PPE. The increase in concerns relating to staff safety is due to the pandemic particularly in the early months when new ways of working had to be introduced.

Concerns Raised by Division



Concerns Raised by Profession



In 2020-21 there has been an increase in the range of different professions that contacted the FTSU Guardian, which demonstrates an increased awareness of the Guardian role amongst staff in the Trust.

4.6 FTSUG Feedback /Evaluations received:

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback has been provided by staff that have spoken up and has been predominantly positive. The number of evaluations returned has also increased.

Quarter 2019-2020	Feedback received	Would you speak up again? Yes	Suffering Detriment (staff perception)
Total	30	30	0

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

'Liz is supportive and caring and I wouldn't hesitate to take a concern to her again, I have the belief that she will act on the concern and protect anonymity and did not rest until the concern has been dealt with.'

'Liz was prompt at replying to our e mail and arranging a meeting for us. We all felt listened to and supported by her. The result of us speaking out has so far proved positive'

4.7 Case Study

The inclusion of a case study in the report illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

The FTSU Guardian received an email from a staff member acting as spokesperson for a group of staff who had concerns which they had raised previously with managers. They felt had these had not been addressed and wanted the FTSUG involved.

The concerns included

- Staffing levels leading to unmanageable workloads
- Impact of COVID on ways of working resulting in additional workload which they felt should be managed elsewhere
- Lack of working mobile technology
- New ways of working that had been introduced which were not working as well as could be
- Impact on moral
- Consistency of HR policies

FTSUG arranged to meet the team members and go through the concerns and asked what outcomes they would like to achieve. They said they wanted to feel valued, listened to and be involved in making service decisions. After the meeting FTSUG met senior managers and shared the concerns. The management arranged an urgent meeting with the team to discuss the issues and from that meeting, the following outcomes were achieved:

- An acknowledgement that communication was not always as good as it could be and the team and the managers agreed to work on improving this together.
- Communication arrangements were agreed to ensure that the team felt they were not only kept informed but involved in decision making going forward, and that they could speak to senior managers should they have concerns or suggestions to improve service delivery in their area.
- Senior leaders undertaking an establishment review and the outcome of that shared.
- A commitment that decisions made would involve everyone concerned and that everyone could and should contribute to discussions.
- An understanding that there needs to be a consistent approach to policies.

FTSUG contacted the team and asked if they were happy with the outcomes, they said they were and that the whole experience had been very positive and wanted to share their experience to encourage others to 'speak up'.

5. Regional and National Information and Data

5.1 National update

The National Guardians Office (NGO) will be releasing the third and final module of its e-learning package for healthcare workers later in 2021, although no date has been released. These have all been developed in partnership with Health Education England. The third module is aimed at Senior Leaders.

People directorate will be looking to incorporate all modules into trust training.

National figures released for 2019-20 show a total of 16,199 cases were raised with Guardians, an increase of almost 4000 cases on the previous year. Of these :

- 13% were raised anonymously (an increase of 1% from 2018-19)
- 36% included an element of bullying/harassment (decrease of 5% from 18-19)
- 23% included an element of patient safety (decrease of 6% from 18-19)
- 3% indicated detriment as a result of speaking up (reduction of 2% from 18-19)

The NGO have introduced a new recording category of 'Worker Safety' which will include psychological safety, the recording of this additional category is effective from April 2021.

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. The regional network is also developing a 'gap analysis' tool for NGO case reviews.

6. Proactive work of the FTSUG during 2020-21

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at Trust inductions for Doctors, Overseas Nurses and Staff who are currently shielding
- Completion of FTSU presentation for all new staff inductions
- Attendance at Regional meetings
- Completion of all outstanding actions form the 2019 NHS Audit Yorkshire
- Attendance on Health & Wellbeing Steering Group

Future Plans

- Work of future combined Champions to include Pride and Respect and Health and Wellbeing is being considered by the People Directorate and the identification of appropriate training.
- Continue to work with the Divisions to ensure that learning from concerns is embedded into practice.
- Continue to raise profile of the Guardian
- Work with the Health & Wellbeing Guardian
- Use social media to continue to raise awareness of FTSUG and the role
- Submission of case study to the NGO 100 voices (for the first time)

7. Indicators of Success

The NHS Staff Survey results for the following questions are used by the National Guardians Office (NGO) to calculate the Freedom To Speak Up Index for each trust. The 2019 score for NLaG is 73% which means that NLaG is ranked towards the bottom of the table. Model Hospital data indicates that peer organisations are 77.9% and national median is 78.9%. The 2020 score will be released late May/early June.

However, there is evidence from the 2020 staff survey that staff are feeling more valued and there has been an improvement in the majority of questions, which is reflected below. The 2020 survey also had a new question asking if staff feel safe to speak up.

NUMBER	QUESTION	NLAG 2018	NLAG 2019	NLAG 2020	National Average for combined Acute and Community Trusts
13d	The last time you experienced harassment, bullying or abuse at work, did you or a colleague	43.8%	48.4%	46.5%	47.2 %

	report it?				
16c	The last time you saw an error, near miss or incident that could have hurt staff or patients/service users, did you or a colleague report it?	94.6%	95.7%	Not in 2020 survey	95.1%
17a	My organisation treats staffs who are involved in an error, near miss or incident fairly.	49.2%	48.6%	52.7%	60.9%
17b	My organisation encourages us to report errors, near misses or incidents.	84.8%	85.2%	85.7%	88.7%
17c	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	59.3%	60.1%	64.4%	72.3%
17d	We are given feedback about changes made in response to reported errors, near misses and incidents.	46.9%	48.5%	51.9%	61.7%
18b	I would feel secure raising concerns about unsafe clinical practice.	65.4%	65.1%	68.1%	71.9%
18c	I am confident that my organisation would address my concern.	48.3%	48.7%	50.5%	60.7%
18f	I feel safe to speak up			58.7%	65%

8. Conclusion

The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian over the last year and how this work supports the Trust's overall strategic objective of being a good employer. It also links with the Trust priorities of 'leadership and culture', workforce and quality and safety.

9. Recommendation

The Trust Board is asked to:

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

Compiled by Liz Houchin 19th May 2021

NLG(21)118

DATE OF MEETING	1 June 2021
REPORT FOR	**Trust Board of Directors**
REPORT FROM	Lee Bond, Chief Financial Officer
CONTACT OFFICER	Brian Shipley, Deputy Director of Finance
SUBJECT	**Executive Report – Finance – M01**
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee
EXECUTIVE SUMMARY	This report highlights the reported financial position of Month 01 of the 2021/22 reporting period

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Risk 6				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
			✓		✓

Executive Report – Finance Month 1

Highlights	Lowlights	Risks

DATE OF MEETING	Tuesday 1st June 2021
REPORT FOR	Trust Board (Public Board)
REPORT FROM	Jug Johal Director of Estates and Facilities
CONTACT OFFICER	Jug Johal Director of Estates and Facilities
SUBJECT	Estates and Facilities Executive Report
BACKGROUND DOCUMENT (if any)	Not applicable
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Not applicable
EXECUTIVE SUMMARY	The report provides a brief overview of the highlights, lowlights and risks within the services in the Estates and Facilities Directorate. Updating the board of key successes and outcomes and current/future projects. Facilities Services: Review and implementation of the independent NHS Food Service report & the revised National Standards of Healthcare Cleaning, considering potential cost implications and developing an action plan to support. Along with the Trust Procurement team, collaborating with York & Harrogate (NoECPC) for retendering of Linen & Laundry Services Trust investment into replacement Patient Beverage, replacement floor cleaning equipment used in communal areas and upgrade of the CCTV systems Commercial Services: More efficient usage of trust administrative space during Covid-19, with job roles that are able to work agile doing so and mobilization of the New Beacon House There is a steady increase in private patient activity and Theatre availability offered Trust accommodation occupancy levels remain high and the team continue to support clinical services Compliance:

	Training compliance effected by Covid-19 which means additional training required when restrictions lifted Estates and engineering: Extensive Trust wide improvements to essential infrastructure completed however the ageing estate will shortly require significant investment Estates Projects: Successful implementation of the £1.828m BLM programme for 20/21 and c£6.2m additional funding program devised of IPC, Critical Care and Critical Infrastructure

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Not applicable

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

Facilities Services

Highlights	Lowlights	Risks
• Implementation of the revised National Standards of Healthcare Cleaning released on 26th April 2021. GAP analysis and Action Plan in place to deliver all changes during 2021, ahead of the allocated implementation time frame of 12 months	• Potential cost implications as a result of the review. • Further cleaning changes since Covid 19 guidelines implemented	• Functional risk assessments review • Additional Resource • Revised auditing programme with all stakeholders • Impact on quality
• Review of the independent NHS Food Service report released November 2020 ongoing. Trust action plan created (working document) and owned by the Catering Sub group (CSG) and reviewed by the Nutritional Strategy Group (NSG).	• NHSI/E forming specialised group to assess impact, offer guidance, post report • Some recommendations could increase cost, but not quality	• Step away from local suppliers • Increased waste • Increased costs to support delivery model, capital equipment and infrastructure
• NLaG collaborating with York & Harrogate (NoECPC) for retendering of Linen & Laundry Services, tender to be launched June/July 2021 led by NoECPC, Trust procurement team in support	• Previous process collapsed, operating on contract extension however, service and quality remain high	• Collaboration to share any legal costs
• Trust investment into replacement Patient Beverage trolley delivered by the Hospital Support Assistant (H.S.A) team, with maintenance support enables hydration support for next 5 years • Security Car Parking Retender including investment into CCTV system, new partner appointed (Bidvest Noonan) to commence 1st July 2021 • Trust investment during March 2021 for replacement floor cleaning equipment used in communal areas, improves efficacy, and efficiencies with performing, state of the art equipment	• Relationship with ISS drawn to a close, on positive terms	• CCTV project clashes with high volume of existing schemes. Plan in place to minimise risk
• Developing waste processing strategy to improve upon waste collections from sites, processing and streaming to waste routes maximising recycling, reuse and enabling further efforts to reduce waste in line with National guidance post Covid and increased healthcare waste output	• Pandemic has increased consumption of consumables resulting in enormous waste outputs	• Resource investment to build upon legislative need

Commercial Services

Highlights	Lowlights	Risks
• New Beacon House has created a non-clinical administration hub in the community and has also created an agile working space for flexibility. • As a number of community buildings were closed in response to Covid, we ensured continued service delivery to patients by re-locating community teams to alternate buildings. The focus now is on re-occupying Children's Centres as they are re-opened. • More efficient usage of trust administrative space during COVID, with job roles that are able to work agile doing so. • Seamless relocation of over 250 staff as part of previous years Capital Projects – DPOW MRI, SGH AAU/ED • Steady increase in private patient activity now Covid-19 restrictions are easing. Theatre availability now starting to be offered to private patient services • Decontamination Services (DSA) activity value at Goole improved from March to above apportioned Minimum Services Level for Decontamination Services. Activity value at DPoWH improved from March, however was 4% below apportioned Minimum Services Level. • Continued to support clinical teams with accommodation in the Roost and at SGH, being able to provide accommodation to newly arriving colleagues where they have needed to self-isolate following travel. • Provision of meals to staff ceased in March, continuing to work with Elior to improve service offer. This includes the newly launched "Breaz" app which allows colleagues to order through the app for a click and collect service, thus minimising the need to stand in queues during breaks.	• Agile Working Steering Group has yet to deliver an approved Agile Working Policy to embed and empower teams to continue to adopt agile working practices undertaken during pandemic response into future ways of working. • Lack of Private Patient activity over the past year and still unable to secure a regular weekly/ monthly theatre session which would allow for better planning and performance • Overall Trust activity value reduced by 1% from March, falling to 7% below the DSA Minimum Services Level; • Demand for accommodation at both sites exceeds supply. SGH is particularly impacted. • Following Trust provision of meals the utilisation of the restaurants is low, when coupled with a lack of visitors this is putting pressure on the service provider.	• Agile working must continue as there is potential that we will not be able to offer admin space to teams (especially at DPOW) or adhere to Space utilisation policy and social distancing • Ability to achieve income targets in relation to PP and OSV. • Continuation of reduced activity will lead to failure of achieving Minimum Services Level and result in further adjustment payments; • If the Trust is unable to provide accommodation this can impact workforce and patient care.

Safety & Statutory Compliance

	Lowlights	Risks

ESTATES & ENGINEERING

Highlights	Lowlights	Risks
• The estates team successfully completed a management restructure at the end of FY 19/20, the aim of which is to provide more ownership at the granular level, which directly improves oversight and control of assurance in the Trust. • Extensive Trustwide improvement to essential infrastructure; water treatment, medical gas, ventilation, roof works. Circa £1M invested in water infrastructure at DPoW has resulted in improved heating efficiency and contributes to the removal of some high risks from risk register. As a cohort we managed to spend the government committed funds on developing the site infrastructure, and as a result have been granted more funding this FY. • The pandemic, whilst it has put pressures on all teams, it has developed closer collaboration with clinical counterparts as we strive to make the environment better for staff and patients alike. • Good progress has been made towards recruitment, both internal promotions and external appointments. This has changed the dynamic of the team and created a new drive. • Ongoing drive to digitise and develop estates management through Computer Aided Facilities Management (CAFM) system. • Medical gas improvements across the Trust has seen a big increase in resilience; CPX manifolds at both main sites, flow rates meters installed at key strategic places trust wide, BOC survey, 2nd Evaporator to be installed. This has provided greater assurance to the Trust and improved patient safety.	• Staffing levels and fluctuations at SGH have been a struggle; this has created delays to essential work and compliance. • Due to the increased level of funding received by the Trust, and the subsequent volume of work, has impacted the capacity of our key contractors to complete work in a timely manner. • Increase in funds required for large scale BLM and capital projects has meant a reduction in the overall 21/22 BLM available for other key risk works. • The volume of capital works has impacted the ability to perform ongoing estate compliance work due to strain on technical resources.	• The ageing estate, much of it nearing the end of its serviceable life will start to need significant investment to ensure Trust resilience. Recent EPC funding will help aspects, but there still remain roof leaks, which ultimately will affect clinical and non-clinical areas. • Ageing workforce. This coming year will see the retirement of a portion of the staff. Given historic recruitment issues due to poor levels of pay, early succession planning is essential. • Ongoing support to capital works impacting on estate compliance.

CAPITAL PROJECTS

Highlights	Lowlights	Risks

• Successful completion of a number of Capital Projects including:
  • Ward 29 refurbishment project at SGH
  • The new CT Scanner facility at DPoW
  • The 'back-to-back' MRI Scanner facility at DPoW
  • Refurbishment of the X-ray facility at GDH
• Successful commencement on site of the new MRI facility at SGH
• Successful implementation of the £1.828m BLM programme for 20/21
• Successful implementation of the c£6.2m additional funding programme, including:
  • IPC [£1.3m funding]
  • Critical Care [£1.4m funding]
  • Critical Infrastructure [£3.496m funding]
	• Impact of Covid-19 on project works on site during mid-2020
	• Difficulties and delays in recruiting sufficient staff to deliver projects effectively and sustainably
		• Supply chain and material resource availability impacting on ability to deliver projects
		• Potential for short-term supply / demand issues leading to inflation within the supply chain impacting on ability to deliver projects
		• Difficulty in recruiting staff to both permanent and fixed-term roles
		• Lack of funding 21/22 impacting on ability to complete urgently-needed critical infrastructure works

NLG(21)120

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Gill Ponder, NED / Chair of Finance & Performance Committee
CONTACT OFFICERS	Lee Bond, Chief Financial Officer
SUBJECT	**F&P Committee Highlight Report – April & May 2021 – FINANCE ONLY**
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY	The attached highlight report summarises key issues presented to, and discussed by the Finance & Performance Committee at its meetings on 28 April & 26 May 2021 and worthy of highlighting to the Trust Board.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable	BAF Risks SO3-3.1 & SO3-3.2				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓	✓		

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	1 June 2021
Report From:	Finance & Performance Committee – 28 April & 26 May 2021
Highlight Report:	

Finance Report – 28 April 2021

- Final month of March saw deficit of £3.74m against a planned deficit of £2.15m.
- Trust achieved 2020/21 Financial Plan and Control Total. Year-end saw surplus of £0.16m, £4.76m favourable against the initial planned deficit of £4.59m adjusted to £0.16m after the annual leave provision and loss of non clinical income included in the plan allowed under NHSEI performance metrics.
- Trust delivered CIP savings of £10.5m, overachievement of £0.1m. Recurrent delivery was £6.31m.
- Key themes continued in March, as per previous months, of:
    - Income ahead of plan, especially from Pathlinks and HEE.
    - Clinical pay pressures.
    - Reduced clinical supplies spend.
    - Lower depreciation costs and improved cash balances.
- Underlying financial position remains extremely challenging, with focus on increased nursing agency costs and ongoing high Covid-19 expenditure.

Further Finance Issues

- National assumptions require the Trust to deliver £3.0m surplus for H1 of 2021/22.
- Committee received and supported draft budgetary allocations for Divisions and Directorates for first six months of year. Committee noted remaining income level uncertainty; review and validation of investments; Covid-19 expenditure; inflation and savings assumptions and need to operate within the system control total.

Finance Report – 26 May 2021

- Month 01 of FY2021/22 saw surplus of £0.31m against a planned £0.32 surplus.
- Early non-validated reports suggest over-delivery of activity against minimum base threshold set at 70% of 2019/20 levels. Likely that Q1 ICS position will not be formally assessed by NHSI until July at earliest.
- Key issues for forward consideration and action are:
    - Delivery of core Elective Recovery Programme.
    - Exceed 85% activity thresholds to capitalise on ERF additional income.
    - Enhance CIP delivery
    - Reduce Covid-19 expenditure.

Confirm or Challenge of the Board Assurance Framework:
No specific BAF challenge undertaken however review, scrutiny and discussion of Finance Report provided assurance that current risks are understood and being addressed at this early stage in FY 2021/22.
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. **Gill Ponder** **Non-Executive Director / Chair of Finance & Performance Committee**

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)121

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Ivan McConnell, Director of Strategic Development
CONTACT OFFICER	Kerry Carroll, Deputy Director of Strategic Development
SUBJECT	**Executive Report - Strategic & Transformation**
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The attached report provides an update and overview of the Strategic Objective 4 – To work more collaboratively The attached template provides the highlights, lowlights and risks against the Trust Priorities 4 and 9. The Board is asked to note: • The service development through the Humber Acute Services Review • The continued development of partnership and system working

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	**Strategic Risk 8:** Inability to pursue a clear organisational strategy that staff and stakeholders are aware of and support **Strategic Risk 9:** Lack of an integrated ICS, Humber

	and Trust clinical strategy which delivers long term system, service and organisational sustainability including the ability to attract inward investment

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

Strategic Service Development and Improvement – May 2021
Strategic Objective 4 – To work more collaboratively

Trust Priority 4: **Service Development and Improvement**

- With Hull University Teaching Hospitals, we will complete the Interim Clinical Plan, including:
    - the delivery of a revised leadership and clinical delivery approach for oncology, haematology and dermatology by May 2021;
    - the joining together of the clinical services of ENT, ophthalmology, cardiology and urology under a single service leadership by March 2022;
    - improved access and treatment pathways, including a redesigned community approach by March 2022.
- With partners in the Humber Acute Services Review, we will engage fully in leading and supporting the development by the end of 2021 of a Pre-Consultation Business Case (PCBC) for the delivery of new models of care for:
    - Urgent & Emergency Care
    - Maternity, Neonates & Paediatrics
    - Planned Care and diagnostics

Trust Priority 9: Partnership and System Working

- We will play a full part in the development of the Humber Coast and Vale (HCV) Health & Care Partnership, including the:
    - Humber Partnership Board
    - Acute Collaborative
    - Community Collaborative
    - Integrated Care Partnerships of North and North East Lincolnshire
    - HCV Cancer Alliance and associated professional networks
- We will play a full part in other national and regional networks, including professional, service delivery and improvement (e.g. GIRFT), and operational.

Trust Priority 4:

- With Hull University Teaching Hospitals, we will complete the Interim Clinical Plan ***(programme 1)***
- With partners in the Humber Acute Services Review, we will engage fully in leading and supporting the development by the end of 2021 of a Pre-Consultation Business Case (PCBC) for the delivery of new models of care for ***(programme 2)***

Highlights	Lowlights	Risks

• Pre-Consultation Business Case framework established to commence populating in line with timescales • Lincolnshire and Doncaster system engagement • NHSE/I pilot training complete for Delivering Service Change – creating bespoke NLaG/HUTH training package for all staff • Committees in Common to support increased collaboration and delivery agreed (Terms of reference in development)		

Trust Priority 9: Partnership and System working

- We will play a full part in the development of the Humber Coast and Vale (HCV) Health & Care Partnership
- We will play a full part in other national and regional networks, including professional, service delivery and improvement (e.g. GIRFT), and operational.

	Lowlights	Risks
		• Aligning the development /strategies/objectives/ priorities of the PCNs to HASR

NLG(21)123

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Neil Gammon, NED / Chair of Health Tree Foundation Trustees' Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	Health Tree Foundation Trustees' Committee – Terms of Reference
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Health Tree Foundation Trustees' Committee – 13 May 2021
EXECUTIVE SUMMARY	The Terms of Reference were reviewed at the HTF Committee meeting held on 8 March and subsequently agreed at the meeting held on 13 May 2021. Changes are tracked on the attached paper for ease of reference.

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Finance

HEALTH TREE FOUNDATION TRUSTEES COMMITTEE

Membership and Terms of Reference

Reference:	DCT041
Version:	3.1
This version issued:	~~06/01/20~~01 01 06 21
Result of last review:	Minor changes
Date approved by owner (if applicable):	~~28/11/19~~13/05/21
Date approved:	~~27/03/18~~
Approving body:	Charitable Funds Trustees ~~Funds~~ Committee
Date for review:	~~November, 2020~~March 2021
Owner:	~~Paul Marchant, Chief Financial Accountant~~ Lee Bond, Chief Financial Officer
Document type:	Terms of Reference
Number of pages:	8 (including front sheet)
Author / Contact:	~~Paul Marchant, Chief Financial Accountant~~ Lee Bond, Chief Financial Officer

Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

1.0 Purpose

1.1 The Trustees Committee is tasked with overseeing and managing the affairs of the Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds. The working name of the Charity is The Health Tree Foundation.

1.2 The Trustees Committee must ensure that the Charity acts within the terms of its declaration of trust, and all appropriate legislation, on behalf of the Trust Board as Corporate Trustee.

2.0 Authority

2.1 The Trust Board exercises its role as Corporate Trustee through its review and control over the Terms of Reference of the Trustees Committee, and through its powers to appoint to the Trustees Committee.

2.2 The Trust Board delegates authority to receive, manage and utilise charitable funds to the Trustees Committee.

2.3 Expenditure commitments must be approved in line with the delegation limits set out in Appendix A. The final decision on any expenditure rests with the Trustees Committee.

2.4 Investment and disinvestment decisions remain the preserve of the Trustees Committee.

2.5 The Trust Board will review the working of the Trustees Committee through the reporting arrangements set out in section 3, in order to perform its role as Corporate Trustee.

2.6 The members of the Trustees Committee shall act independently of the Trust Board when making decisions about expenditure.

2.7 The Trustees Committee must ensure that the expenditure decisions are granted only to further the charity's purposes for the public benefit and for no other purpose.

3.0 Accountability & Reporting Arrangements

3.1 The Trustees Committee is established as a formal sub-committee of the Trust Board, under the Trust Constitution Part IV Section 6.8 d. These Terms of Reference shall have effect as if incorporated into the Trust's Constitution, and shall only be amended by agreement of the Board.

3.2 The minutes of the Trustees Committee will be formally recorded and submitted to the Trust Board once agreed by the Committee.

3.3 The Trustees Committee will supply the Trust Board with a highlight report following each meeting, outlining investment and disinvestment decisions, and material expenditure commitments, in line with limits set out in Appendix A.

3.4 The Trust Board shall have access to all reports and papers of the Trustees Committee. These must include regular comprehensive financial reports and progress updates.

3.5 The Trustees Committee must ensure that accounts for Charitable Funds are completed in line with regulatory standards and deadlines, and made available to the Trust Board and Audit Risk and Governance Committee.

4.0 Responsibilities

The responsibilities of the Charitable Trustees Committee are to:

- Manage the affairs of the Northern Lincolnshire and Goole NHS Foundation Trust Charity within the terms of its declaration of trust and appropriate legislation including that of the Charity Commissioners of England and Wales
- Implement procedures and policies ensuring that accounting systems are robust, donations are received and coded as instructed and all expenditure is reasonable, clinically and ethically appropriate
- Ensure funding decisions are appropriate and are consistent with the Trust's objectives and to ensure such funding provides added value and benefit to the patients and staff of the Trust, above those afforded by Exchequer funds
- Maintain engagement and monitoring arrangements for major projects utilising significant funding provided by the Charity
- Monitor and review fund balances, and where appropriate amend the structure of individual funds (e.g. merging, deleting, rationalising)
- To manage the investment of funds in accordance with the Trustee Act 2000 and if necessary to appoint fund managers to act on its behalf
- Maintain a proactive approach to fund raising, including charitable giving, legacies, and publicity as well as arranging appropriate communications on all matters associated with the Charity
- Review and agree audited Annual Report & Accounts
- Ensure that Trustees Committee membership is refreshed and that undue reliance is not placed on particular individuals when undertaking responsibilities of the Committee
- Review and update these Terms of Reference annually, recommending any changes to the Trust Board
- Evaluate its own membership and performance on an annual basis

5.0 Membership

5.1 Core membership

The Trust Board acts as Corporate Trustee of the Charity. The Trustees Committee shall be appointed by the Trust Board from amongst the Non-Executive and Executive members of the Trust Board, and the local community, and shall consist of the following voting members:

- An independent Chair
- 3 Non-Executive Directors;
- Executive Directors:
  - Chief Executive
  - Medical Director
  - Chief Nurse
  - ~~Director of Finance~~ Chief Financial Officer
- 2 Independent Trustees

5.2 In attendance:

- Health Tree Foundation Charity Manager
- Chief Executive of Smile Foundation
- Director of Estates and Facilities
- Director of People
- Associate Director of Communications
- Chief Financial Accountant
- Assistant Director of Finance, as required
- Governor Representative
- Investment Representatives, as required
- Other Trust staff and stakeholders as required

5.3 Charitable Funds Executive Clinical Champions

The Trustees Committee shall have two Charitable Funds Executive Clinical Champions, the Medical Director and the Chief Nurse. The role of the Clinical Champions is to provide expert clinical opinion on all HTF matters where appropriate, particularly around the question of the impact of HTF wishes on patient experience. They will also be responsible for approving expenditure between £5001 - £25,000 as per Appendix A.

6.0 Procedural issues

6.1 Frequency of Meetings

The Committee shall meet no less than four times a year, although at more regular intervals should the Committee so determine. Notice of each meeting, including an agenda and supporting papers, shall be forwarded to each member of the Charitable Trustees Committee not less than five working days before the date of the meeting.

6.2 Independent Chair and Trustees

The Independent Chair and Trustees shall be appointed by the Trust Board.

6.3 Secretarial Support

The ~~Director of Finance~~Chief Financial Officer will ensure that appropriate administrative support is available to provide support to the Chair and members of the Charitable Trustees Funds Committee.

6.4 Attendance

6.4.1 Permission for Trustees to Nominate Deputies

In the absence of the Chair, a Non-Executive Committee member will be nominated by the Chair to perform this role. Other Trustees may not nominate deputies to act on their behalf.

6.4.2 Attendance by Trustees

All Committee members will be required to attend 75% of meetings. The Trustees Committee will maintain and publish annually a register of attendance.

6.5 Quorum

6.5.1 The Committee will be quorate when:

- A minimum of four Trustees are in attendance
- At least two Independent external or Non-Executive Trustees are in attendance, and
- At least one Executive Director Trustee is in attendance

6.5.2 Where the ~~Director of Finance~~Chief Financial Officer is unable to attend the Committee, they remain responsible for ensuring that appropriate technical advice and support is still available to the Committee in order to support effective execution of its duties.

6.6 Minutes of Meetings

The Charity Manager will agree the agenda items with the Committee Chair; produce all the necessary papers and attend the meetings. The Committee shall be supported by the Chief Financial Accountant, who will provide the financial updates and attend the meetings. ~~agree the agenda items with the Committee Chair, produce all the necessary papers, and attend meetings.~~

The Directorate of Finance will provide an appropriate individual to take minutes, keep a record of matters arising and issues to be carried forward. The minutes, once formally

agreed at a subsequent meeting of the Trustees Committee, will be presented to the Trust Board in order to support the Trust Board's role as Corporate Trustee. The Trustees Committee Highlight Report will be agreed by the Committee Chair and presented to the Trust Board by one of the Non-Executive Directors.

6.7 Review

The Terms of Reference will be published on the Trust Intranet and will be reviewed annually.

7.0 Equality Act (2010)

7.1 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.

7.2 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.

7.3 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.

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

The electronic master copy of this document is held by Document Control, Directorate of Governance & Assurance~~Trust Secretary~~, NL&G NHS Foundation Trust.

Appendix A

CHARITABLE FUNDS – DELEGATION LIMITS

1.	Up to £250	Authorisation from Health Tree Foundation Charity Manager
2.	Between £251 - £5,000	Authorisation from the Fund Guardian
3.	Between £5,001 - £25,000	Authorisation from Fund Guardian and from either of the Charitable Funds Executive ~~Lead Directors~~Clinical Champions, i.e. the Medical Director or the Chief Nurse
4.	Above £25,000	As above, plus further authorisation from the Committee

The Trustees Committee will exercise final authority over all decisions, and will set out appropriate guidelines, as required; to support this delegated decision making process.

All investment and disinvestment decisions relating to the funds held by the Charity will require the authorisation of the Trustees Committee.

The Committee is required to approve expenditure above £25,000, but all expenditure items above £1,000 will be reported to the Committee.

Individual expenditure commitments above £50,000 in value, and all investment or disinvestment decisions, will be reported for oversight purposes to the Trust Board as Corporate Trustee, through the regular Highlight Report.

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NLG(21)124

DATE OF MEETING	1 June 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 – April 2021
BACKGROUND DOCUMENT (if any)	Audit, Risk & Governance Committee Agenda Papers 22 April 2021
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Not Applicable
EXECUTIVE SUMMARY	The attached highlight report summarises the key issues presented to, and discussed by the Audit, Risk & Governance Committee at its meeting on the 22nd April 2021: **1.** **Draft Annual Accounts 2020/21**: Received and discussed by the Committee, and approved for submission. **For Board to Note.** **2.** **Going Concern Report 2020/21**: The Committee endorsed the view that the Trust is a going concern for the 2020/21 annual accounts process. **For Board to Note.** **3.** **Risk Strategy**: The Medical Director updated the Committee on the development of the Trust's Risk Strategy in terms of improving understanding and use within the organisation. **For continued monitoring by the Committee as part of their work plan**.

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	1st June 2021
Report From:	Audit, Risk and Governance Committee held on 22nd April 2021.

Highlight Report:

1. **Draft Annual Accounts 2020/21** – received by the Committee, and key points highlighted by the Assistant Director of Finance – Planning and Control. Approved for submission to NHSE/I and the External Auditor (Mazars).

2. **Going Concern Report 2020/21** – following discussion, and with the agreement of the External Auditor, the Committee endorsed the view that the Trust is a going concern for the purposes of the annual accounting exercise for 2020/21.

3. **Risk Strategy** – the Committee received a progress report on the development of the Trust's Risk Strategy from the Medical Director. The Medical Director advised that the Trust does already have a comprehensive Risk Strategy in place. The development plan is to improve understanding and use of risk management within the organisation. Following discussion the Committee agreed that they should monitor progress with the development of the Strategy and include this item in the Committee's work plan going forward.

Confirm or Challenge of the Board Assurance Framework:

The Trust Secretary updated the Committee on the position with the development of a new Board Assurance Framework, following the Trust Boards revisions to the strategic objectives, the risk scoring approach and the risk appetite statement for 2020/21.

Action Required by the Trust Board:

The Trust Board is asked to note the key points raised by the Committee, and consider any further action needed.

Andrew Smith
Non-Executive Director and Chair of Audit, Risk and Governance Committee

NLG(21)125

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Helen Harris, Director of Corporate Governance
CONTACT OFFICER	As above
SUBJECT	Non-Executive Director Statutory Roles
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The paper provides the updated version of the Non-Executive Director Statutory Roles.

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

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

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

Non-Executive Director Statutory & Other Lead Roles & Responsibilities

NED	NED Chair of Trust Meetings & Board Sub-Committees	Deputy Chair and / or Attendee	NED Statutory Role	NED Assurance Role	Linkages through CoG Working Group
Terry Moran Trust Chair	Council of Governors (CoG) Trust Board Remuneration and Terms of Service (RATS) Committee			Oversight of CoG Development Oversight of Trust Board & Trust Leadership Development	Appointment & Remuneration Committee (ARC) for Non-Executive Directors (NEDs)
Linda Jackson Vice Chair and Acting Senior Independent Director		Trustee of Health Tree Foundation (HTF) Rotational attendance at Quality and Safety Committee (Q&SC), Finance and Performance Committee (F&PC) and Workforce Committee meetings Member of the RATS Committee	Raising Concerns		Governor Assurance Group (GAG) ARC for NEDs
Mike Proctor NED *Attached to Family Services Division*	Q&SC (including statutory requirements that fall within the remit of the Committee's Terms of Reference (TOR)	Deputy Chair of Workforce Committee Trustee of HTF Member of the RATS Committee		End of Life Ockenden Recommendations Complaints – NED Champion	GAG

Andrew Smith NED *Attached to Clinical Support Services Division*	Audit, Risk & Governance (ARG) Committee (including statutory requirements that fall within the remit of the Committee's TOR)	Member of the RATS committee Deputy Chair of F&PC Member of Q&SC			GAG
Gillian Ponder NED *Attached to Surgery and Critical Care Division*	Chair of F&PC (including statutory requirements that fall within the remit of the Committee's TOR)	Member of ARG Committee Member of the RATS Committee Trustee of HTF		Security Management NED lead	GAG
Michael Whitworth NED *Attached to the Medicine Division*	Chair of the Workforce Committee (including statutory requirements that fall within the remit of the Committee's TOR)	Deputy Chair of ARG Committee Deputy Chair of Q&SC Member of the RATS Committee		Strategic Development Equality, Diversity, Inclusion and Wellbeing	GAG
Stuart Hall Associate NED		Member of the F&PC Member of the ARG Committee Member of RATS Committee			

Maneesh Singh Associate NED *Attached to Community and Therapies Services*		Quality and Safety Committee Trustee of the HTF Workforce Committee Member of the RATS Committee		Mortality and Morbidity Safeguarding/LD and Dementia	
Neil Gammon	Independent Chair of HTF				

*Non-Executive Directors have a shared responsibility for Doctors Disciplinary.

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NLG(21)126

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Dr Peter Reading, Chief Executive
CONTACT OFFICER	As above
SUBJECT	Executive Director Statutory Roles
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Executive Team Meeting – 25 May 2021
EXECUTIVE SUMMARY	The paper provides the updated version of the Executive Director Statutory Roles.

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

TRUST BOARD – EXECUTIVE STATUTORY ROLES

TRUST BOARD - EXECUTIVE STATUTORY ROLES

AREA	EXECUTIVE LEAD	EXECUTIVE ROLE	REFERENCE
Overall Responsibility for the Trust	Chief Executive	Accountable Officer	NHS Act 2006
Emergency Preparedness	Chief Operating Officer	Accountable Officer for Emergency Preparedness	Emergency Preparedness Resilience and Response (EPRR), NHS England
Medical Devices	Chief Operating Officer	Medical Devices Lead	Medical Devices Handbook
Finance	Chief Financial Officer	Accounting Officer	NHS Act 2006
	Chief Financial Officer	Counter Fraud, Bribery and Corruption Board Lead	Health and Social Care Act 2012 – Service Condition 24 of the NHS Standard Contract / Government Functional Standard GovS 013: Counter Fraud
Information Management / Governance	Medical Director	Caldicott Guardian	HSC1999/012
	Chief Information Officer	Senior Information Risk Officer (SIRO)	Data Security & Protection Toolkit (includes UK GDPR, Cyber Security, & Data Protection Act)
Health & Safety	Director of Estates and Facilities	Lead Executive for Health & Safety	Health & Safety at Work Act 1974
	Director of Estates and Facilities	Medical Gases Executive	Health Technical Memorandum (HTM) 02-01
	Director of Estates and Facilities	Heating & Ventilation designated Person	HTM 03-01
	Director of Estates and Facilities	Water Responsible Person	HTM 04-01
	Director of Estates and Facilities	Electrical LV Designated Person	HTM 06-02
	Director of Estates and Facilities	Electrical HV Designated Person	HTM 06-03
	Director of Estates and Facilities	Specialist Services (Lifts) Designated Person	HTM 08-02

	Director of Estates and Facilities	Environment & Sustainability Responsible Person	HTM 07-02
	Director of Estates and Facilities	Fire Board Level Director	Fire Safety (Regulatory Reform) Order 1985 HTM 05-01
	Director of Estates and Facilities	Security Management Director	NHS Commissioning Contract
	Chief Operating Officer	Radiation Protection Advisor	Ionising Radiation Regulations 1999
Infection Control	Chief Nurse	Director of Infection Prevention & Control (DIPC)	Health & Social Care Act 2008 Code of Practice on Control of Infection
	Chief Operating Officer	Decontamination Lead	Health & Social Care Act 2008 Code of Practice on Control of Infection
Safeguarding	Chief Nurse	Safeguarding Executive Lead	Safeguarding Accountability Assurance Framework NHS Standard Contract
Freedom of Information Act	Associate Director of Communications	Freedom of Information Act Lead	Freedom of Information Act
Freedom to Speak Up	Director of People	Freedom to Speak Up Guardian	NHSE Requirement & requirement of NHS Standard Contract
Quality / Patient Safety	Medical Director	Quality Executive Lead	Francis Inquiry
	Medical Director	Executive Lead for End of Life Care	More Care, Less Care Report 2013
	Chief Nurse	Responsible Person for Compliance with Complaints Regulations	NHS Complaints Regulations
	Medical Director	Guardian of Safe Working Hours	NHS Employers
	Medical Director	Responsible Officer for Revalidation	General Medical Council
	Medical Director	Mortality Lead	Learning From Deaths Report 2017; NHS England
	Chief Operating Officer	Cancer Lead	Calman Hine 2001
	Chief Operating Officer	Mental Health Lead	Mental Capacity Act 2005

	Chief Nurse	Maternity Champion (Board Level)	Ockenden Report 2021
Human Tissue Authority	Medical Director	Designated Individual	Human Tissue Authority Act
Care Quality Commission	Medical Director	CQC Registered Manager	Health & Social Care Act 2014
Sustainability	Director of Estates and Facilities	Trust Board Lead (Executive)	Delivery A Net Zero National Health Service, October 2020
Equality & Diversity	Director of People	Board Executive Lead	Equality Act 2010
	Director of Estates and Facilities	Executive Board Lead for Tackling Inequality	NHS England, Phase 3 of the Covid response https://www.england.nhs.uk/wp-content/uploads/2020/08/implementing-phase-3-of-the-nhs-response-to-covid-19.pdf

SENIOR MANAGER ROLES		
SENIOR MANAGER LEAD	**ROLE**	**REFERENCE**
Chief Pharmacist	Accountable Officer for the Destruction of Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373)
Chief Pharmacist	Accountable Officer for Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373)
Medicines Safety Officer	Medicines Safety Officer	Patient Safety Alert NHS/PSA/D/2014/005
Chief Pharmacist	Non-Medical Prescribing Lead	NMC Code of Conduct
Head of Medical Engineering	Medicines Devices Safety Officer	Patient Safety Alert NHS/PSA/D/2014/006
Organ Donation Lead	Organ Donation	NHS Blood Transfusion 2008
Medical Examiner	Lead Medical Examiner	Dept of Health & Social Care's Death Certification reforms programme for England (part of the National Patient Safety Strategy 2020)
Associate Director of Clinical Quality Governance	Patient Safety Specialist	NHS England Patient Safety Strategy https://www.england.nhs.uk/wp-content/uploads/2020/08/identifying-patient-safety-specialists-v2.pdf

The Senior Manager Lead Roles are to support Executive Directors in their statutory duties

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NLG(21)127

DATE OF MEETING	Tuesday 1st June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Jug Johal – Director of Estates & Facilities
CONTACT OFFICER	Bill Parkinson – Head of Safety & Statutory Compliance
SUBJECT	Annual Health & Policy Statement Update
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Estates & Facilities Governance Group Health, Safety & Fire Group Audit, Risk & Governance Committee All approved document to submit to Trust Board
EXECUTIVE SUMMARY	*The annual statement has been amended to include reference to the work on mental health and wellbeing and transformation work which may require short notice temporary disruption but not to the detriment of health, safety & wellbeing.* *Changes made from previous version are highlighted in yellow for ease of reference.*

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

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

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

(please tick ✓)					

Directorate of Estates & Facilities

HEALTH & SAFETY AT WORK POLICY STATEMENT

Reference:	DCM081
Version:	11.7
This version issued:	May 2021
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Trust Board
Date for review:	May, 2022
Owner:	Jug Johal, Director of Estates & Facilities
Document type:	Miscellaneous
Number of pages:	6 (including front sheet)
Author / Contact:	Bill Parkinson, Head of Safety & Statutory Compliance

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.

HEALTH AND SAFETY AT WORK POLICY STATEMENT

Northern Lincolnshire & Goole NHS Foundation Trust recognises its health and safety duties under the Health and Safety at Work etc Act 1974, the Management of Health and Safety at Work Regulations 1999 (as amended) and Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

In keeping with the Trust's Strategic Plan the transformation of the services and it's sites the Trust is committed to the health and wellbeing of employees, contractors, patients and other members of the public. This will be achieved by providing a working environment, appropriate controls and suitable training which satisfy the health and safety standards set out in regulations, practices and procedures, codes of practice, contracts and specific Northern Lincolnshire & Goole NHS Foundation Trust policies.

During this period of transformation there is likely to be some disruption in relation to some services, traffic and patient flows and car parking arrangements until the works are completed. The Trust will look to keep these disruptions to a minimum and will not be to the detriment of the health and wellbeing of anyone. Regular updates on progress and forewarning of any temporary changes will be issued at the earliest opportunity to give suitable advance notice to service users and staff alike. However, it is recognized that there may be changes which may occur at short notice and service users and staff are asked to accept these as part of the overall move towards the Trust objectives.

This Health & Safety Policy Statement outlines the Trust's commitment and approach to the management of health & safety and does not provide the detail on the management of specific health & safety risk topics. Policies and procedures covering the assessment and control of specific health & safety risks (e.g. Occupational Road Risk, Lone Working, Violence & Aggression etc) are in place. These documents are maintained within a central document control system, which ensures that a consistent approach is adopted, that suitable consultation and approvals processes are in place and that documents are regularly reviewed and updated, and are made available to staff as appropriate.

Whilst the Chief Executive is ultimately responsible for the implementation of effective health and safety arrangements, as outlined in the Trust's Risk Management Strategy, the Director of Estates & Facilities has delegated responsibility from the Chief Executive for all elements of in relation to health & safety (whilst accepting that the Medical Director and Chief Nurse have delegated operational responsibilities within their areas). The Deputy Director of Estates & Facilities in turn has responsibility for the central co-ordination of these arrangements, with the day to day management of health & safety management at local level being devolved to Directorates.

The Trust Board and Directors/Managers therefore collectively and individually accept their duties and responsibilities arising from the Health and Safety at Work etc Act 1974.

The Trust recognises that a proactive approach to the management of health & safety risks is considered an essential element in a good safety management system. As part of its approach, the Trust has in place a system of formal and informal inspections, visits and audit processes which include Directors and Governors. Where appropriate, the Trust also sources external verification of its health & safety management arrangements.

In complying with its duties to its employees as outlined in the Health and Safety at Work etc Act 1974 and the Management of Health and Safety Regulations 1999 (as amended) the Trust is committed to:

- Introducing, developing and maintaining safe systems of work which employees and others working for the Trust are expected to follow and also to reviewing and improving existing systems to further raise standards
- Increasing the knowledge and skill base of its employees in relation to health and safety, ensuring that staff are competent to identify, assess and manage health and safety risks within their working environment
- Supporting Directorate/Division forums to ensure active involvement in health & safety matters and performance
- Using internal data acquired from reactive sources (e.g. incident reports) as well as proactive systems (e.g. inspections, site visits and audits) together with information from managers and staff and external sources (e.g. legislation updates, etc) to allow the Trust to review the robustness of its safety management system and afford the opportunity to benchmark its performance against other Trusts
- Setting both annual and longer-term strategic objectives as part of the business planning process in order to further develop and improve health and safety arrangements/standards
- Maintaining a robust incident/accident reporting system, which facilitates learning lessons through corrective action and re-audit and the identification of the underlying or root causes of failures identified
- Ensuring that equipment is purchased to required specifications, meets all statutory requirements and that staff using equipment have received adequate instruction and training and importantly that inspection and maintenance occur as required
- Maintaining a comprehensive Trust-wide Risk Register and Central Risk Assessment System which includes specific health and safety risks and which are used to assist in the setting of priorities and the allocation of resources as well as in the development of health and safety planning
- Developing a positive safety culture throughout the organisation through our vision and values and strategic objectives
- Implementing a strategy to promote and improve the mental health and wellbeing of staff within the Trust
- The provision of health surveillance for its employees where appropriate
- The appointment of competent personnel to support and advise staff in all areas of health and safety
- The development of a safety management system to a recognised certified standard

In accordance with statutory provisions the Trust will ensure that adequate resources are allocated to achieve the above commitments.

In addition to the responsibilities of the Trust as an employer, all employees and other persons working for the Trust, e.g. volunteers and contractors, are expected to participate and co-operate with the systems of work implemented in order for the Trust to discharge its statutory duties. This also involves taking reasonable care of themselves and others who may be affected by their actions (or omissions), including the safe and appropriate use of equipment (including safety equipment) and reporting any safety issues appropriately.

The Trust Board, both directly and through its designated sub-committees will monitor performance against agreed health & safety objectives with any issues escalated where required.

Formal monitoring of the Trust's Safety Management System is undertaken through a variety of measures as mentioned above. A formal audit plan is also in place and outcomes are reported to and are monitored by the Trust Health, Safety & Fire Group and, as required, the Audit, Risk & Governance Committee and Trust Board.

This Health and Safety Policy Statement will be reviewed annually, or sooner should the need arise.

Peter Reading	**Jug Johal**
Chief Executive	**Director of Estates & Facilities**
Version: 11.7	**Reviewed & Re-issued**

The electronic master copy of this document is held by Document Control, Trust Secretary, NL&G NHS Foundation Trust.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)128

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Helen Harris, Director of Corporate Governance
CONTACT OFFICER	As above
SUBJECT	Trust Board Business Reporting Framework 2021/22
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The report provides the latest update of the Trust Board Reporting Framework 2021/22.

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

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

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

Trust Board - Business Reporting Framework

Agenda Item	Committee Oversight	Lead	Frequency	Approval	2021						2022				
					April	June	August	October	December	February	April	June	August	October	December
Business Items															
Declarations of Interest	N/A	Chair	Bi-monthly												
Chair's Opening Remarks	N/A	Chair	Bi-monthly												
Chief Executive's Briefing (to include Trust Priorities)	N/A	Chair	Bi-monthly												
Minutes of the Previous Meeting	N/A	Chair	Bi-monthly												
Trust Board Action Log	N/A	Chair	Bi-monthly												
Patient Story	N/A	Chief Nurse	Bi-monthly												
Staff Experience	N/A	Director of People	Bi-monthly		TBC										
Integrated Performance Report	All Committees	Director of Corporate Goverance	Bi-monthly												
Trust Board - Business Reporting Framework	N/A	Director of Corporate Goverance	Bi-monthly												
Register of Directors Interest and Fit & Proper Persons	N/A	Chair	Annual	✓											
Trust Strategy	N/A	Chief Executive	3 Yearly												
Strategic Objective 1 - To Give Great Care															
Executive Report - Quality & Safety	Q&SC	Executive Leads for Q&SC	Bi-Monthly												
Executive Report - Performance	F&PC	Executive Lead for Performance	Bi-Monthly												
Q&SC Highlight Report & Board Challenge	Q&SC	NED Chair of Q&SC	Bi-Monthly												
F&PC Highight Report & Board Challenge	F&PC	NED Chair of F&PC	Bi-Monthly												
Infection Control Annual Report	Q&SC	Chief Nurse	Annual												
Safeguarding Annual Report	Q&SC	Chief Nurse	Annual												
Annual Quality Account	Q&SC	Medical Director	Annual	✓											
Annual Establishment Review of Safe Staffing	Q&SC	Chief Nurse	3 times per year		Maternity Review		Inpatients Review		Community Review		Maternity Review		Inpatients Review		Community Review
Annual Complaints Report	Q&SC	Chief Nurse	Annual												
Quality Improvement Update	Q&SC	Chief Nurse	Twice Yearly												
Annual Review of Mental Health Strategy	Q&SC	Chief Operating Officer	3 yearly												
Strategic Objective 2 - To Be a Good Employer & Strategic Objective 5 - To Provide Good Leadership															
Executive Report - Workforce	WC	Director of People	Bi-monthly												
WC Highlight Report & Board Challenge	WC	NED Chair of WC	Bi-monthly												
Freedom to Speak Up Guardian Update	WC	Freedom to Speak Up Guardian	4 times a year		Q3	Q4 inc Annual	Q1		Q2		Q3	Q4 inc Annual	Q1		Q2
Gender Pay Gap Report	WC	Director of People	Annual												
Modern Slavery Statement	WC	Director of People	Annual	✓											
Equality & Diversity Strategy	WC	Director of People	3 yearly	✓											
People Strategy	WC	Director of People	3 yearly	✓											
Staff Survey	WC	Director of People	Annual												
Workforce Equality Standards Annual Report (WRES)	WC	Director of People	Annual												
Workforce Equality Disability Standards (WDES)	WC	Director of People	Annual												
Guardian of Safe Working Hours Annual Report	WC	Medical Director	Annual												

Agenda Item	Committee Oversight	Lead	Frequency	Approval	April	June	August	October	December	February	April	June	August	October	December
Strategic Objective 3 - To Live Within Our Means															
Executive Report - Finance	F&PC	Chief Financial Officer	Bi-monthly												
Executive Report - Estates & Facilities	F&PC	Director of Estates & Facilities	6 monthly												
Executive Report - Digital	F&PC	Chief Information Officer	6 monthly												
F&PC Highight Report & Board Challenge	F&PC	NED Chair F&PC	Bi-monthly												
Major Capital / Overarching Capital	F&PC	Chief Financial Officer	Annual												
Business Planning / CIP Timetable	F&PC	Chief Financial Officer	Annual												
Estates Strategy	F&PC	Director of Estates & Facilities	5 yearly	✓											
Digital Strategy	F&PC	Chief Information Officer	3 yearly	✓											
Operational & Financial Plan	F&PC	Chief Operating Officer	Annual	✓											
Annual Accounts - Delegation of Authority	AR&GC	Chief Financial Officer	Annual	✓											
Winter Plan	F&PC	Chief Operating Officer	Annual												
Strategic Objective 4 - To Work More Collaboratively															
Executive Report - Strategic & Transformation	TBC	Director of Strategic Development	Bi-monthly												
Clinical Strategy	F&PC	Director of Strategic Development	3 yearly												
HTFC Highlight Report & Board Challenge	HTFC	Chair of HTFC	Bi-monthly												
Governance															
AR&GC Highlight Report & Board Challenge	AR&GC	NED Chair of the AR&GC	4 times a year												
Fire Annual Report	AR&GC	Director of Estates & Facilities	Annual	✓											
Annual Accounts / Going Concern / Audit Letter / Annual Report & Annual Governance Statement	AR&GC	Various	Annual	✓											
LSMS Annual Report and Workplan and Security Annual Report	AR&GC	Director of Estates & Facilities	Annual	✓											
Emergency Preparedness, Resilience & Response Annual Report	AR&GC	Chief Operating Officer	Annual												
Health & Safety Policy Statement	AR&GC	Director of Estates & Facilities	Annual	✓											
Board Assurance Framework (BAF)	All Committees	Director of Corporate Goverance	4 times a year			Q4	Q1		Q2	Q3		Q4	Q1		Q2
Board Assurance Framework - Deep Dive	N/A	Executive Team	Bi-monthly												
Trust Constitution & Standing Orders	Trust Board & COG	Director of Corporate Goverance	3 yearly												
Trust Scheme of Delegation and Powers Reserved for the Trust Board / Standing Financial Instructions	AR&GC	Chief Financial Officer	3 yearly	✓											
Audit Committee Annual Report	AR&GC	NED Chair of AR&GC	Annual	✓											
Risk Management Strategy	AR&GC	Medical Director	3 Yearly (next 2024)	✓											
Timetable of Board & Sub-Committee Meetings	All Committees	Director of Corporate Goverance	Annual	✓											
Review of the Protocol for Matters Reserved for Private Meetings	N/A	Director of Corporate Goverance	Annual	✓											
Annual Reports															
Review of Trust Board, Board Assurance Sub-Committees & Approval of Changes to Terms of Reference	All Committees	Chair, Vice Chair & Chairs of Sub-Committees	Annual	✓											
Board Development Programme	N/A	Chair	Annual												
Items for Information															
Communications Round-Up	N/A	Associate Director of Communications	Bi-monthly												
Guardian of Safe Working Hours	WC	Medical Director	4 times a year		Q3	Q4	Q1		Q2		Q3	Q4	Q1		Q2

Agenda Item	Committee Oversight	Lead	Frequency	Approval	April	June	August	October	December	February	April	June	August	October	December
Documents Signed Under Seal	N/A	Director of Corporate Goverance	Quarterly												
Sub-Committee Minutes - Public & Private	All Committees	NED Chairs	Bi-monthly												
Patient Experience Report incorporating Annual inpatient survey result and action	Q&SC	Chief Nurse	4 times a year		Q3	Q4	Q1		Q2		Q3	Q4	Q1		Q2
Executive & Non-Executive Director Statutory & Other Lead Roles	N/A	Vice Chair / Director of Corporate Governance	Annual												
Medical Appraisal and Revalidation Annual Report (AOA)	WC	Medical Director	Annual												
Review of Board Performance & Effectiveness	N/A	Chair	Annual												
Other															
Trust Board Self-Certification	N/A	Chair	Annual in May												

Items for Trust Boards - Guidance for Papers				
Title	**Description**	**Frequency**	**Source**	**Action**
Adult & Child Safeguarding Annual Report	The purpose of the report is to provides assurance that Trust is compliant with safeguarding duties. To update the Trust Board on safeguarding activity, issues and risks.	Annually	There are multiple sources but the link below is fairly comprehensive. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper#hide14	Assurance
Annual Emergency Planning Position & Plan - EPRR Self-Assessment Assurance Report	The purpose of this document is to provide guidance to organisations completing the EPRR annual assurance process by: providing an overview of the Core Standards for EPRR outlining roles and responsibilities of the organisations involved defining the participating organisations setting out the EPRR annual assurance process. The Civil Contingencies Act 2004 and the NHS EPRR Framework requires NHS Acute organisations to plan for, respond to and recover from major incidents. The purpose of this paper is for information purposes detailing the work of the Emergency Planning Team.	Annually	Annually, NHS England issues a set of EPRR Core Standards on which the trust has to complete a self assessment. https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-annual-assurance-guidance-v1.pdf	Incorporated within the Annual Report
Annual Plan / Draft Operational & Financial Plan	NHS Operational Planning and Contracting Requirements	Annually	See NHS Operational Planning and Contracting Guidance 2021/22 https://www.england.nhs.uk/operational-planning-and-contracting/	Approval
Annual Quality Account	Improving quality in organisations: All organisations should implement plans to improve quality of care, particularly for organisations in special measures; drawing on the NQB's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services; and participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare. To formally adopt the Quality Account in public session.	Annually	See page 7 of https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmwrk.pdf	Assurance
Annual Report and Accounts including Annual Governance Statement and Quality Report	The Department of Health and Social Care (DHSC)'s Group Accounting Manual (GAM) requires NHS trusts to include an annual governance statement (AGS) in their annual report.	Annually	https://improvement.nhs.uk/resources/nhs-foundation-trust-annual-reporting-manual/ https://improvement.nhs.uk/resources/quality-accounts-requirements/	Assurance
Annual Report from the Director of Infection Prevention and Control	The purpose of this report is to inform and provide assurance to the trust Board, patients, public and staff of the processes in place at NLAG to prevent and control healthcare associated infections (HCAI). To provide an update on the Trust's Infection Prevention & Control activities and information on actions in place	Annually	Health and Social Care Act (2008) : Code of Practice for the NHS on prevention and control of healthcare related guidance. https://www.nice.org.uk/guidance/ph36/chapter/Quality-improvement-statement-1-Board-level-leadership-to-prevent-HCAIs	Approval
Audit Committee Annual Report	To provide assurance to the Trust Board that the Audit Committee is functioning in accordance with its Terms of Reference and in line with the requirements of the NHS Audit Committee Handbook	Annual	In line with the requirements of the NHS Audit Committee Handbook (HFMA) and contributes to the Annual Governance Statement.	Approval
Caldicott Guardian Annual Report	To advise the Board of work undertaken by and in support of the Caldicott Guardian during the preceding year	Annual	The Caldicott Guardian is appointed by the Trust Board and The Caldicott Guardian has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and issues at Board Level, and wherever appropriate within the Trust's overall governance framework.	Assurance
Delivering a Net Zero Health Service	The Publication of the Delivering a Net Zero Health Service for NHS in October 2020 set a mandatory framework for NHS organisations. This includes sustainability indicators reported nationally through systems, such as the Greener NHS Dashboard and produce a Green Plan to be approved byt the Board along with an annual summary of progress towards net zero.	Annual	Carbon Reduction forms part of Annual Report and Accounts. Annual sustainability reporting is now mandated for clinical commissioning groups (CCGs) and trusts by the NHS Standard Contract (Service Condition 18). See Page 45 of this link. https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf	Assurance
Flu Vaccination Information	In order to ensure your organisation is doing everything possible as an employer to protect patients and staff from seasonal flu we ask that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of 2018.	Annually		Noting
Freedom to Speak up Guardian Reports including Annual Report	The report provides an update from the Trusts Freedom to Speak Up Guardian in relation to any national or local developments relating to Raising Concerns or Whistleblowing. To provide thematic reporting to the Board on the themes and issues that are being reported to the FTSUG. The Trust Board is responsible for setting the culture and tone of the organization and in line with the Trust's values of openness, compassion and learning.	6 Monthly	Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts .https://improvement.nhs.uk/documents/2468/Freedom_to_speak_up_guidance_May2018.pdf The requirement for NHS organisations to establish a Freedom to Speak Up Guardian (F2SUG) arose from the recommendations made by Sir Robert Francis in his report into failings at Mid Staffordshire Hospitals NHS Foundation Trust. There is also an expectation that the F2SUG will report directly to the Chief Executive Officer and the Trust Board on the issues that are being reported to them.	Approval
Health and Safety Risk Management Annual Report	HSE Gudance sets out an agenda for the effective leadership of health and safety. It is designed for use by all directors, governors, trustees, officers and their equivalents in the private, public and third sectors. Provided primarily for assurance given the overall responsibility of the Trust Board for Health & Safety in the organisation and the potential individual and corporate consequences of health and safety breaches.	Annually	Various requirements See link https://www.hse.gov.uk/pubns/indg417.pdf	Assurance
High Level Risk Register	To inform the Board of the Trust's highest rated risks which are currently logged on the Corporate Risk Register.	Three times per year	This quarterly report is included as part of the Board reporting framework.	Assurance
Information Governance/Cyber Security reporting	Data Security and Protection Toolkit. Information Governance is a key component of the Trust's governance framework and has regulatory consequences if requirements are not adhered to.	Annually	Some general reference to the Board but does not include specifc board reporting requirements https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit	Assurance
Medical Appraisal and Revalidation Annual Report - Annual Organisational Audit	This Report provides information about the medical appraisal and revalidation system and processes over the year, highlighting key issues and action being taken to respond to them. Revalidation is a statutory obligation with which the Trust must comply. Reports provide assurance that requirements are being met and that governance arrangements are robust.	Annually	A Framework of Quality Assurance for Responsible Officers and Revalidation https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/04/fqa.pdf	Assurance

Title	Description	Frequency	Source	Action
Mortality (SHMI and HSMR) Update	Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals". This was reinforced by the recent findings of the Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning. Understanding and tackling this issue will not be easy, but it is the right thing to do. There will be legitimate debates about deciding which deaths to review, how the reviews are conducted, the time and team resource required to do it properly, the degree of avoidability and how executive teams and boards should use the findings. This first edition of National Guidance on Learning from Deaths aims to kickstart a national endeavour on this front. Its purpose is to help initiate a standardised approach, which will evolve as we learn. Following the Learning from Deaths conference on 21st March 2017 we will update this guidance to reflect the collective views of individuals and organisations to whom this guidance will apply to ensure that it is helpful. To monitor the Trust's mortality performance.	Various	National Guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These add new mandatory disclosure requirements relating to 'Learning From Deaths' to quality accounts from 2017/18 onwards. These new regulations and the explanatory memorandum are available at http://www.legislation.gov.uk/uksi/2017/744/introduction/made.	Noting
NHS Provider Licence Self-Certification	NHS foundation trusts and trusts must self-certify that they can meet the obligations set out in the NHS provider licence. The licence includes requirements to comply with NHS acts and constitution, and with governance requirements. NHS foundation trusts designated to provide commissioner requested services are also required to complete a self-certification on the availability of resources to deliver those services.	Annually	The NHS Provider Licence https://improvement.nhs.uk/resources/self-certification-guidance-nhs-foundation-trusts-and-nhs-trusts/ NHS foundation trusts and trusts must self-certify that they can meet the obligations set out in the NHS provider licence. The licence includes requirements to comply with NHS acts and constitution, and with governance requirements. NHS foundation trusts designated to provide commissioner requested services are also required to complete a self-certification on the availability of resources to deliver those services.	Assurance
NHS Resolution Maternity Incentive Scheme	Self Declaration	Annually	https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf	Assurance
NHS Staff Survey Report and Action Plan	Provides an overview of the annual NHS National Staff Survey. The report is to provide assurance regarding engagement, quality and people management matters across the Trust.	Annually		Noting
Ockenden	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.	3 monthly to Q&SC & 4 monthly to Trust Board	https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf	Assurance
Patient Experience Report incorporating Annual inpatient survey result and action, and Annual Complaints Report	Quarterly reports collating the various sources of patient feedback are produced by the Patient Experience Team.	Three times per year & Annually	Patient experience information supports the CCG in making decisions about local health services. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 statutory instrument 309 requires NHS bodies to provide an annual report on its complaints handling, which must be available to the public. To provide the Board with oversight around the management of complaints following the report of the Chief Inspector of Hospitals Inspection.	Assurance
Quarterly Report from the Guardian of Safe Working Hours – This is a requirement of the Junior Doctors contract Ts&Cs	The 2016 junior doctors contract (Schedule 6, para 11) requires the Guardian of Safe Working an overview and assurance of the trusts compliance with safe working hours for doctors across the trust and to highlight and detail any areas of concern. The report is to demonstrate the work of the Guardian in championing safe working hours in the trust to ensure the protection of patients and doctors.	Quarterly	See Page 35 https://www.nhsemployers.org/-/media/Employers/Documents/Need-to-know/Terms-and-Conditions-of-Service-for-NHS-Doctors-and-Dentists-in-Training-England-2016-Version-2--30-March-2017.pdf	Assurance
Research and Development Annual Report	Sets out the strategic objectives, how the strategy is delivered, benchmarking data and provides commentary arou	Annual	Research, development and innovation are fundamental to excellence in healthcare which is one of the guiding principles of the NHS as set out in the NHS Constitution. The Trust is required to demonstrate adherence to national guidance and current legislation.	Noting
Risk Management Strategy	To approve Strategy Updates	Annual	The management of risk underpins all strategies, processes and activities that lead to the achievement of the aims and objectives of the Trust.	Approval
Safer Staffing and Expectations relating to nursing, midwifery and care staffing capacity and capability	It is an expectation set out in the National Quality Board that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability. Boards are actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made. Boards monitor staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift-to-shift basis, versus planned staffing levels. They examine trends in the context of key quality and outcome measures. They ask about the recruitment, training and management of nurses, midwives and care staff and give authority to the Director of Nursing to oversee and report on this at Board level.	6 monthly	NQB guidance published in November 2013 (http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf) - page 7. It is a national requirement that a staffing assessment is submitted twice a year in order that the Board is aware of the Trust's position against national guidance and can take action where appropriate.	Approval
Timetable of Board and Committee Meetings	To approve the annual timetable of Board and Committee meetings for the year ahead	Annual	As part of the overall governance structure for the organisation	Noting
Workforce Race Equality Standard (WRES) Action Plan & Workforce Disability Equality Standard (WDES)	To enable organisations to compare their performance with others in their region and those providing similar services, with the aim of encouraging improvement by learning and sharing good practice.To provide a national picture of WRES in practice, to colleagues, organisations and the public on the developments in the workforce race equality agenda. To inform the Board of the work of Equality and Diversity throughout the Trust and progress in relation to the actions in the Equality and Diversity System2.	Annually	The Trust is required, by the Equality Act 2010, to eliminate discrimination, victimisation and harassment, advance equality of opportunity and foster good relations between different groups and required to publish Equality. To ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the work place - aligned to the strategic objective to be an employer of choice	Assurance

Update Reports shared through Executive and Non-Executive Director Highlight Reports		
Committee & Report Update	**Update included within Executive Report**	**Update included within NED Chair Report**
Quality & Safety Committee		
Nursing Assurance Report	X	
Serious Incident Report	X	
Mortality Update	X	
CQC Update (to include costs when required)	X	
Medicines Management Annual Report		X
Delivery of Mixed Sex Accommodation - Annual Declaration of Compliance to Trust Board		X
CNST & Ockeden (Maternity) (Four Monthly)	X	
Patient Experience Analysis Quarterly Report		X
Caldicott Annual Report	X	
Research and Development Annual Report		X
Medical Appraisal and Revalidation Annual Report (AOA)		X
Mental Health Strategy Progress Update	X (Yearly)	
Workforce Committee		
Annual Organisational Audit (AOA)		X
Flu Vaccination Update Rates		X
Flu Vaccination Self-Assessment		X
Self Assessment Review - Health Education England	X	
Freedom to Speak Up Strategy		X
People Strategy Progress Update	X (Yearly)	
Equality & Diversity Progress Update	X (Yearly)	
Audit, Risk & Governance Committee		
Risk Management Strategy Progress Update	X (Yearly)	
Information Governance/Cyber Security Reporting (IG Toolkit)	X (Yearly)	
Local Counter Fraud Specialist Annual Report		X (private board - item for information)
Chief Executive Reporting		
Approval of CQC Statement of Purpose	X	
Trust Strategy Progress Update	X (Yearly)	
Finance & Performance Committee		
Digital Strategy Progress Update	X (Yearly)	
Estates Strategy Progress Update	X (Yearly)	
Other		
Trust Constitution & Standing Orders	X (When Required)	
Clinical Strategy Progress Update	X (When Required)	
High Level Risk Register	X (3 times per year)	

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)129

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Dr Peter Reading, Chief Executive Ivan McConnell, Director of Strategic Development
CONTACT OFFICER	Helen Harris, Director of Corporate Governance
SUBJECT	Committees in Common Terms of Reference - Humber Acute Strategic Development Committee
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Executive Team Meeting Chair
EXECUTIVE SUMMARY	1. The purpose of the report is to request that the Board appoints a new Committee, namely the Humber Strategic Development Committee. • There is a requirement for a decision-making forum at Board level, for both NLaG and HUTH. • A Committees in Common approach is recommended to promote collaborative working. • Legal advice has been sought and used to inform the terms of reference presented for approval. • The HUTH Board approved the HUTH Committee Terms of Reference at its meeting on 11 May 2021. 2. The NLaG Committee TOR has been enhanced in the areas of authority, decision making, chairing the meeting in the absence of the Trust Chair, and the delegated decisions. It is recommended that the Trust Board: • Appoints a new committee, 'Humber Acute Strategic Development Committee'. • Approves the Terms of Reference, attached at Appendix 1, and associated delegated authority.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	**a) Description of Strategic Objective 1 – 1.3:** To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. **Risk to Strategic Objective:** The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable. **b) Description to Strategic Objective 3 - 3.2:** To secure adequate capital investment for the needs of the Trust and its patients. **Risk to Strategic Objective:** The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades. **c) Description to Strategic Objective 4:** To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. **Risk to Strategic Objective:** The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment. **d) Description to Strategic Objective 5**: To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. **Risk to Strategic Objective:** The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

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

Northern Lincolnshire & Goole NHS Foundation Trust (NLAG)
Trust Board

Committees in Common - Humber Acute Strategic Development Committee

1. Purpose of the Report
The purpose of the report is to request that the Board appoints a new Board Committee to support collaborative working with Hull University Teaching Hospitals NHS Trust.

2. Background
To support the ongoing work of the Humber Acute Services Review, NLaG and HUTH CEO's and Chair recommend implementing a governance structure that will ensure that they have single focussed discussions on major areas of service change.

Following legal advice, it was recommended that these discussions take place in Committees in Common (CiC). This would be two Committees meeting at the same time in the same room, or virtual meeting. The terms of reference are virtually the same, with the exception of Membership and Section 1.9 to reflect the different legal requirements of a Foundation Trust and a NHS Trust.

The ultimate decisions on any future action will be governed by the relevant guidance and legislation for each organisation. To facilitate this, as part of the agenda, each Committee would meet separately for a section of the meeting to agree decisions pertaining to that Trust.

3. Terms of Reference
The draft Terms of Reference are attached at Appendix 1.

The terms of reference were drafted initially by the Director of Corporate Governance and Director of Strategic Development. This draft was then shared with the Chair and CEOs of both organisation prior to being finalised by a working group of the Director of Corporate Governance, Director of Strategic Development, Director of Strategy and Planning (HUTH) and Director of Quality Governance (HUTH). These are based on a standard legal template for CiC and adapted to meet the functions required of these committees.

The core responsibilities of the CiC are detailed below:

The NLaG Committee and HUTH Committee, acting through the CiC, will provide assurance, advice and guidance and take decisions on behalf of the relevant Boards of both NLaG and HUTH on:

- The design and delivery of the HAS Programme
  - Programme 1 – Interim Clinical Plan
  - Programme 2 – Core Service Change – UEC / Maternity and Paediatrics and Planned Care/Diagnostics
  - Programme 3 – Strategic Capital.

- This will include ensuring:

    - There is effective oversight of work stream interdependencies and a balanced approach that maximises the potential of each Place while optimising overall delivery across the Humber geography

    - Proposed out of hospital pathway changes are aligned with the programme outputs and contribute to the delivery of new ways of working

    - Alignment of capital funding bids to programmes of change – seeking to maximise success

    - The work undertaken in Programmes 1 and 2 underpins the development of our joint Strategic Outline Case for major capital investment within both NLaG and HUTH

    - The work programmes lead to improved strategic workforce planning addressing system wide skills gaps, more integrated and inter operable ICT, more integrated diagnostics improving patient access and outcomes

    - Where appropriate that resources are pooled for delivery of services.

4. NLaG Committee

Since the approval of HUTH Committee TOR at its Board meeting on 11 May 2021, the TOR for the NLaG Committee has been enhanced to further strengthen:

- the authority of the committee (TOR section 2.3)

- decisions reserved to the Trust Board of NLaG (TOR section 2.4)

- chairing of the meeting in the absence of the Trust Chair (TOR section 5.1.3)

- delegated decision to the NLaG Committee (TOR Appendix A).

The HUTH Board will be asked to consider the amendments made to the NLaG Committee and in turn may require its HUTH Committee TOR to be amended to reflect the changes made.

5. Recommendation

It is recommended that the Trust Board:

- Appoints a new committee, ‘Humber Acute Strategic Development Committee’.

- Approves the Terms of Reference, attached at Appendix 1, and associated delegated authority.

Helen Harris
Director of Corporate Governance
June 2021

Northern Lincolnshire and Goole NHS Foundation Trust

Chief Executive's Office

TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER TRUSTS (NLAG COMMITTEE)

Reference:	
Version:	1.0
This version issued:	
Result of last review:	N/A
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Trust Board
Date for review:	June, 2022
Owner:	Peter Reading, Chief Executive
Document type:	Terms of Reference
Number of pages:	9 (including front sheet)
Author / Contact:	Helen Harris, Director of Corporate Governance

Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

1.0 Introduction and Purpose

1.1 The following definitions will apply in this Terms of Reference:

NLaG:	Northern Lincolnshire and Goole NHS Foundation Trust
NLaG Committee:	The Committee established by NLaG to meet in parallel with the committee established by HUTH
HUTH:	Hull University Teaching Hospitals NHS Trust
HUTH Committee:	The Committee established by HUTH to meet in common with the committee established by NLaG

1.2 NLaG and HUTH are implementing a governance structure which will ensure that they have single focussed discussions on major areas of service change. These discussions would take place in the Committees in Common (CiC). The ultimate decisions on any future action would be governed by the relevant guidance and legislation for each organisation.

1.3 The principal focus of the CiC would be to discuss and agree actions in relation to major areas of potential service change. This relates in particular to the work that is being undertaken within a number of programmes of work including:

- Humber Acute Services (HAS)
- Collaborative of Acute Providers (CAPs)
- Integrated Care System (ICS) and Integrated Care Partnership (ICP) developments
- Strategic Capital applications via the ICS.

1.4 The NLaG Committee and HUTH Committee, acting through the CiC, will provide assurance, advice and guidance and take decisions on behalf of the relevant Boards of both NLaG and HUTH on:

- The design and delivery of the HAS Programme
  - Programme 1 – Interim Clinical Plan
  - Programme 2 – Core Service Change – UEC / Maternity and Paediatrics and Planned Care/Diagnostics
  - Programme 3 – Strategic Capital.
- This will include ensuring:
  - There is effective oversight of work stream interdependencies and a balanced approach that maximises the potential of each Place while optimising overall delivery across the Humber geography.
  - Proposed out of hospital pathway changes are aligned with the programme outputs and contribute to the delivery of new ways of working
  - Alignment of capital funding bids to programmes of change – seeking to maximise success

- The work undertaken in Programmes 1 and 2 underpins the development of our joint Strategic Outline Case for major capital investment within both NLaG and HUTH
- The work programmes lead to improved strategic workforce planning addressing system wide skills gaps, more integrated and inter operable ICT, more integrated diagnostics improving patient access and outcomes
- Where appropriate that resources are pooled for delivery of services.

1.5 NLaG and HUTH have both agreed to establish a committee, which shall meet simultaneously with the corresponding committee from the other trust, but which will each take decisions separately on behalf of their own trust. This will be called the Humber Acute Strategic Development Committees.

1.6 The two Trusts have each decided to adopt terms of reference, in the same form, with the exception that membership of the committees may be different.

1.7 The NLaG Committee shall work co-operatively with the HUTH Committee.

1.8 The Trusts have entered into a Joint Working Agreement on [x and x xxxx 2021] and agree to operate their committees in line with the Joint Working Agreement.

1.9 Under paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006, the constitution of a Foundation Trust may provide for any of the powers exercisable by the Board of Directors on behalf of the Foundation Trust to be delegated to a committee of its directors. Section 32 – Appointment of Committees and Sub Committees, of the Standing Orders of the Trust Board provides that: "Subject to SO 33.0, the board may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee."

2.0 Authority

2.1 NLAG's Trust Board has agreed to establish and constitute a Committee to be known as the Humber Acute Strategic Development Committee (the NLaG Committee).

2.2 The NLaG Committee and HUTH Committee are authorised by the Boards of NLaG and HUTH to investigate or have investigated any activity within their terms of reference.

2.3 The NLAG Committee will make decisions over all matters set out in Section 1.3, 1.4 and Appendix A.

2.4 Decisions reserved to the Trust Board of NLaG

2.4.1 The following functions are reserved to the Board of Directors of NLaG (albeit that this shall not fetter the ability of NLaG to delegate such functions to another Committee or person):

a) The reserved matters set out in Section 1.3, 1.4 and Appendix A.

2.4.2 Notwithstanding paragraph 2.4.1 above, any functions not delegated to the NLaG Committee in Section 1.3, 1.4 and Appendix A of these terms of reference shall be retained by the NLaG Trust Board in line with its Scheme of Delegation and Schedule of Matters Reserved to the Board of Directors.

3.0 Accountability and Reporting Arrangements

3.1 The minutes of the NLaG Committee meetings shall be formally recorded by the Director of Corporate Governance and presented to the NLaG Trust Board with update reports as required.

4.0 Responsibility of Members and Attendees

4.1 Members of the Committees have a responsibility to:

- be guided by and act consistently with the Seven Principles of Public Life
- act as 'champions' and lead by example (reflecting the Trusts' values), disseminating information, agreements and good practice as appropriate
- adhere to the principles of collective decision making. [**Note:** Where concerns regarding decisions may exist, members have a responsibility to ensure these concerns are aired at the time of the decision so that they can be discussed and resolved and/or recorded.]
- ensure that when matters are discussed in confidence at the meeting, such confidences are maintained
- declare any conflicts of interest / potential conflicts of interest in any of the agenda items in accordance with Trust's policies and procedures
- attend at least 80% of meetings, having read any papers in advance.

5.0 Membership

5.1 Core Membership

5.1.1 The NLaG Committee will include the following members:

- Trust Chair[1]
- Chief Executive
- One Non-Executive Director
- Chief Operating Officer
- Director of Strategic Development (Non-Voting)
- Chief Financial Officer
- Chief Nurse

[1] Who is also Chair of HUTH

- Medical Director

5.1.2 The Chair of the NLaG Committee is the Trust Chair. In the absence of the Trust Chair, the Non-Executive Director will be asked to chair the meeting.

5.1.3 When the NLaG Committee meets in common with the HUTH Committee, and in the absence of the Trust Chair, then one Non-Executive Director (in consultation with NLaG and HUTH Chief Executives) from each of the NLaG Committee and the HUTH Committee shall chair and run the meeting on a rotating basis.

- For relevant items (for example the agreement of common standards) the Chair of the NLaG Committee shall ensure there is appropriate expert advice (e.g. Director of Estates & Facilities, Director of People, Chief Information Officer) available to the Committee

5.1.4 Where members of the meeting are unable to attend, a suitable deputy can be nominated to attend, as appropriate, and at the discretion of the Chair.

5.2 Other Persons Attending Meetings

5.2.1 Other Executive and Non-Executive Directors may be requested to attend specific meetings of the Committee.

5.2.2 All Non-Executive and Executive Directors who are not members of the Committee will be free to attend all meetings of the Committee.

5.2.3 The Committee may, from time to time and as the agenda dictates, require attendance from other Senior Officers of the Trust not mentioned above.

5.3 For the avoidance of doubt, such attendees shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of the NLaG Committee.

5.4 The Chair of the NLaG Committee may at their discretion permit other persons to attend its meetings, but for the avoidance of doubt, any persons in attendance at any meeting of the NLaG Committee shall not count towards the quorum or have the right to vote at such meetings.

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings of the NLaG Committee shall be set before the start of the financial year.

6.1.2 Meetings will normally take place bi-monthly. However, the Chair of the Committees may increase this frequency or call extraordinary meetings where a delay in decision-making could impact on the HAS Programme.

6.1.3 The secretary will administer the meeting including making arrangements for the meeting and for the provision of formal minutes after the meeting. The draft minutes and action log shall be circulated two working days after the meeting. The draft agenda shall be developed by the Secretary and agreed by the NLaG Committee Chair at least 10 clear days before the next NLaG Committee meeting.

6.1.4 A risk register will be developed for the Committee, risks and mitigations will be captured and managed by each Trust's Board of Directors.

6.1.5 All final NLaG Committee reports must be submitted five clear days before the meeting.

6.1.6 The agenda and supporting papers shall be forwarded to each member of the NLaG Committee and planned attendees not less than three clear days before the date of the meeting. In exceptional or urgent circumstances, a shorter period may be acceptable, at the discretion of the Committee Chair.

6.2 Quorum

6.2.1 A meeting of the NLaG Committee will be deemed to be quorate when there is attendance by at least one Non-Executive Director and also three voting Executive Directors] ensuring appropriate input into the meeting.

6.2.2 When considering if the meeting is quorate, only those individuals who are members can be counted; other attendees cannot be considered as contributing to the quorum.

6.3 Voting

6.3.1 Each member of the NLaG Committee shall have one vote.

6.3.2 The NLaG Committee shall reach decisions by a simple majority of members present, but with the Chair of the Committee having a second and deciding vote, if necessary.

6.3.3 If any member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum.

6.4 Review

Terms of Reference will normally be reviewed annually.

7.0 Equality Act (2010)

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

7.2 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.

7.3 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.

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

The electronic master copy of this document is held by Document Control, Director of Corporate Governance, NLaG NHS Foundation Trust.

Appendix A – Decisions of the NLAG Committee

Type of Decision	Delegated to the NLAG Committee	Reserved for NLAG Trust Board of Directors
Strategy	Decisions arising from the Northern Lincolnshire and Hull Hospitals Clinical Services Strategy (e.g. on future service configuration and pathways of care)	NLAG Clinical Strategy
	Decisions on any relevant common Northern Lincolnshire and Hull Hospitals clinical standards, procedures or protocols – reflecting National Standards, Royal College Guidance and NHSE/I Guidance (e.g. GIRFT)	NLaG Quality Standards
	Consideration between HUTH and NLAG on the design and delivery of the key workstreams within the HAS Programme • Programme 1 – Interim Clinical Plan • Programme 2 – Core Service Change – UEC / Maternity and Paediatrics and Planned Care/Diagnostics • Programme 3 – Strategic Capital. To include consideration of: • Clinical pathways and models of care • Strategic workforce planning • Strategic finance planning • Impact analysis – equalities/health economy • Linkages to emerging Place Based Partnerships	Recommendation to the Board for consideration of "significant service change" in accordance with s 242/244 of the NHS Act 2006 and s14z2 of the 2012 NHS Act
	Consideration on any common large-scale strategic projects (e.g. digital, HASR) that are delegated to it by the Board, to include: • Potential investment options and partnerships • Affordability • Sustainability • Delivery of our role as Anchor Organisations supporting the delivery of economic regeneration, inward investment and employment.	Recommendations to the Board for significant capital investment
Finance	Consideration of any Northern Lincolnshire and Hull Hospitals capital investment plans for significant change, to include: • Capital options appraisal: PCBC, SOCs, OBCs and FBCs • Revenue implications of the cost of capital • Deliverability • Sustainability	NLAG Capital Plan / Medium & Long Term Plan Recommendation to the Board on significant capital investment

Workforce	Consideration on proposals to establish joint teams or joint senior appointments across fragile and vulnerable specialties. (Alignment with the agreed intra-Trust appointments process will be required through the Remuneration and Terms of Service Committee or its equivalent for Agenda For Change posts)	Recommendation to the Board of any potential joint Leadership positions
	Consideration on any joint workforce strategy of the two trusts, ensuring appropriate alignment with the national People Plan and the HCV HCP Plan.	Recommendation to the Board of any potential joint Leadership positions

NLG(21)130

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Terry Moran, Chair
CONTACT OFFICER	As above
SUBJECT	Board Performance & Reflection – April 2021
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The Report provides overall feedback from the meeting held on the 6 April 2021

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	To provide strong leadership (Strategic Objective 5)				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

TRUST BOARD – REVIEW OF MEETING
(ratings 1 to 4: 1 = low/poor, 4 high/good)

Date of Meeting: Tuesday, 6 April 2021

Business Conduct		**Rating (1-4)**				**Comments**
		1	**2**	**3**	**4**	
1	How effective was the new agenda style (ie. by Strategic Objective)?		**1**	**5**	**2**	• It will perhaps take some time to become familiar but I felt that it covered the territory effectively and logically. • Yes this gives it some focus and is certainly heading in the right direction, although some things fit across more than one objective. • I think the structure is great. • Clear and provided forum for effective debate, facilitating a very busy agenda.
2	Did the Board focus on the appropriate agenda items?		**1**	**5**	**2**	• Yes I think so, but I will feel better about this once the annual cycle of business has been concluded and the structure between board/sub-committees agreed. • Still believe there are items for information which have been replicated by presentation at sub-committees.
3	Where appropriate, were relevant items debated at the relevant Board Assurance Sub-Committee prior to being submitted to the Trust Board?	**1**	**1**	**4**	**2**	• Too much repetition of items covered in sub-committees. Clearly a lack of confidence in governance structures in some quarters. • I don't know – unable to say. I am hoping that this will become clearer for me now that I am clear that the Sub-committees are NED lead and assurance to hold the

						executives to account. I am used to a more collaborative way of working within the sub-committees, so this is learning for me.
4	How effective were the new style of reports from the Executive Directors?	1	**2**	**4**	**1**	• The report from the COO was very good and should be used as an exemplar for the others. The 'highlights' & 'lowlights' categories provided a balanced coverage. • Generally poor – too little exception reporting, too long. • Still no guidance/consistency of what is required. I did 15, others did 2. Happy to follow whatever format is required. I will do shorter highlight reports moving forward. • Very variable. Some very good, others not so. • Much better. However in papers that have been considered by Committee these should where possible be marked as for information only. If not the case, any debate should either be restricted to the content of an executive summary or summarised by the Committee Chair**.**
5	Were you satisfied with the overall quality of papers from all Executive and Non-Executive Directors?		**2**	**4**	**2**	• Yes. • Generally poor – too little exception reporting, too long. • I would prefer consistency of approach, but this I accept may not be possible. • Prefer more focus on Executive Summary.

6	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.			**3**	**1**	• The report from the COO was very good and should be used as an exemplar for the others. The 'highlights' & 'lowlights' categories provided a balanced coverage. • Strategy paper was brief and to the point. • No. • The paper presented by the Acting COO was well laid out and easy to follow. • Performance. • Finance report (078) restricted to one page Exec summary with associated appendixes. • The one from the Deputy Coo on operational issues was very clearly presented.
Meeting conduct & timing		**1**	**2**	**3**	**4**	**Comments**
7	Did the tone and conduct of the meeting feel that you were able to contribute constructively?		**1**	**2**	**5**	• I increasingly feel NED input and challenge is not appreciated. Responses leave items open to an extent. • Yes I always feel I am given the opportunity to contribute by the chairman.
8	How effective was the chairing of the meeting? Please include a comment if required.			**1**	**7**	• I was very impressed with the Chair's calm and measured approach to some inputs. • The Chair does an excellent job of chairing board meetings made difficult during this transition period whilst we are clear about how the board will operate and given that it is virtual.
9	Was the length of the meeting appropriate?			**6**	**2**	• Yes moving in the right direction. • Still too ambitious in terms of content and resultant timings.

10	Any Other Comments: • I really would like to see more structure moving forward. I made comment at board development session. Report requests are last minute, discussions take place without the executive director and not sure what is and is not required at the board. I do hope that getting the annual cycle of business will assist with this.

NLG(21)131

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Neil Gammon, NED / Chair of F&P Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	Finance & Performance Committee – Minutes of meetings held on 24 February and 31 March 2021
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee – Minutes approved at the meetings held on 31 March & 28 April 2021.
EXECUTIVE SUMMARY	Minutes of the Finance & Performance Committee held on 24 February & 31 March 2021.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	BAF Risk 6				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **24 February 2021 – via Teams**

PRESENT:		
	Neil Gammon	Non-Executive Director / Chair of F&P Committee
	Andrew Smith	Non-Executive Director
	Stuart Hall	Associate NED, NLAG / Vice Chair, HUTH
	Peter Reading	Chief Executive
	Linda Jackson	Vice Chair, NLAG / Associate NED, HUTH
	Lee Bond	Chief Financial Officer
	Shaun Stacey	Chief Operating Officer
	Jug Johal	Director of Estates & Facilities
	Brian Shipley	Deputy Director of Finance
	Ian Reekie	Lead Governor
	Simon Tighe	Deputy Director of Estates & Facilities (For Items 5.2 & 11.3)
	Anne Barker	Finance Admin Manager (Minutes)

PRIVATE AGENDA ITEMS

Item 1 02/21 **Apologies for Absence**

Apologies for absence were noted from Ivan McConnell; Helen Harris; and Maria Wingham. It was also noted that Lee Bond would be late joining due to attending a HUTH meeting.

Item 2 02/21 **Declarations of Interest**

There were no declarations of interest made.

Item 5 02/21 **Presentations for Assurance**

5.2 Site Security and Car Parking Services

Simon Tighe presented the report which sought approval to award a contract to Bidvest Noonan for Site Security and Car Parking for a 5 year contract term with an option to extend for a further 2 years. The total contract value is £9.58m for the 7 years.

Simon Tighe explained that a full tender exercise had been undertaken with six bids returned with only two compliant; the incumbent supplier, ISS Mediclean did not tender. A full tender analysis was undertaken with E&F and Finance Directorate colleagues and Simon Tighe thanked the finance team for the work in the background.

Simon Tighe explained that through this investment the Trust will secure an upgrade to the CCTV system which will help enhance public and staff safety.

Linda Jackson noted the good news on the level of investment in the contract but asked for clarification on the 5yrs+2yrs contract and the capital over the contract term with a reduced annual financial impact and asked if this was based on 5 years or 7 years. Simon Tighe explained that this would be paid back over five years but if was decided to extend the contract for the additional two years the sum would be £9.58m.

Jug Johal added that the improvements to the CCTV systems would help protect staff from violence and aggression. He noted that the car park income is additional revenue and he fully supported the report and the recommendation to the Committee to approve and recommend it to the Trust Board for final approval.

Option two within the report proposed extending with the incumbent provider for a further 12 month period which Jug Johal did not feel comfortable with given that they did not bid for the new tender. It was noted that ISS did not bid as they stated that it was a non-profitable contract.

Stuart Hall noted that it was not an insignificant contract and asked if the Committee could have sight of the scoring mechanism. Simon Tighe explained that it was included as an Appendix and it was agreed to provide the scoring mechanism as an addendum to the private F & P minutes.

Action: Anne Barker

Brian Shipley referred to the increase in the capital investment for the CCTV and suggested it would be useful to compare these figures against the cost of the Trust commissioning that work itself, noting the increase is £1.3m over 5 years. This would allow a comparison to be made to see if it represents value for money against the Trust undertaking the work. Jug Johal agreed to provide that breakdown.

Brian Shipley also referred to the recommendations table and asked about the capital over 7 years and asked for clarity what the figure would drop down to in those last two years.

Action: Jug Johal

Peter Reading suggested that in his experience, when companies were well established and decide not to bid this potentially sets alarm bells ringing. If the proposed contract represented a strategic shift then he would be more reassured, but if a company like ISS cannot make money are we proposing to let the contract to a lesser experienced contractor and is there therefore a chance that they would provide a poorer quality service. He asked Simon Tighe if more explanation could be given as to why ISS were not able to make money.

Simon Tighe explained, in confidence, that there was a break down in relations with ISS MD so when asked if they wanted to engage he said, “No”. That individual had now been moved out of the region and the company had re-engaged with the Trust but this happened too late in the process for them to be able to then bid so for assurance to the Committee, it was related to a person rather than anything else. Jug Johal said the increased overheads particularly had affected their profit. He noted that in the tender exercise there was particular assurance given around the labour costs, a significant part of the contract and he is content that the new proposed supplier could deliver satisfactorily.

Peter Reading asked about the pay rates and whether the Trust would be comfortable with them. Simon Tighe explained that the current staff will TUPE over so not a new labour force coming in. He confirmed that they are paid a living wage and Peter Reading was happy with the confirmation.

Andrew Smith stated that it was presented well, noting confirmation to Linda Jackson’s question, he referred to the suggestion that the incumbent came “late to the party” and asked if there was any risk to the Trust that we did not explore opportunities and had they not ruled themselves out would it have been a more attractive proposition.

Simon Tighe stated that he had been assured that this was not a risk as no formal notification from them was received that they then wanted to be included following the refusal by the former MD of ISS.

It was noted that this item would also be brought to the Trust Board the following week.

Following discussion and review the report was approved.

11.3 Deep Dive – Water

Simon Tighe, for the benefit of those NEDs new to the Committee, gave a brief background to the legionella situation that occurred in 2015. He explained that the HSE came onto site then and undertook a thorough investigation resulting in six Improvement Notices being served on the Trust, predominately concerning policy and procedures and drawings. These were all completed in the allotted timescales.

A further Improvement Notice relating to GDH was subsequently served by a different HSE inspection team. The Trust appealed against this. It was agreed that the Improvement Notice would be withdrawn if the Trust also withdrew its appeal, which is what took place It was noted that the cost to the organisation for HSE to conduct the investigation was £244k and despite the Trust pressing for the investigation to be closed no recent contact had been made.

Stuart Hall thanked Simon Tighe for the clarity and despite the considerable cost it appears that things are still not finalised. Simon Tighe explained that the Trust legal team have asked for a conclusion and that the investigation be brought to an end but no formal response had been received. Jug Johal added that the amount of evidence provided to HSE was significant and had to be in hard copy. NLAG's counsel include water experts and they periodically make contact with HSE but remain confident that everything that was asked for had been provided. Stuart Hall was happy to take assurance from the explanation as long as the process is documented and the Trust had fulfilled their statutory obligations.

Andrew Smith had a query on the report on the table on page 9 and the inherent risks in the defects listed. He asked if it was possible to put in place measures to address these risks and if not, do we have a means of control. Simon Tighe explained that the urgent and high risks are classified by the external company that conducted the assessment. He noted that a new British Standards document had been issued which provides new guidance and numerous changes which need to be acted on in the Health Care environment. Simon Tighe confirmed that there are a number of control measures in place including; robust flushing routines. In addition, improvements had been made to the BMS system with additional temperature control thus providing mitigation to the risks.

Andrew Smith suggested that after listening to Simon Tighe's answer, the report did not do justice to the risk mitigation work undertaken by the E&F Directorate. Whilst it was necessary to have the raw numbers presented, amplifying detail of work completed, underway and planned to address the defects would be beneficial and enhance assurance evidence.

Neil Gammon asked that thanks were passed on to James Lewis who had prepared the report.

Action: Jug Johal

Following the discussion the Committee noted the report and were assured that the water systems and any associated risks were being managed in an appropriate manner subject to further clarity being included in future reports. Jug Johal also suggested that a one page briefing note could be provided for the next meeting.

Action: Jug Johal

10.20am *Lee Bond joined the meeting.*

Item 15 02/21 **Any Other Urgent Business**

Jug Johal highlighted to the Committee that the car parking area next to the Assisted Living Centre at DPOW consisted of two areas, one owned by the Trust and one by a local landowner. Up to now the Trust staff have had the ability to use this space but the landowner is now interested in selling to the Trust. Jug Johal explained that he would be reluctant at this point to approach the Local Authority on this matter and highlight a potential loss of Trust car parking spaces. The reason was that he did not want to run the risk of this knowledge, in the hands of the Local Authority, adversely affecting the planned multi deck car parking area as part of the ED scheme. He explained that the proposed purchase negotiations for the land had already been discussed with the Executive Directors but wanted to ask if any NED would be interested in being involved in the land transaction.

Linda Jackson suggested discussing at the NED meeting taking place later that day, which was agreed.

Action: NEDs

Post Meeting Note: At the NED meeting it was agreed that it was not necessary for a NED to be involved in the operational matter of the potential car park purchase.

Item 11 02/21 **Date, Time of next meeting**

Wednesday, 31 March 2021 – 9.00-12.00pm via Teams Meeting

MINUTES

MEETING:	**Finance & Performance Committee**	
DATE:	**31 March 2021 – via GoToMeeting**	
PRESENT:	Neil Gammon	Non-Executive Director / Chair of F&P Committee
	Stuart Hall	Associate NED, NLAG / Vice Chair, HUTH
	Mike Proctor	Non-Executive Director
	Linda Jackson	Vice Chair, NLAG / Associate NED, HUTH
	Andrew Smith	Non-Executive Director
	Lee Bond	Chief Financial Officer
	Shauna McMahon	Director of Digital Services
	Jug Johal	Director of Estates & Facilities
	Ivan McConnell	Director of Strategic Development
	Brian Shipley	Deputy Director of Finance
	Ian Reekie	Lead Governor
	Ab Abdi	Acting Deputy Chief Operating Officer (rep Shaun Stacey)
	Anne Barker	Finance Admin Manager (Minutes)
IN ATTENDANCE:	Angie Legge	Associate Director for Quality Governance

Item 1 03/21 **Apologies for Absence**

Apologies for absence were noted from: Peter Reading, Dr Kate Wood; and Shaun Stacey (rep Ab Abdi)

Item 2 03/21 **Declarations of Interest**

There were no declarations of interest made.

Item 3 03/21 **To approve the minutes from the previous meeting held on 24 February 2021 - Public**

Neil Gammon noted on Page 5 of the minutes, a reference to '…inviting Divisions to the meeting to update on performance issues…' and advised the Committee that where performance is off-target or issues have arisen, the Divisions would be invited as required.

The minutes were approved as an accurate record.

To approve the minutes from the previous meeting held on 24 February 2021 - Private

Deep Dive - Water – Jug Johal had suggested a briefing note would be provided to this meeting and this was included under Matters Arising.

The minutes were approved as an accurate record.

Item 4 03/21 **Matters Arising**

It was noted that all actions were captured either on the Action Log or on the agenda. Neil Gammon confirmed that all actions against his name had been completed.

4.1 Pathology Sexual Health & HIV – Post Tender Analysis

Lee Bond presented the paper, which outlined the internal, post-tender analysis following NLAG's unsuccessful retendering exercise. Lee Bond explained that despite reducing the price significantly the Trust did not get through the first gateway due to falling short on IT systems. This service was profitable and the failure to retain the contract would result in a financial loss of approximately £600k in the next financial year.

Linda Jackson referred to the £632k net impact suggesting some could be off-set by Covid testing and the Lincolnshire Community Health Services repatriation of sexual health. Lee Bond explained that the Virgin contract of £100k was already included in the figures and the analysis showed a £400k impact on the bottom line. In terms of staffing this would have to be managed as we go forward.

Ian Reekie queried the size of the Pathology facility and staffing at Louth. Brian Shipley agreed to investigate and report back at the April meeting.

Action: Brian Shipley

Neil Gammon noted that other services are being provided within Pathlinks but not supported by a formal contract and asked if that was a risk. Lee Bond agreed to enquire and report back at the April meeting.

Action: Lee Bond

Stuart Hall referred to the submitted bid and noted that NLAG failed on the minimum criteria of 3 of 8, IT related, technical responses. He asked if there were any lessons that could be learned for future contracts. Shaun McMahon advised that in terms of the NHS Data Protection & Security Toolkit she would have expected to meet the requirements by the time the contract commenced.

Ivan McConnell noted that originally this was a yes/no question on integration and only one bidder could pass that test. Lee Bond advised that he had asked Ivan Pannell in procurement and Mick Chomyn from Pathlinks to follow up on how the Trust would have scored on the price submitted to understand how competitive we would have been, and if considerably lower may go back and question value for money.

Following discussion the Committee noted the report.

4.2 Action Log

The action log was reviewed as follows:

9 – Strategic Development – Capital spend outlining level of risks – Lee Bond advised that whilst the Trust had received capital money for the ED amounting to £30m of £60m required, our continued committing to contracts presented a small risk, whilst awaiting formal IAAU business case approval. It was agreed that Lee Bond and Jug Johal would draft a short summary of the issues for the next F&P Committee meeting in April.

Action: Lee Bond / Jug Johal

10.1 – Business Planning & Performance – This item had been overtaken by events and the committee agreed to close it.

5 – Reference Cost Process and Submission / Service Line Reporting (SLR) Utilisation – Linda Jackson sought assurance that SLR was still being used as she did not see much evidence of this. In terms of reference costs, Lee Bond suggested bringing an update on costing to the April F&P Committee meeting.

Action: Lee Bond

Stuart Hall agreed with Linda Jackson's comments and was interested in how model hospital fits in with this. Lee Bond suggested that SLR would become less important as finance systems focussed more on cost base.

5.4 – Clinical Data Improvement – Lee Bond advised of a programme of work with clinical coding teams at both HUTH and NLAG which had highlighted a number of queries or areas where more investigation was required. Shaun McMahon added that following on from the improvement in coding practices as a result of the Grant Thornton work, there were further improvements to realise. It was agreed that an update would be brought back to the next F&P Committee.

Action: Lee Bond

Mike Proctor asked if the patient admin system (PAS) could pick up co-morbidities directly into coding without Clinicians being involved. Shaun McMahon confirmed that improvements around data would be seen with the two big projects being undertaken this year i.e. Data Warehouse and PAS upgrade.

6 – Divisions to be invited to attend F&P – This item to be closed on the action log.

7 – Finance Report – Financial implications of CQC costs – included within the Finance Report therefore this item was closed.

CLOSED ITEMS – 16 – Car Parking Charges

Jug Johal referred back to this item which had been closed until further national guidance had been received. Guidance had now been received and a report had been provided to the Committee at item 10.1 on the agenda.

Item 10 03/21 **Estates & Facilities**

10.1 DoH Car Parking Concessions

Jug Johal presented this item advising that guidance had been received from NHSE/I with a number of car parking concessions to be introduced from April 2021. Those concessions were as follows:

- Free parking for blue badge holders, both staff and patients
- Frequent outpatient appointments – This would require some slight adjustments to what the Trust previously had in place
- Parents of sick children – This was already in place at the Trust
- Free parking for staff working night shifts – This is difficult to implement so it has been proposed to give a 33% tariff reduction for staff identified as working 33% night shifts over a 12 week period, with free parking for those members of staff who work full time night shifts.

Lee Bond asked for clarification on the 33% reduction, presuming that this would only apply if and when the government re-introduce charging for staff parking, which Jug Johal confirmed.

Item 5 03/21 **Presentations for Assurance**

5.1 CQC Progress Report

Angie Legge presented this report and advised that she is covering Lucy Kent's vacant post, pending successful recruitment.

Andrew Smith questioned if focus had been lost, referring to progress (Page 6) which highlighted poor attendance by CQC ambassadors. He acknowledged that there is a lot of work going on but asked if it was worth revisiting the report to make it more user friendly and reformat it to highlight those areas off track. Andrew Smith noted, by way of example, the table on page 5, which was difficult to compare across the months and suggested again that it may be a chance to revisit.

In response Angie Legge stated that focus had not been lost and that there had been productive meetings with divisions, particularly focused on the red RAG rated areas and their mitigation plans. As part of that, despite some actions remaining red rated, she confirmed that we are safe.

In terms of the CQC ambassadors, Angie Legge advised that a review of the process had been undertaken resulting in the work being shared between Angie Legge and Ryan Sutton the Associate Director for Quality Improvement. She said that CQC ambassadors help drive improvement in their areas so the team plan to re-invigorate that process with some CQC focus input.

Andrew Smith did not think the report did justice to this detailed explanation. Angie Legge added that as the CQC were expected to be undertaking an inspection in the near future the report would be revisited once Lucy Kent's successor had been appointed. She agreed to note the Committee's comments and would make minor adjustments to the report, whilst retaining its broad structure.

Lee Bond referred to the red rated actions, specifically Community Nursing (page 6), which he did not think had been highlighted by the CQC previously. Angie Legge explained that whilst this had not been raised before some pre-emptive action / work is being undertaken on where the likely risks are; the Community Nursing related to performance so felt that this could be an issue that could potentially arise.

Neil Gammon referred to the Areas of Learning (page 7), specifically the need to ensure actions put in place remain embedded and asked if it is an increasing concern that some actions have to be re-opened or is it just a one-off. Angie Legge explained that this was a general concern shared by Lucy Kent and the crucial importance of embedding new or revised processes features regularly in conversations with Divisions.

Stuart Hall referred to this section, specifically the changing nature of the CQC monitoring process and the supply of evidence and stated the need to make sure that the evidence is captured. Ab Abdi added that the CQC need to be assured of grip and control and the organisation has come a long way in providing evidence. In terms of embedding processes, Ab Abdi highlighted that a significant number of mechanisms are in place to ensure processes work and do not deviate for future inspections.

It was agreed to add this topic to the highlight report.

10.00am *Angie Legge was thanked for attending and she left the meeting.*

5.2 Out Patient Department Transformation Programme

Jackie France attended the meeting to present the report and highlighted key issues to note.

A system-wide programme management governance structure is in place with a Primary/Secondary Care Clinical Interface Group established. This provides a vehicle to introduce clinical changes across the system at pace.

Jackie France explained that Patient Initiated Follow Up had now been introduced in all specialties. Rather than patients being added to a routine follow-up list the responsibility is put in the patients' hands and whilst this is not appropriate in all cases it has the potential to be used for 30% of patients. We are one of the few Trusts to implement across all specialities and after a slow beginning it is gaining pace.

She described the Connected Health Model, which has been Introduced with 1 PCN in Cardiology. This is an innovative, MDT style approach to outpatients, and has already seen a significant discharge rate from the follow-up waiting list with overdue patients reduced to zero.

A joint project is underway with primary care for GPs to risk stratify and review overdue follow-up patients in medicine specialities. There have been 3900 patients have been reviewed with up to 20% being identified for ongoing management in primary care.

Virtual appointments have been a success as a result of Covid restrictions and have already exceeded the target of 33% by 2024. The challenge will be to maintain over the coming months but we have sustained the position over the last 2-3 months.

Lee Bond queried how the virtual appointments are being recorded i.e. as first outpatient attendance or separately. Jackie France explained that we are recording for both new and follow-ups but will record the mode of delivery as virtual rather than face to face, and confirmed 30% in totality, across all specialties.

Mike Proctor commented that Covid had been a catalyst for lots of changes and queried if now improvements are being seen whether clinicians are desperate to get back to how they used to work and how that could be prevented. Secondly he stated that Quality & Safety Committee look into patients on follow-up lists, particularly in Ophthalmology, and asked to what extent other services in the community could assist with backlogs of patients that we cannot see.

Jackie France explained that we are continually monitoring the new processes and where we do see any dip in performance we will review it with the specialty. We have undertaken a patient and clinician survey which shows that both are, in the main, content with the new ways of working. This is particularly true for those services which cater for the elderly and children so will continue to use patient voice to push this way of working, and work with clinicians to break through barriers.

Ivan McConnell highlighted the need to think about future system wide approaches, noting that 80% of primary care appointments are via telephone, not video, and a survey of Humber region had noted 50% of electives are happy for services to be conducted virtually. High percentages of outpatient attendances do not need to be on site so need to be aware not just for the organisation but also system wide.

Stuart Hall referred to NLAG as a paradigm leader and added that this was a highly commendable piece of work. He would like to plagiarise and publicise it at HUTH. Jackie France explained that the work on the Connected Health Model is already being shared with HUTH and the CCGs and GPs in the East Riding.

Jackie France noted that the opportunities of rolling out this model to other specialties are significant and the team are currently looking at greater involvement of Surgical specialties. She added that whilst the follow-up lists still look substantial, particularly in Ophthalmology, the lists are reducing in other specialties.

Ivan McConnell complimented Jackie and her team on the good work that is being done across the system but observed that as the plans are developed, numbers of patients seen in various locations will alter, with potentially many implications. If more outpatients are seen and treated in a community setting, there may be stranded asset costs as well as the need to build that future model of care, with the associated organisational development. There will be infrastructure implications and funding flow alterations. He added that whilst this is not something to worry about today, he wanted the Committee to be sighted on this for the future.

Lee Bond agreed with Ivan McConnell regarding the transfer of resources, noting that the timing was important, together with a system realisation of when the tipping point is reached and what the future investment profile needs to be.

Following review and discussion Jackie France was thanked for attending and she left the meeting.

It was agreed to take Item 9 next on the agenda to allow Shauna McMahon to leave to attend another meeting.

Item 9 03/21 **Strategic Development**

9.1 Digital Strategy Update

Shauna McMahon presented a brief Digital Strategy update and highlighted the discussions held nationally on how CQC will be raising the profile of Digital. She explained the current recruitment for two clinical leadership roles; Chief Medical Information Officer has been recruited with the Chief Nurse Information Officer being re-advertised.

Shauna McMahon updated on the ICS, advising that they are currently in the process to recruit an Interim Chief Digital Information officer (CDIO) to lead on setting up digital service delivery, prioritising projects, funding and structure. A digital strategy is currently being drafted for the ICS which will include system wide collaboration.

Digital Aspirant funds of £2.5m have been received in the Trust with the majority committed to improving IT infrastructure.

Shauna McMahon highlighted current challenges including establishing a Work Plan for the next year which includes too many requests and insufficient capacity so careful prioritisation will be needed. Significant work around data warehousing will be included, which will allow automation of how data is pulled through the various systems.

Neil Gammon highlighted that the Finance & Performance Committee work plan will be circulated for input from Executive Directors and will now include Digital as a discrete category.

10.30am *Following the update Shauna McMahon left the meeting.*

Item 5 (cont'd) 03/21 **Presentations for Assurance**

5.3 Medicine Division – Discharge to Assess Programme

Ab Abdi presented the presentation and highlighted key issues to note.

The National Hospital Discharge policy was published in September 2020 and the Trust works with system partners to ensure full compliance with the policy. Ab Abdi highlighted the improvements so far including 90-95% of wards across all sites have daily ward rounds which helps identify patients for discharge earlier in the day; North and North East Community Hubs formed; and robust governance structure in place. Improvement also seen in LOS and the Trust has had best performance of super stranded patients for the last few months, noting the LOS at 3.99 for both sites compared to the national average of 4.2.

Mike Proctor raised some questions. Why is the report titled "Discharge to Assess" when much more is covered in it? Why does the graph on super-stranded patients (page 7) show a significant fall then a gradual increase? Finally, could the patients discharged before mid-day be realistically discharged the day before?

Ab Abdi answered the three questions in turn. The name of the report was chosen to demonstrate that NLAG is compliant with national policy.

The graph depends on how one looks at it. A trend line demonstrates improvement but there will be variation in the 21+ day and super-stranded patients and it is important to compare the same period last year. However, the report from the region shows that NLAG are one of the few improving in this regard and are recognised for their progress with the Discharge to Assess model.

Ab Abdi said that NLAG have carried out a significant amount of work on LOS but acknowledged there was still a long way to go. With the IAAU NLAG were making sound progress in the region, noting compliance with the long term plan.

Lee Bond referred to the graphs and said that the difference between the low point and now is equivalent to two wards worth of patients. He highlighted that the HUTH position is better on super-stranded with the problem at NLAG in ED being around the exit from ED. He questioned whether appropriate pressure is being applied to clinicians in terms of the timing of ward rounds and improvement in early discharge. He asked if consistent use is made of Estimated Date of Discharge and whether wards were given daily targets for discharge numbers and times of those events.

Ab Abdi responded and suggested that HUTH is slightly behind NLAG in this regard. He agreed that there was further work required but that progress was being made.

Ivan McConnell noted that nurse led discharge is being headed by Ellie Monkhouse.

Item 6 03/21 **Review of NLAG Monthly Performance and Activity Delivery (IPR)**

It was agreed to take this report as read and consider questions raised.

Neil Gammon noted that he did not always see evidence to back up the assertions made in the report and suggested this should be considered for future reports.

Andrew Smith referred to the graph on page 14 and asked if diagnostics would be sufficient when NLAG has increased capacity and would that affect surgery downstream. Ab Abdi stated that capacity is a major challenge. This aspect is being addressed, including the use of the independent sector and community diagnostic hubs.

Ian Reekie referred to the Ophthalmology performance and the veracity of the statement made by staff governors that Ophthalmology Clinicians and Theatre capacity is not being utilised. Neil Gammon confirmed that he did follow this up and it was explained that GIRFT team are looking at Ophthalmology but sometimes theatres are not used because of last minute changes or patients are in the wrong places because of rezoning.

Ab Abdi explained that Ophthalmology are making positive progress creating capacity, including theatre utilisation work looking into efficiency with tangible actions on how to improve further; this is being supported by NHSI. Neil Gammon commented that processes need to be embedded to avoid delays.

Neil Gammon asked about the ED task and finish group and Ab Abdi explained that they examine how to improve flow and have now evolved with system partners supporting with the outcome of a system wide, improvement action plan.

In terms of governance an action plan is taken to the A & E delivery board on a fortnightly basis for monitoring purposes and Ab Abdi added that unscheduled and emergency care arisings are now catching up with pre-covid levels.

Ivan McConnell commented that Ab Adbi is giving the Committee assurance, with the biggest issue being the teams being tired and whilst they do not want to see ambulances backed up they are in a difficult place with the bed base. Ab Abdi added that the ambulance issue is historical and that challenge is ever present. Work is underway to create a better, more sustainable relationship with EMAS supported by NHSI.

Linda Jackson commented to Ab Abdi that he should not go away from the meeting feeling disheartened. Whilst the Committee need assurance they appreciate the hard work from the operational teams as we recover from Covid. The Committee agreed.

6.3 BAF Risk 1

It was noted that the constitutional targets would not be achieved.

Item 7 03/21 **Review of NLAG Monthly Financial Position**

7.1 Finance Report – M11

Brian Shipley gave a brief overview of the report and highlighted key issues to note including:

- Forecast remains as per month 10 of an adjusted year end £2.4m surplus against plan.
- Elective incentive schemes potential for penalties now formally stopped.
- Agreement of outline business case for AAU and impairment included as planned.
- Part of plan to assume £2.9m loss of clinical income; £2.1m recovered with the balance received in additional top up income.
- Annual leave provision, notification to expect 80% funded i.e. 4 out of 5 days. May get fully funded but will not know until final accounts.

- Flowers Legal case – agreed settlement, broadly in line with Trust assumptions. Will receive additional cash payment next month. Potential risk that this is extended to non-A4C staff, predominantly Medical Staffing, which the Trust will need to assess as part of its year end process.

The Committee had no questions to raise and Brian Shipley and the team were thanked for the report.

7.2 Financial Special Measures (FSM) Update – Letter

Lee Bond advised that the FSM letters will continue to be circulated for information as the discussions progress with the FSM team. Reference was made within the letter to the Financial Recovery Board with a question as to what had happened to that meeting. The CEO had advised that this meeting had run its course. The FSM team were keen to understand what would be replacing it and Lee Bond advised that he would be discussing with Shaun Stacey with the suggestion to include a more detailed financial element into the PRIMs meetings. Linda Jackson agreed that PRIMs should be dealing with this.

Brian Shipley advised that governance was again raised at a meeting the previous week and a diagram is needed on how and where PRIMs fits in and once this is done he will provide a copy for the F&P Committee.

Action: Brian Shipley

7.3 Underlying Financial Position

Brian Shipley outlined a current assessment of the Trust's underlying financial position in the absence of national guidance. He noted, though, that the guidance had been received since this report had been prepared and the assumptions made were broadly in line with requirements. It was noted that the underlying deficit was £25m including FRF.

Mike Proctor asked if there was an overarching financial message across the organisation and into the public Trust Board meetings. It was suggested that Ockenden may come with separate funding and there are some things that the Trust wants to do but cannot make investments with savings already difficult.

Lee Bond explained that it was expected that £45m would be given to achieve a breakeven position but actually there is a starting £15m deficit with a third of that due to investments made by the organisation. £5m loss of income with catering and car parking due to Covid noting that this was a national decision. Assumed CQC investment will be funded. The key pressures are as a result of almost £12.5m recurrent investments (as outlined in the paper at Appendix 2). Lee Bond said that he was being realistic in seeking to dampen down expectations, except case by case considerations linked to recovery business cases. Nationally, £1bn had been set aside for recovery post-Covid and it may be possible to obtain some of that funding.

Community nursing service demand has grown with no associated income but nursing teams are reviewing establishments and how to manage that position.

Lee Bond noted that Brian Shipley had taken a prudent approach to cost pressures in the paper. The real challenge is with the money provided to NLAG previously it could be expected that the deficit would be cleared but that is clearly not the case. The POE re-structure will cost money; can we afford to do it now? Primary care, in the shape of CCGs may have resources and on a system wide approach, some transfers may be possible or necessary. Further broad discussions across the system at executive level would be needed to resolve the issues and create a sustainable, system financial plan.

7.4 2021/22 Financial Planning Update

Lee Bond presented this paper and explained that he had asked the Finance team to prepare a proposed budget for 6-months, utilising the information available at that time which included block contract and the budgetary arrangements that had been in place for 2020/21.

Lee Bond explained that NHSI/E require a system wide financial plan that delivers a breakeven position. Within that would be included various surplus and deficits with a 6-month target of £3m surplus for the Trust. This is calculated based on Q3 actuals for 2020/21 which had a net surplus of £1.5m in three months i.e. £3m for 6 months. Unfortunately, Q3 was not typical, with less work giving rise to underspend.

Lee Bond explained that the task now is to take the financial assumptions provided in the planning guidance and compare with the cost base allocated. A planning round is not required for 2021/22 but a reconciliation phase. Currently liaising with operational teams as cost base uplifted due to increase in numbers of clinicians but not sure that the 2% improvement savings will bridge that gap.

Lee Bond proposed bringing a paper to the next meeting for approval for the next 6 months and will summarise the planning guidance in a briefing document to the NEDs.

Action: Lee Bond

Lee Bond referred to the system wide £1bn for elective recovery which is available dependent on activity. This will be based on a sliding scale i.e. 70% of activity by Q3 will get additional financial incentives increasing to 85% by July. If above this figure in July will get 120% in tariff but the ability to secure monies is at system level dependent on both NLAG and HUTH getting to those figures. If this is based on the whole ICS will also include York and Harrogate so hopefully they will be tied together and NLAG and Hull together.

Lee Bond suggested that any questions could be directed to him outside the meeting.

7.5 Draft Capital Plan – 2021/22

Lee Bond presented the paper which provided a summary of the Trust's proposed Capital programme for 2021/22 and explained that this is currently in draft and is subject to change following final confirmation of a balanced plan for the ICS.

Lee Bond added that the ICS total was originally £10m-£15m over-committed but the teams were now working on achieving a balanced position. He explained that the AAU and ED capital is completely protected and the main issues are around depreciation and the capital programme.

The final plan will be brought back to the next meeting for approval.

Action: Lee Bond

7.3 BAF Risk Review – Risk 6

The risk rating remains the same and will be reviewed in the new financial year, ideally with the risks separated into two as discussed previously.

Item 8 03/21 **Strategic Development**

There was no update this month.

8.1 BAF Risk Review

Ivan McConnell advised that there would be a Clinical Board the following week and the BAF Strategic Development would be rewritten therefore more information would be provided at the next meeting.

Item 11 03/21 Estates & Facilities

10.2 BAF Risk – Deep Dive – Lifts

Jug Johal presented the update on the assurance model focusing on the safe management of passenger lifts and highlighted key issues to note.

Jug Johal highlighted that the passenger lifts are on the risk register rated at 16. This is not as high as some other services, as the lifts are well maintained and have been replaced where required through the capital programme. Over the next few years more replacements will be required and will form part of the capital programme.

In terms of the action plan included within the report, Jug Johal explained that 139 actions have been completed and by the next report four more should have been removed.

Jug Johal advised that some of the work has currently slipped behind schedule due to higher priority Covid issues. NLAG's Authorised Persons have multiple duties so it can be a balancing act on where funding is directed with water, fire and oxygen having higher priority over the last 12 months. Neil Gammon asked if this was a concern and Jug Johal confirmed that the lifts are well maintained by the contractors and not in-house so there is no major concern.

Following review and discussion the report was noted.

Estates Briefing Note

Jug Johal referred to the last meeting of the F&P Committee and the water system update and had proposed providing further clarification in the form of a briefing note which he hoped the Committee would find useful.

Andrew Smith commented that the update was useful and demonstrated a good approach to risk mitigation and recognises the difficult situation with the estate and how issues are being addressed. He asked how worried should the NEDs be that this could be a high risk to patient safety. Jug Johal explained that water is one of the specialised areas that is most worrying along with the infrastructure across the Trust which has ageing pipework.

Jug Johal referred to page 11 of the report and the mitigation actions that had been taken, explaining that they err on the side of caution and have been criticised in the past for obtaining too much water sampling but feel it is justified after the issues previously discussed in terms of Legionnaires disease. He added that mitigation actions are quite robust and provide assurance that everything possible is being carried out to enhance safety.

10.3 BAF Risk Review – Risk 7

There was no update this month and Jug Johal explained that the risks will be updated over the next 12-24 months following a number of major schemes including fire alarms.

Item 12 03/21 **Items for Information**

12.1 F&P Work Plan 2020/21 & 2021/22 (Version 9)

It was noted that the work plan would be circulated to the Exec Directors for review and amendment.

Action: Neil Gammon

12.2 Performance Letters to Divisions following PRIMs meeting had been provided for information.

Item 13 03/21 **Matters to Highlight to other Trust Board Assurance Committees**

There were no issues raised to highlight to other Trust Board Assurance Committees.

Item 14 03/21 **Matters for Escalation to the Trust Board**

It was agreed that the following issues would be highlighted to the April Trust Board.

- CQC Report
- Outpatient Transformation Programme
- Operational Performance
- Car Parking Concessions
- M10 Finance Report
- Underlying Financial Position
- 2021/22 Financial Planning Process

Item 15 03/21 **Any Other Urgent Business**

There was no other business raised.

Item 16 03/21 **Date, Time of next meeting**

Wednesday, 28 April 2021 – 9.00-12.00pm via Teams 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	Apols			Apols	✓	✓
Tony Bramley		✓	✓	✓	✓	✓	✓			✓		
Stuart Hall		✓	✓	✓	✓	Apols	✓			✓	✓	✓
Andrew Smith						✓	✓			✓	✓	✓
Jim Hayburn		✓	✓	✓	✓	✓						
Lee Bond						✓	✓			✓	✓	✓
Peter Reading		-	-	-	Apols	-	-			-	✓	Apols
Shaun Stacey		✓	✓	✓	✓	Apols	Apols			✓	✓	Apols
Jug Johal		Apols	✓	✓	✓	✓	Apols			✓	✓	✓
Ivan McConnell		✓	✓	Apols	✓	✓	✓			✓	✓	✓
Shauna McMahon										✓	-	✓
Marcus Hassall		-	-	-	-	-	-					
Kathryn Helley		✓	✓	✓	✓	✓	Apols					
Helen Harris			✓	-	-	-	-			Apols	Apols	-
Brian Page		Apols	Apols	✓	Apols	Apols	✓					
Ian Reekie							✓			Apols	✓	✓
TOTAL ATTENDEES		**8**	**9**	**9**	**9**	**8**	**8**			**9**	**10**	**9**

* Meeting Cancelled

NLG(21)132

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee
CONTACT OFFICER	As above
SUBJECT	Quality & Safety Committee Minutes – January – March 2021
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The report includes the minutes of the Quality and Safety Committee held between January and March 2021

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Minutes

Meeting: **QUALITY & SAFETY COMMITTEE**
Date: **Friday 15 January 2021**
Time: **9.30am – 11am**
Venue: **Virtual meeting**

MINUTES

Mike Proctor	Non-Executive Director **(Chair of the meeting)**
Kate Wood	Medical Director
Angie Legge	Associate Director for Quality Governance
Neil Gammon	Non-Executive Director
Michael Whitworth	Non-Executive Director
Linda Jackson	Non-Executive Director
Claire Hansen	Deputy Chief Operating Officer
Tony Bramley	Non-Executive Director
Peter Reading	Chief Executive
Ellie Monkhouse	Chief Nurse
Shaun Stacey	Chief Operating Officer

In attendance

John Berry	North East Lincs CCG
Jane Warner (item 08/21)	Head of Midwifery
Sarah Smyth (item 08/21)	Divisional General Manager Women & Children's
Ian Reekie	Governor
Laura Coo	PA to the Medical Director **(for the minutes)**

01/21 **Apologies for Absence:** Shaun Stacey, Jeremy Daws, Jan Haxby and Helen Harris

02/22 **Chair's opening remarks:**

The Chair explained that the meeting had been quite a quick turnaround from the December meeting which had led to difficulties in meeting the deadline for papers. Whist some leeway had been allowed for late submissions for this meeting he reminded the Committee of the importance of giving the membership sufficient time to consider papers and that permission to submit papers later than the prescribed one week in advance of the meeting had to be sought directly from the Chair.

The Chair had attended the NLaG Quality Board the previous week which was chaired by Margaret Kitchen and included the CQC. Mike felt the feedback given during the meeting was very positive particularly from the CQC in terms of their impression of the organisation and what we were doing to meet required actions during the difficult Covid-19 period.

03/21 Declaration of Interest

There were no declarations of interest.

04/21 Minutes of the previous meeting held on 23 December 2020

Tony Bramley referred to the matters arising at the bottom of page two, Tony did not think the Cath lab paragraph made sense and needed rewording. Angie Legge suggested it should say 'Tony Bramley asked if there was a route for the learning to be shared nationally'.

Ellie Monkhouse attended the meeting at 9.40am

Claire Hansen had some minor amendments and would email those through to Laura Coo.

Action: Laura Coo to make amendments as suggested

The minutes were otherwise accepted as a true reflection of the December meeting.

Matters Arising

05/21 No matters arising

06/21 Review of action log

New action log to start

Regular Reports

07/21 Patient Impact Paper including CQC update

Angie Legge referred to the paper distributed which was taken as read, the paper was originally put together to keep track of the key risk issues at this time. Angie was grateful to all the contributors in respect of the paper as it involved a lot of work.

Angie summarised the key points;
The highest risks were staffing and waiting lists. There was an enormous amount of mitigation on identified risks which were reflected in the paper. There had been a lot of work on waiting lists and there was good news with regards to mortality. The target for the Trust was to get within the expected range for the SHMI which had been achieved and the Trust had continued to keep that down. There had also been a lot of other mortality work with regards to the structured judgement reviews and coding amongst other things.

Angie understood the plan was to go back to normal governance from February and therefore asked if the Committee wanted to see this paper again in February.

In response Mike Proctor noted that the return to normal governance in February was still under discussion however Mike wanted the Committee to see the report again in February.

Mike invited any questions or comments.

Kate reminded members of the committee that this was a quality paper as an overview of risk and mitigation rather than detailed assurance. The two key areas were cancer performance and sepsis and whilst there was a lot of talk about mitigation and what should be provided Kate thought the Committee needed to keep sight of that as well as covid and infection control. We could not lose sight of the fact that our cancer performance and sepsis figures were not where they needed to be.

Following up on Kate's point on the sepsis issue, Tony Bramley mentioned that this had been talked about for a long time at this Committee as well as the WebV issue which Tony understood had been resolved and therefore welcomed clarification as to what the issue was. Unfortunately Kate was not at MIG on Friday where she anticipated this would have been discussed in detail but this was one area we had struggled with in the past.

Under the cancer section Ian Reekie thought it was clear that procedures had largely moved to St Hughs for cancer and electives were no longer taking place at SGH and would now be at GDH. Ian asked if there was any evidence to suggest that patients were reluctant to travel to GDH.

Ian understood that the PALs office had moved to West Arch due to the works to extend A&E at DPoW and wondered what impact this had on the service.

Under the CQC actions the report stated that information had been sent to CQC that did not provide assurance, Ian asked if that meant data was being sent which we knew would not provide assurance or was that the feedback from CQC.

Ian also asked for clarification on the black ambulance breaches as the figures did not tally up.

Claire Hansen left the meeting at 9.46am

Kate responded with regards to the cancer surgery and alternatives for complex work. The paper was obviously written at a point in time and when the paper was written all our cancer work was going to St Hughs and GDH with HOBS at both GDH and St Hughs. We had six lists per week at St Hughs but the contract was for 20 however St Hughs did not have the HOBs in place to deal with anything greater than two. What Ellie Monkhouse, Shaun Stacey and Kate had discussed and agreed was to ring fence beds on the DPoW site for those high risk patients. Kate was very happy with that arrangement given the reason for not having them at SGH was related to infection control and DPoW did not have the same issues.

With regards to the PALs office being relocated Ellie Monkhouse advised this was because that part of the building was being knocked down as part of the provision for A&E but as most of the contact with the PALs office was telephone contact Ellie did not envisage any problems.
In response to the CQC question Angie noted that all of the data that was sent to the CQC went through robust scrutiny but until the action was turned blue to show it had been embedded, the evidence was not entirely assuring but did reflect the position we were in. Robust discussions were had with Lucy Kent and the divisions and when the evidence was shared it would be highlighted where additional evidence was required.

Kate added that the CQC understood the layers of assurance and this was about being completely transparent.
It was noted that the black ambulance figures were an error.

Linda Jackson gave her observations of the report;
Linda felt this was one of the most important reports the committee received from an assurance point of view and asked Angie to feed back to divisions that their input and work was appreciated.

In terms of cancer Linda could not get a feel for what the cancer waiting position was and what the actual concerns were.

Whilst the risk stratification for the waiting lists sat with this Committee Linda thought it should be the Finance and Performance Committee (F&P) that looked at the data. Staffing was one of the key concerns and the report mentioned the target of 4.1% for sickness and wondered where we were with that.

Neil Gammon commented that there was an intention to hold a truncated F&P meeting on 27 January and they would have the usual suite of performance information so could look at that in a reasonable amount of detail from a performance point of view. It was worth pointing out that Shaun Stacey was very keen for this to come back to be able to provide assurance.

In her experience as an associate NED at Hull Linda knew that they did a deep dive in terms of what was the issue and trajectory was and what they were doing with their highest volume waiting areas.

Ellie added that with regards to sickness levels they were hovering around 30% but they did have roughly 52/53 staff on maternity leave some of whom had been supported to not work clinically or to go on maternity leave earlier than planned.

Shaun Stacey joined the meeting at 10am

Mike asked Shaun for clarity about whether there had been any evidence of reluctance from patients to travel given that some of the elective work had moved to GDH. Shaun was not aware of any issues.

With regards to the black ambulance breaches Shaun would clarify after the meeting.

Shaun updated that we were trying to move Grimsby patients to St Hughs but there was a significant change to the contract in the independent sector that NHSE had been rolling out until December. NLaG were able to take over 100% of St Hugh's activity which meant we were able to create a high Observation cancer area and achieved 92% in our recovery plan however it was worth noting this had not been without difficulties. The new contract did not allow 100% so teams had to use the standard process to transfer the individual episodes, it also allowed the independent provider to select patients. The Trust was continuing to transfer approx. 60 patients a month to St Hughs. In terms of GDH that had restarted and would be operating seven days a week. Patients were being supported where necessary with transport.

Jane Warner and Sarah Smyth joined the meeting at 10.10am

Shaun needed to check that data with regards to ambulance breaches but there was a significant rise in 60 minute breaches in December due to lack of flow the lack of flow. Since October there had been significant exit block. Shaun would need to validate the data before being able to comment further. Events had been held to look through discharges to identify issues in the process. There were 126 closed beds during November and December and all bays/wards had to be closed and deep cleaned before being reopened which was inhibiting ambulance flow. The issue of exit block had now been removed and had reduced to 26 closed beds putting us in a much better position compared to November / December time. Since 2 January there had only been 89 black breaches with six clear days of no black breaches so far.

John Berry commented that in respect of complaints it was really good to acknowledge where those complaints would be closed by 28 February but asked if that included those for CCG. Ellie suggested for John to pick that up with the team for clarity.

Mike summarised that the level of questioning on this paper reflected how useful it was to the committee and the board. One of the main issues picked up was sepsis and particular concerns with worries with cancer were also noted.

Kate referred back to an earlier discussion and clarified that this same paper would be provided for next month's QSC. When people had talked about reverting back to our normal governance arrangements Kate clarified this was not part of our normal governance process so if we were reverting back to normal governance everybody needed to be made aware that they needed to prepare their papers.

Linda had agreed to take this to the NED meeting for the final decision but should we go ahead with resurrecting the meetings Linda had suggested doing shortened agendas and hopefully get full governance up and running by the end of the financial year. In terms of clarity we should expect this paper at the next QSC.

08/21 **Women & Children's update including any specific CNST**

Jane Warner and Sarah Smyth attended to provide a verbal update in relation to CNST and the Ockenden Report. Mike Proctor had explained the reason for the verbal update and the committee were in support of that.

Shaun Stacey left the meeting at 10.22am

Ellie Monkhouse appreciated why the paper had not been uploaded but would like to have a look at the paper before it was shared with the committee.

Jane gave a brief overview of the key issues;
As Sarah has just alluded to this was the usual quarterly update. Jane was sure everybody was aware that there were 10 safety actions to meet for CNST of which there was current compliance with six and the remainder were being progressed. These had been changed numerous times due to Covid and there had been a further extension of the sign off date to 15 July 2021.
Last time they had met five of the safety actions were met, the actions were then revised and there were further expectations and they had now met six. Some of the actions were easier to achieve than others.

The division had been stuck on the fourth safety action relating to Clinical Workforce due to the anaesthetic rotas but had now met the anaesthetic element. Now the teams were only waiting for the neonatal medical workforce and needed a rota for this, but it was not feasible to put that into action at this time and that would be escalated to the Board.

Safety action six, involving the saving babies lives care bundle had five elements and they had achieved one of those elements. The community midwives had found they were not really assured for the women who smoked and were carrying out further audits.

Lawrence Roberts had started work for uterine clinics.

They were not where they should be for Fetal monitoring compliance but that was around their multidisciplinary team and was clearly articulated in the response to the Ockenden report.

They were In the process of commencing pre-term clinics just waiting for the consultant obstetrician to start in post.

Multi-disciplinary training was highlighted in the paper and it was clear to see where they were not achieving.

Safety action nine concerned Safety Champions; they had recently welcomed Mike Proctor as their Non-Executive Director Safety Champion. There had been a lot of safety work but that not enough and needed to be further work undertaken.

They had managed to keep going through the pandemic and were all motivated to do so.

The Ockenden report was very well received and there was buy in from everybody. This had been written by Donna Ockenden and the Trust had to provide evidence to NHSE/I that the Trust had met specific Targets by 15th January. There was a very protracted assessment and assurance tool to complete, which initially had to be ready for today but the national requirement had been changed to15th February.

The seven immediate actions that had come out of the Ockenden report interweaved with CNST so although it was a dreadful report for the families to read, as the Head of Midwifery, Jane felt they were already on that road to improvement. Sarah added that the timescales had changed with regards to Ockenden but this gave them time for challenge and confirm with Ellie Monkhouse which could only strengthen challenge evidential base.

Kate Wood added that it was obviously difficult to comment about the paper, but with regards to the CNST actions she was conscious that we were now nearly 10 months in with the pandemic and it would be helpful to understand if we felt the money was invested appropriately with regards to CNST. With regards to Ockenden Kate asked what the timescale was for looking at the evidence, did we have timestamps for that scrutiny prior. Jane met with Ellie Monkhouse and Mike Proctor and other colleagues the previous Tuesday and it was felt at that time we were not in a position to go through the tool. Jane had written an executive summary and the assurance tool was going to scrutiny prior to going to the Trust Board on 2 February.

Ellie was happy with that and accepted Kate's point, the original idea behind this quarterly report was not just about CNST which was why Ellie wanted to ensure the report reflected everything not just CNST.

Peter Reading's observation, having been involved in the meetings with Jane and Sarah recently, was that they did very well in front of the CQC and the regional lead. The presentation was excellent and the feedback was extremely positive. Peter also thought the event arranged on Friday attended by approx. 60 people was a success so wanted to give that positive feedback. It made it easy for Peter when he had a team of this quality responding as they were. Mike agreed with Peter's comments and the impression the team gave. Mike mentioned that although the deadline had been extended, the Trust should continue to push forward at pace.

Jane Warner and Sarah Smyth left the meeting at 10.42am

Highlight reports

09/21 Mortality Improvement Group (MIG)

Item deferred and will be distributed after the meeting.

10/21 Quality Governance Group (QGG)

Angie Legge referred to the highlight report distributed. The key things to note were the Ophthalmology waiting lists, it was an improving picture but seemed to have stalled a bit recently and Angie was worried that the regional picture was not progressing as quickly as it needed to to support this. Work was still on going for the risk stratification.

On the point about Ophthalmology Tony Bramley was concerned about the role of NewMedica with this. On a number of occasions a contractor provider had been suggested as the solution to our problems. Tony thought in the past a lot of time and money had been spent and wondered if the strategy could reviewed at some point possibly in F&P this was a plea to learn from what had happened previously.

Linda Jackson thought this report was really informative and well written and on the risk stratification it was good to see they had asked questions themselves with regards to impacts. In response Kate informed that this Committee got a risk stratification paper every other month and reminded members that this was a quality assurance committee and performance issues needed to go to F&P. Linda agreed and thought everybody needed to get used to referring things to other committees. Mike Proctor thought the referral process would be easier once the truncated committees got back up and running

Neil Gammon would raise Tony's point at F&P and with Surgery and Critical Care.

11/21 Patient Safety Champions

Item deferred

Items for Information

12/21 Quality Governance Group (QGG) minutes

13/21 Mortality Improvement Group (MIG) minutes

14/21 Quality section of the IPR

15/21 Quality Priorities paper for Execs

16/21 Any Other Business

NEVER event

Angie Legge informed members that there had been a further NEVER event, this was for the same patient from the previous never event. The patient came back on 8th January to have a further procedure to have a lens put in on top of the one inserted previously at St Hughs but when they did that they put a lens in of the wrong size. This appeared to be because the checking process was not adhered to quite as it should have been; this was an additional lens which unlike regular lenses, they come in both positive and negative number sets. This patient was given a plus five but should have been given a minus 5. The good news in this was the lack of harm received as it was spotted while the patient was still in theatre under local anaesthetic and the team were able to change the lens there and then.

Obviously the purpose of the investigation was to look at what was done and what had happened, but Kate Wood asked for confirmation that duty of candour had been carried out which Angie confirmed it had.

Mike Proctor asked how the lessons learned from the first incident were published in the department so he could understand what had wrong in the intervening period which stopped them being learned for the second incident. Kate's understanding was that people had reflected and understood what had gone wrong but Kate would be doing some work with the investigator to see what they felt had gone wrong. Angie clarified that the surgeon was also involved in reviewing the first case but had not been the surgeon, and was not the lead investigator. Both the Lead Investigator and surgeon had been part of the meeting to review what had happened and to determine immediate actions.

17/21 Matters to Highlight to Trust Board or refer back to QGG

- Patient Impact paper for the Trust Board on 2 February

18/21 Meeting review

Mike Proctor formally thanked Tony Bramley for his contribution to this Committee for many years he had been very supportive to Mike since he started in post and Mike was sure he would be missed from the Committee.

Date and Time of the Next Meeting:

Friday 19 February 2021 at 9:30am - 11:00am to be held virtually

The meeting closed at 10.57 am

Northern Lincolnshire and Goole NHS Foundation Trust

Minutes

Meeting: **QUALITY & SAFETY COMMITTEE**
Date: **Friday 19 February 2021**
Time: **9.30am – 11am**
Venue: **Virtual meeting via MS Teams**

MINUTES

Mike Proctor	Non-Executive Director **(Chair of the meeting)**
Kate Wood	Medical Director
Andrew Smith	Non – Executive Director
Michael Whitworth	Non – Executive Director
Peter Reading	Chief Executive
Dawn Harper	Deputy Chief Nurse

In attendance

Ian Reekie	Governor
Jan Haxby	Chief Nurse North East Lincs CCG
Kelly Burcham (item 28/21)	Head of Risk
Lucy Kent (item 30/21)	Associate Director Compliance and Assurance
Helen Harris (item 31/21)	Trust Secretary
Laura Coo	PA to the Medical Director **(for the minutes)**

19/21 **Apologies for Absence:** Shaun Stacey, Ellie Monkhouse (Dawn Harper to represent), Angie Legge, Jeremy Daws

20/21 **Chair's opening remarks:**

Mike Proctor was experiencing IT issues therefore Michael Whitworth stepped in as chair to begin the meeting.

21/21 **Declaration of Interest**

There were no declarations of interest.

22/21 **Minutes of the previous meeting held on 15 January 2021**

The minutes were accepted as an accurate record of the previous meeting.

Matters Arising

23/21 No matters arising

24/21 **Review of action log**

There were not any actions added to the action log yet.

Issues referred from other Board sub-committees

25/21 Ophthalmology performance (from F&P)

Mike Proctor joined the meeting at 9.40am

Mike Proctor advised that the concerns related to Ophthalmology were around the outsourcing of activity which was behind plan. This committee were asked to look at potential harm.

Angie Legge had advised that this was identified as a significant issue at the Quality and Governance Group (QGG). At that time there were 7000 Ophthalmology patients on the follow up list that had since increased to over 9000. Mike was particularly concerned about patients with glaucoma and in danger of sight deterioration or sight loss but believed it should be passed through the QGG for a more detailed review including; the types of ophthalmic conditions, how overdue their appointment were, the nature and extent of risk stratification and assessment of potential and actual patient harms.

Kate Wood and colleagues agreed that was the most suitable way forward. Jan Haxby queried if there was anything that the Commissioners could do to support this. Mike thought that the focus on patient harms was an NLAG issue but the CCG might want to consider how they could help further from a contractual perspective.

Action: The QGG to undertake a review of ophthalmology long waits for follow up and report back to QSC in April 2021 (Laura Coo to add to the Action Log)

26/21 Trust Document Control (from ARG)

Mike had been advised by the ARG that there were significant numbers of documents that were past their review date and a request was made for the QSC to consider whether this constituted a clinical risk.

Peter Reading noted that there had been a series of discussions about the documents but to keep it in context there were thousands of these documents which when they were written had a review date automatically added so it did not mean once that review date was up that they were no longer safe or had to be changed. This was being followed through and they were putting a structured review process in place. It was anticipated that this would resolve the issue for both ARG and QSC.

Regular Reports

27/21 Clinical Harm Update

Kate Wood referred to the paper distributed which was taken as read and summarised the key points. There were more patients on the 52 wk pathway that needed validation but that also fitted in with the number of patients on our follow up waiting list needing appointments.

Andrew Smith could not see the clarity of the risk for the backlog but asked were they comfortable that there were not any patients at risk in the backlog. In response Kate advised that the reason they were behind was because activity had to be reduced out of necessity because of Covid. The process should be done in the next month or two which would help the clinicians and admin teams to work through at a better pace. Every time a patient was seen in the clinic they would go through risk stratification with

the clinician. There were patients who after that risk stratification would of been fine and did not need to be seen for another six months however we were now coming to that six months' time. Andrew thought there could still be some clarity on timescales and it was about rigor of the way the mitigation of the issue was documented. Kate added that all of the divisions had committed to be up to date by the end of March 2021.

Mike Proctor asked whether the change in process on risk stratification and assessment of clinical harms had made a difference yet. Kate advised that the process was still going through various groups and had not actually been finalised yet but it was absolutely crucial although Kate had hoped there would be greater traction at this stage.

The committee noted the content of this report and would pass the summary to the board.

28/21 CLIP Report

Kelly Burcham attended the meeting at 10am

Kelly referred to the CLIP Report distributed which was taken as read. Kelly acknowledged the report was lengthy and contained a lot of information to take on board but it was part A that was the essential element for this committee.

Kate Wood agreed that the key element of CLIP report was that triangulation of the themes that were identified from multiple sources

Andrew Smith was concerned with the number of downward (deteriorating) trends and the lack of link between the identified mitigations and the ability of the mitigations to reduce risks. It was agreed that this element of the report required improvement.

Peter Reading thought in terms of design and content the report was shaping up really well but pointed out that the numbers around complaints received did not tally up as we had been told they were going down rapidly. Peter saw the difficulties in getting family support with getting DNAR's to do with communication and wondered if we could drill into the report to look into DNAR issues and whether there could be a targeted piece of work. In response Dawn Harper informed that every complaint received regarding DNARs was passed through the EoL group and in terms of complaints they had managed to get through the backlog in December and had closed all of the complaints through the old process. All complaints were all now in the new process and were being closed within 60 days.

Kate Wood advised that RESPECT was the new document replacing DNACPR, part of that was because of lack of planning in the period for end of life. HTF had funded the role of RESPECT across all of NLaG. The document itself was helpful but required training. The Trust had adopted it as well as the rest of the region but there was still work to be done it was ongoing and would not happen overnight.

Jan Haxby thanked Kelly for the excellent report and liked the triangulation as it was really important to see the themes coming through. One of the things that was missing for her was the timeframes i.e. how timely were complaints being responded to. The CCGs could see things happening but it would be helpful to see how quickly

they were being responded to and if there was a clear process to demonstrate that changes had been made which was the final piece of the loop.

Ian Reekie asked for clarification as to what CCG incidents were. In response Jan advised that all CCGs had to have a process by which the public could come to the CCGs independent of a provider and it was then for them to ensure it was picked up with the provider. The CCG did get a lot of incidents where something had happened in their own practice but in N E Lincs they included any incidents in Adult and Social Care too. If they had any incidents they would liaise and work with NLaG. Kate commented that the GPs had an app which fed through to the CCGs which the GP's also used and that seemed to work well.

Referring back to the report as a whole Mike Proctor thought that the thematic triangulation was very helpful but was not sure that other elements added very much in terms of where it left us and thought there needed to be further discussions about how to develop the report. He stressed also the need to 'sharpen up' the links and interactions between identified risks, their mitigations, the resultant expectations on residual risk and the tolerance on these.

Action: Further discussions on the content of this report in advance of the next time was due to be considered by the QSC (Laura Coo to add to action log)

Kelly Burcham left the meeting at 10.20am

29/21 Deviations NICE Guidance

None to discuss

30/21 CQC Progress update

Lucy Kent attended the meeting at 10.05am

Lucy referred to the report distributed which was taken as read as highlighted the key points. Lucy thought as organisation huge strides had been made with our relationship with the CQC. The Trust now had a different relationship with the CQC and was moving away from ticking off actions to a more continuous improvement approach. In terms of overall progress we had managed to keep going despite the impact of covid and Lucy thanked all of the teams for their contribution. This update was taking a slightly different focus and was not just about being monitoring but about preventing harm. There had been a culture where people had not taken notice of the Mandatory training and PADR requirements and were treating them as an option but that was slowly changing. Quite a lot of the actions had been signed off but CQC wanted reassurance that they continued which was why the 15 steps etc. on the wards were introduced. There had been some really big issues resolved such as 24/7 Obs cover and staffing issues in maternity, risk stratification and clinical harm. They all required a significant amount of work from Lucy and the divisions to keep that momentum going. Lucy did still have to go back to divisions for answers but when they worked across divisions they had good results.

Andrew Smith asked what the significance was where it said 'not on the risk register' was that to just trigger the conversations or did it actually need to be added to the risk register. Lucy informed that was to trigger the conversation to decide if it needed to be added to the Risk Register. Whilst Andrew agreed he asked if there could be something included to show what was being done with that to make it clearer.

Mike Proctor was relieved that colleagues had continued to focus on CQC actions despite the pandemic. Mike commented that having recently completed some mandatory training online he had found the ESR system really difficult to navigate and thought it was not user friendly. With regards to the 15 steps as NEDs they were really keen to get back involved so they could understand the difficulties first hand.

Kate Wood thanked Lucy for all of her work over the past year, there was no way otherwise we would have been able to get to where we were now and she would be missed and Mike echoed those comments on behalf of the Committee. Lucy would be leaving the Trust at the end of April.

Conversations in the organisation needed to be moved away from CQC and to continuous governance. This took it back to the culture change. Kate was really grateful for the support from external providers and felt it was key for people to realise the importance of assurance and that it continued to move forward.

Lucy Kent left the meeting at 10.20am

31/21 BAF

Helen Harris attended the meeting at 10.15am

Helen referred to the report distributed which was taken as read. Helen advised that the BAF was going through a substantial refresh and the support from Jeremy Daws had been very significant but this was an evolving piece of work. The Trust had been undertaking a review and the report distributed was the current version but we would see a completely different approach. Helen and her team had worked with Kate Wood and had made some changes but had not been able to update the full amount of information due to the information not being available at that time. They felt that RAG rating the individual ones gave a better idea of where they were. Mortality had showed an improving SHMI and EoL was making a significant progress. Ophthalmology remained a significant risk to the organisation and Kate was one of the executive owners of that risk.

Mike Proctor appreciated the work that had gone into making the BAF more informative. With regards to the SHMI Kate noted that it had been very clearly articulated that there was a disparity between the in and out of hospital SHMI. It was identified a number of years ago that there was probably some work to be done with our CCG colleagues about that. A multi-agency EoL group had been set up which Jan Haxby chaired. There was a specific piece of work happening with NHSE/I, who were working with the EoL team to do the structured judgement reviews from a completely impartial perspective. Kate hoped to get the outcome of that soon and to be able to implement some changes. Jan Haxby had also set up an out of hospital EoL group, looking at EoL pathways, support to care homes and how they could support frailty pathways. The work from Grant Thornton highlighted EoL and Frailty and Jan hoped we would start to see changes with that specific area. There had already been some training with care homes the idea was that all of the careers had some routine training i.e. for monitoring blood pressures etc. There had already been three cases in the last month where an ambulance would have been called had they not received that training to support them so Jan thought we should start to see some real impact from that too.

Mike looked forward to seeing the further developments of the BAF and thanked Helen for attending.

Helen Harris left the meeting at 10.45am

32/21 Patient Impacts report

Kate Wood referred to the paper distributed which was taken as read and invited any comments or questions.

Ian Reekie asked about the infections, should the committee be getting more information rather than a fairly general statement. In response Kate commented that the issue was that a number of our patients who were asymptomatic were moving around site when they were deemed green and were harbouring the infection before passing it on. Our numbers had been low for nosocomial infections and there had been discussions with the site team about patient moves but Kate took on Ian's point about the numbers and the issue that happened about 48 hours ago. Patients who started off negative might then become positive. In our area the numbers were fairly static and were not reducing. There would hopefully be some communications going out externally about that.

Mike Proctor thought it was a question we could put to our infection control team but it demonstrated that hospitals could be dangerous places too. This was something that was really fundamentally important. Andrew Smith thought this was a good informative report. Dawn Harper informed that the complaints team had just started to receive complaints from families about the nosocomial spread.

33/21 Quality Priorities

Kate Wood referred to the report distributed which was taken as read and invited any comments or questions.

Mike Proctor asked if these could be looked at in conjunction with the themes from the CLIP report. Although Kate thought the report spoke for itself, Kate thought it would be helpful to have people's thoughts and guidance. Ian Reekie was really pleased that safety of discharge had been included but was disappointed about the lack of metrics in this particular area. Ian thought it was entirely right that the EPMA was being used but made a personal request for Parkinsons medication to be included as a specific measure.

Mike also had some concerns about some of the KPI's identified for the discharge focus which he considered to be too process orientated and not clearly related to the safety of the patients. He also asked whether the same day emergency care (SDEC) changes might change the importance and significance of measures like percentage of discharges before 12md.

In response Kate advised that the discharge of patients early in the day was about the safety of the patients as if they were discharged later there would not be any services available to them.

Jan Haxby added that they had a conversation about the quality priorities in their commissioning review group yesterday and they all agreed they were the relevant priorities from a commissioning perspective. The only thing they picked up on was

that they felt there were an awful lot of them but were genuinely in support of all of those things.

Action: The Committee recommend the approval of the suggested quality priorities to the Board.

Highlight reports

34/21 Mortality Improvement Group (MIG) & Grant Thornton end of project report

Kate Wood had wanted to pick up the EoL work but that was picked up through the BAF conversation.

35/21 Quality Governance Group (QGG)

Taken as read.

36/21 Serious Incident Review Group (SIRG)

NEVER Event was progressing as per the normal SI review process.

37/21 Patient Safety Champions

Taken as read.

Items for Information

38/21 Quality Governance Group (QGG) minutes

39/21 Mortality Improvement Group (MIG) minutes

40/21 Quality section of the IPR

41/21 Quality Account Plan progress / draft

42/21 Community & End of Life update

43/21 Any Other Business

Nothing raised

44/21 Matters to Highlight to Trust Board

For Trust board

- The overarching message was the need to document more clearly the links between risk, their mitigations, the expected residual risk and the Trust's tolerance of residual risk.

45/21 Meeting review

Mike Proctor thanked everybody for providing their papers in a timely manner this month.

Date and Time of the Next Meeting:

Friday 19 March 2021 at 9:30am - 11:00am to be held virtually

The meeting closed at 11.03am

Northern Lincolnshire and Goole NHS Foundation Trust

Minutes

Meeting: **QUALITY & SAFETY COMMITTEE**
Date: **Friday 19 March 2021**
Time: **9.30am – 11am**
Venue: **Virtual meeting via MS Teams**

MINUTES

Mike Proctor	Non-Executive Director **(Chair of the meeting)**
Andrew Smith	Non-Executive Director
Angie Legge	Associate Director for Quality Governance
Dawn Harper	Deputy Chief Nurse
Kate Wood	Medical Director
Michael Whitworth	Non-Executive Director
Peter Reading	Chief Executive

In attendance

Ian Reekie	Governor
Jan Haxby	Director of Quality & Nursing for CCG
Anne-Marie Hall (item 53/21)	General Manager, Medicine
Simon Thackray (item 53/21)	Divisional Clinical Director, Medicine
Vicky Thersby (item 54/21)	Head of Safeguarding
Helen Harris (item 56/21)	Trust Secretary
Laura Coo	PA to the Medical Director **(for the minutes)**

46/21 **Apologies for Absence:** Shaun Stacey, Lynn Benefer, Ellie Monkhouse (Dawn Harper to represent), Jeremy Daws,

47/21 **Chair's opening remarks:**

Mike Proctor advised that following the meeting last month we were in a process of development of the BAF and the Integrated Performance Report (IPR). It was hoped that the BAF would be ready for the April QSC meeting and whilst the IPR would be discussed briefly today it was recognised that it was still a work in progress.

48/21 **Declarations of Interest**

There were no declarations of interest.

49/21 **Minutes of the previous meeting held on 19 February 2021**

Dawn Harper referred to the third paragraph on page three and noted that it was not accurate all complaints had not been closed, they had met the 85% target but not quite all.

The minutes were otherwise approved as an accurate record of the previous meeting.

Matters Arising

50/21 There were no matters arising.

51/21 Review of action log

Action 25/21 from February meeting; Ophthalmology performance – this was due to report back to this committee in May. Angie Legge was asked about the wording of this action and as she was not at the last meeting was unsure what was required in the review. Mike Proctor explained that he was looking for a review on what conditions those patients had, how long they had been waiting, to what extent they were overdue and the extent of clinical harms.

Action 28/21 from February meeting; CLIP report – there was a really good discussion at the previous meeting about the report and Mike Proctor suggested that Andrew Smith might want to join the meeting that was being arranged to review the CLIP report.

Action: Angie Legge to set up a meeting with herself, Kelly Burcham, Mike Proctor and Andrew Smith to review the content of the CLIP report

Regular Reports

52/21 Key SI Update, including maternity

Kate Wood referred to the paper distributed which was taken as read. Kate explained that the paper had a dual purpose a focus on key serious incidents and all Maternity serious incidents including any risks or mitigations these entailed. With the Ockenden report coming through there had to be a direct line of sight for the maternity incidents and the Board

Kate invited any comments or questions.

Mike Proctor noticed that the summary highlighted that some Sonographers had turned down requests for scans from clinicians and wondered if that was a cause for concern. In response Angie Legge understood that this had been an issue in the Serious Incident and one of the main parts of the work had taken place to improve those discussions between the teams to ensure good communication, so that they were aware of the reasoning from the clinicians and to avoid any inappropriate cancellations. Jan Haxby understood that work had been done from the CCG side too, one issue was about access and another incident where the sonographer had gone against the clinician's decision to scan. Jan asked if the intention would be that the same or similar report would be shared with the Board or whether that would be just a highlight report. Mike would be concerned about the level of detail in these reports if it were to go to a public board as presented at QSC it could make the patients identifiable. The Quality and Safety Committee, as a subcommittee of the board would, on the Board's behalf scrutinise the more detailed report on the SI's and provide a highlight report to the public Board meeting. Peter Reading agreed with Mike's comments but added that there was a live debate ongoing within the Exec team about the cycle of business and agreed that a subcommittee of the board should be considered as the board however not all board members shared the same view. This needed to be a disciplined approach and the proposal would be that papers would go to subcommittees and that would be seen to be the board scrutiny. It was really

difficult to have discussions about SI's without having patient identifiable information and it needed to get to a point where the key information as per the Ockenden report could be suitably scrutinised without compromising the patient information.

Michael Whitworth queried what was in place for support of patients and family members of the SI's. Kate Wood noted that there was a robust process to ensure communication and apologies to the patients and families. Michael Whitworth also asked about whether the minutes from the Quality & Safety Committee would be publicly available. Angie noted that the minutes of this committee went to the Public Board meeting.

Kate made a suggestion that a brief synopsis could be given of how the organisation provided oversight of the SI process, it could also include something about the Commissioner oversight of the process, which would then provide some assurance rather than going through every single SI and the detail behind them. Mike thought that would be really helpful and would provide better assurance. Jan Haxby suggested the report could include themes, Angie Legge noted that these formed part of the quarterly CLIP report.

53/21 Medicine & Urgent Care

Simon Thackray and Anne-Marie Hall joined the meeting at 9.50am.

Anne-Marie and Simon referred to the report distributed which was taken as read. The report highlighted the significant progress that had been made against the CQC actions.

Anne-Marie invited any comments or questions.

Mike Proctor asked for a qualitative sense of what A&E felt like how was the department coping with pressures and the impact on morale.
In response Simon noted he had been with the department for two years now and a lot of the work had been focused on the front door. The work had been from nurses and clinicians and it felt substantially safer than it did before, they had noticed a much greater degree of engagement. One concern was that work had been very much a nursing led endeavour although from a governance point of view they had an excellent governance clinical lead in Grimsby and it was fair to say it was a very different picture to that of 18 months / two years ago. Simon was assured that if an incident did occur that lessons would be learned from them. The CQC visit was due anytime and Simon was confident they now had robust processes in place and it would be a much easier process this time round. The overall patient experience was better; some of the reoccurring themes such as missed fractures were still happening but were being dealt with and there had been less repeated incidents.

Mike asked about the lowlights section of the report and what that meant for the Wards in respect of performance. Simon had looked at it from a specialty point of view; previously patients would have seen a middle grade doctor but they were now trying to get a senior decision maker at the door rather than later referrals for a follow up. It was about dealing with things there and then but there had been a challenge in rostering a senior staff member as close to the front door as possible.

Peter Reading thought the report was really encouraging and mentioned governance leadership on the DPoW site, one of the themes was to try to knit together the two A&E teams so it could be said that we only needed one governance lead but being aware of the nature of the A&E business made that difficult.

Simon responded that there was very little cross department working with the A&Es but that was the nature of the work, and the team had really struggled to get any cross site working. They had tried to break that down and had a lot of success in the wider division but less so in A&E. Medicine was a complex, multi-facetted division to manage and Mike thought the progress that had been identified through this report had been really positive.

Peter mentioned a concern was raised in January 2020 and asked if things had changed, whether the nursing staff were still stressed. Anne-Marie thought the stress levels were better but that there had been higher levels of sickness at the DPoWH site. Anne-Marie emphasised the impact Covid had had on the team, and that this had impacted on stress and sickness. The team were focused on both retention and recruitment using the positives; utilising the new build for A&E as positive advertising for A&E at DPoW but she could not stress enough how exhausted the nursing staff were.

Simon and Anne-Marie left the meeting at 10.09am

54/21 DoLs and Safeguarding

Vicky Thersby joined the meeting at 10.05am

Mike Proctor welcomed Vicky Thersby, the new Head of Safeguarding to the meeting.

Vicky referred to the report distributed that was taken as read. Vicky highlighted that the looked after children for N E Lincs, the numbers of children coming into care, there had been an increase of 27 and NE Lincs were the second highest in the Yorkshire and Humber region based on 2019 figures for children coming into care. This was already on the risk register. She also noted that the mental capacity amendment bill had come in over a year ago but that implementation had been delayed due to covid but the government were keen to get this rolled out in spring. The Trust would have more oversight as to how that would be rolled out once national guidance was published and the team was expecting to provide a report to the board in July setting out a roadmap.

Jan Haxby thought it might be useful to look at the looked after children in more detail outside of this meeting. More resource had been put into the NLaG looked after children team. In the last six to eight months it felt like they had really started to notice they had a much better grip and were in a much better position than they ever had ever been.

Mike thanked Vicky for providing the report.

Vicky left the meeting at 10.14am

55/21 Deviations NICE Guidance

None identified

56/21 Quality section of IPR

Kate Wood referred to the report distributed which was taken as read. This was the first time this committee had received the report in this new format as it was the first time it had been generated by the Performance Team. Kate explained that they were trying to pull things into an IPR format to track the progress through run charts and that would then be expanded out to explain the position and what actions were being taken. The plan was for the whole report to be exception reporting. The narrative that went behind everything was provided by Angie Legge's team for the MD Office and the Chief Nurse team for the nursing metrics.

Kate invited any comments or questions on the structure and contents.

Andrew Smith really liked the new format and supported exception reporting.

Mike Proctor asked about the sepsis screening, what were the issues related to why they were so out of target and asked about WebV related issues.

Dawn Harper responded to say that the narrative box should be reworded; a WebV screening tool had been introduced which was in addition to what was going into the notes but they only had one person providing that training across all of the wards to enable robust implementation, hence the low figures. However, a manual audit had indicated that actual compliance on paper record was far higher.

Helen Harris joined the meeting at 10.20am

Mike wanted to see the performance data expanded into other areas such as falls and pressure ulcers so encouraged its expansion and use into other areas. Kate noted that the initial work on the IPR had focused on pulling out the quality priorities from last year and developing them for the next year.

Peter Reading was encouraged by this report but wanted to see more detail on a wider range of metrics. Kate noted that the first page had the national requirements listed but that the detail had only been completed for the quality priority metrics to date. Kate welcomed suggestions but wanted an explanation as to why they should be included. It would be best to send any suggestions to Angie Legge in the first instance.

The group recognised that the report continued to make progress and thought it was a really key document. Any suggestions were encouraged to be sent directly to Angie Legge but Mike thought this was a really welcomed development in how the organisation was governed.

57/21 CQC Update

Kate Wood referred to the report distributed which was taken as read. Essentially this provided an update on a line by line basis. The executive summary showed there were three main themed areas of concern to the organisation. Mandatory training, diagnostics and capacity. There was a significant backlog in diagnostics and a

request had been made for help to clear that. The CQC were well aware as we had been very open and transparent with them. Additional resource was required for community nursing and Ellie Monkhouse had undertaken an establishment review which showed a significant shortfall in community nursing. Jan Haxby asked if there was some more detailed information about what issues the gaps were in terms of the community nursing, Jan was aware one of those was about seven days services but if she knew what the gaps were in terms of patient need she may be able to help.

Mike Proctor echoed what Jan had said he was not really aware of the risks and where they were and needed to understand the gap and what it meant to understand the impact of that gap.

Peter Reading thought that was very helpful advice and felt that between himself and Dawn Harper they could feed that back to Ellie. Peter noted that the impact would be both patients and on staff. There had not been any uplift since the trust took on the additional work but they saw it as being a specific negotiation with the N Lincs CCG as they considered it to be a block contract.

58/21 Patient Impacts report

Angie Legge referred to the report distributed which was taken as read. Mike Proctor clarified that this was almost a closing report for the governance arrangements put in place during wave two of covid.

Angie summarised that the aim of the report was to indicate, for all of the topics which had formed part of the Patient Impacts Paper, how assurance would flow under business as usual. The assurance column indicated if colleagues felt there was adequate assurance and information coming through in those topics, rather than an indication on whether the topic was no longer a concern. On reflection she could have added a column indicating the level of continued concern or risk. The assurance column had been completed with the clinical lead and Executive colleagues but Angie invited members to comment on whether there was agreement with the levels indicated, and cited a lack of assurance on sepsis as an example.

Mike stated it was almost a summary of the position in terms of assurance which could be quite complex but thought we were at a point in time where we improving our overall risk assessment and were improving. It was a useful summary of where we were in terms of covid. Andrew Smith thought it was a good paper and thought it did all the right things by volume and targeting, providing good information and it gave the information at this point in time while as an organisation we would continue with the journey we were on in developing risk management.

Kate Wood noted that she and Ellie Monkhouse would be producing a paper for Board to indicate our position on quality, now that the Patient Impacts Paper had ceased. Kate asked about the level of detail wanted from that paper for the board as a highlight report. Peter Reading stated he would be guided by the Execs but thought that shorter was better and that the detail should come to the QSC. The sub committees should have the detail in the IPR and the responsibility of the Executive Directors was to write a page summary of key concerns etc. which would then be complimented by the highlight report from the committee.

59/21 IPC Assurance Framework

Dawn Harper referred to the documents which were for information. The report was noted.

Items for discussion/decision

60/21 SLA for Governance Interim Clinical Plan

Angie Legge referred to the document distributed which was taken as read. This was an SLA that covered the interim clinical plan and the clinical pathways that were shared between NLAG and Hull and gave a guide to how we would work with regards to quality governance. The aim had been to keep the SLA straightforward without unnecessary deviation from existing processes. This had already been taken through the Interim Clinical Plan Board and they had asked for it to come through QSC here and at Hull for approval. Peter Reading noticed his name was at the bottom and asked for reassurance that the paper had received scrutiny from the Head of Legal. Angie responded that Gerard Curran had looked at this in some detail from a legal perspective and that the plan was to keep the SLA under review as the pathways were developed. Kate Wood added that this was the sort of SLA she would have liked to of had for the work with St Hughs.

Andrew Smith asked how adherence to the SLA would be monitored. Angie noted that each of the streams had a reporting mechanism, and deviations from the SLA would be reported through those. There were also monthly meetings between herself and her counterpart at Hull where issues arising could be addressed.

Kate Wood asked about the NLAG oversight of the Interim Clinical Plan and its strategic progress. Peter Reading advised that Ivan McConnell, Terry Moran and Peter were working on a case for assurance and governance for HASR. The proposal internally was to develop some sort of strategic development board.

The committee approved the SLA subject to the review processes as discussed.

Highlight reports

61/21 Mortality Improvement Group (MIG)

Kate Wood referred to the highlight report distributed which was taken as read. Kate highlighted that there had been excellent work going on between ourselves, NHSE/I and commissioners.

The out of hospital SHMI remained stubbornly high at the NE Lincs end but work was being done looking into that. There was continued concern around sepsis management.

Ian Reekie commented about the disparity around out of hospital SHMI and noted there was still quite a big gap there and asked whether that was about better integration. Kate reminded members that the out of hospital SHMI was lower at N Lincs than at N E Lincs. The reason was that there was a more specialist palliative care input at the N Lincs end. However the issue was more multi-faceted and needed to be worked through.

Jan Haxby added that there was a whole programme around EoL, there were a number of different work streams and they were looking at the whole pathway. Whilst there was more palliative care at the N Lincs end there was more community nursing at the N E Lincs end which balanced the two out. There was something about it being visible in the records when a patient had been seen by a specialist. There had been a lot of work about the services, and whether we had the right services in community i.e. IV antibiotics which would really help to manage that flow through to the hospital, the out of hospital programme would really help that. She assured the Committee that the out of hospital SHMI was being addressed and worked through.

Mike Proctor added that with regards to EoL when organisation did not provide good care that there was no opportunity to put things right and the impact on relatives could be long lasting so it still remained one of our main priorities. It would be a big challenge about community services and to develop those services moving forward.

62/21 Quality Governance Group (QGG)

Angie Legge highlighted that the key concern remained Ophthalmology. QGG had requested assurance on the harm faced by glaucoma patients but were unable to get the assurance they were looking for and it was something that would be picked up and pursued further.

63/21 Patient Safety Champions

Taken as read

Items for Information

64/21 Quality Governance Group (QGG) minutes

65/21 Mortality Improvement Group (MIG) minutes

66/21 Oxygen HSIB Interim report

67/21 Any Other Business

Nothing raised

68/21 Matters to Highlight to Trust Board or refer back to QGG

Nothing to refer.

69/21 Meeting review

The meeting ran slightly over time but Mike Proctor felt it was going in the right direction with regards to our understanding of the key issues.

Date and Time of the Next Meeting:

Friday 16 April 2021 at 9:30am - 11:00am to be held virtually

The meeting closed at 11.04am

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)133

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Michael Whitworth, NED & Chair of Workforce Committee
CONTACT OFFICER	Michael Whitworth, NED & Chair of Workforce Committee
SUBJECT	Workforce Committee Minutes from 23 February 2021
BACKGROUND DOCUMENT (if any)	Not applicable
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Workforce Committee – 27 April 2021
EXECUTIVE SUMMARY	Minutes of the Workforce Committee meeting held on 23 February 2021 and approved at its meeting on 27 April 2021.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and long term. Ineffective staff engagement and ownership of the Trust agenda affects morale and failure to change and improve the culture.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday 23 February 2021 at 2 pm held virtually via Microsoft Teams

Present:

Michael Whitworth	Non-Executive Director (Chair)
Christine Brereton	Director of People
Paul Bunyan	Associate Director of Workforce
Neil Gammon	Non-Executive Director
Jane Heaton	Associate Director of Strategic Medical Workforce
Linda Jackson	Vice Chair/ Non-Executive Director
Claire Low	Deputy Director of People
Tim Mawson	Governor
Ian Reekie	Governor
Robert Pickersgill	Governor
Michael Proctor	Non-Executive Director
Shaun Stacey	Chief Operating Officer

In Attendance:

Karl Portz	Equality, Diversity and Inclusion Lead
Wendy Stokes	Executive Personal Assistant to Director of People & Organisational Effectiveness *(taking minutes)*

The Chair reported that the agenda had been shortened due to COVID pressures and he went on to thank the People directorate for everything they have done to get the vaccination hubs up and running, well done to everyone involved.

1 Apologies for absence:
Stuart Hall, Rachel Maguire, Ellie Monkhouse, Andrew Smith and Kate Wood

2 Declaration of Interest:
The Chair invited members to bring to the attention of the committee any conflicts of interest relating to specific agenda items. There were no declarations of interest.

2 Minutes of the previous Public meeting held on Tuesday 27 October 2020:
The minutes from the previous meeting held on Tuesday 27 October 2020 were accepted as a true and accurate record.

4 Matters arising from the previous minutes:
No matters arising

5 Review of action log:

Action 71 – Pride and Respect (P&R) Training – speak to Kay Farquharson regarding executive attendance
Training on hold due to COVID as the post holder has been redeployed to help with the vaccination programme. It was agreed to remove this item from the action log.

Peter Reading added that this action is redundant now because Pride and Respect is being looked at going forward to see what phase 2 might look like once the pandemic has settled down. There has already been lots of engagement and the question is does the trust do something different. The Chair asked for this to be added to the work plan and between now and the next meeting the Chair, Christine Brereton and Wendy Stokes will confirm a date for the work plan.
Action: The Chair, Christine Brereton and Wendy Stokes

Action 72 – Internal and External Surveillance Systems Policy – ask Jug Johal to review the policy
A full review of the disciplinary policy is now being undertaken and it is recommended that this action is picked up as part of that review. A lot of work is being done with unions but they are not in agreement with using CCTV in disciplinary cases.

Action 78 – Flu Campaign Update 2019/2020
The Flu Campaign report was received by the Workforce Committee and it also went to the Trust Board. It was agreed to remove this item from the action log.

Action 79 – Update on ACPs
Keep on action log and get an update from Ellie Monkhouse.

Action 80 – Give clarification around Governors roles at committee meetings
Guidance had been provided by Linda Jackson. It was agreed to remove this item from the action log.

Action 87 – Annual safer staffing and establishment review – write to Peter Reading to confirm whether the review needs to be presented at the Workforce Committee for assurance
The Chair confirmed that the annual safer staffing and establishment review is to be presented at the Quality and Safety Committee. It was agreed to remove this action from the action log.

The Chair reported that there was another referral from the Audit Committee that should have been on the action log around the audit review of the establishment control process. There was a suggestion that the digital establishment control platform was being bypassed on occasions. Claire Low added that the review had been completed and there was no link with vacancies being created by stepping outside of the establishment control process. Paul Bunyan agreed that the front end had been tightened up so that roles cannot be advertised until establishment control approval had been granted. It was agreed to add this item to the action log for today's meeting and then close the action down.
Action: Wendy Stokes

6 Items for ratification and assurance:
Both the following papers must go to Trust Board for final approval.

6.1 Gender Pay Gap Report
This report was to be discussed at the Private Trust Board meeting in March 2021. There is a legal requirement that the Trust must publish the gender pay gap data on a yearly basis. The publish date was by the end of March and this morning the trust had been informed that

this has been extended to the 06 October 2021. The actions outlined show how to move forward and the differences between median and average female and male colleagues. The Chair is keen to make sure the Workforce Committee and Trust Board take this issue really seriously and note some of the actions that fall out of this paper moving forward.

Peter Reading stated that there were two issues. In the first table it relates to progress being made in the last year and it looks as though some of the data is skewing things because the table in paragraph 4.11 shows a bigger improvement in the pay gap over the last year. At the top there is a massive increase in 2021 in the mean hourly rate for males and females. Peter Reading believes this is a quirk of the pensions system; it had a £30 million increase in 2020/2021. He cannot explain why the average pay rate went up by 15% in 2021, as it had not happened. He thinks it is the gross figures that need checking, then the denominator for the difference will change and that will show a modest impact on the gender pay gap. More generally across the NHS the pay gap is skewed in different ways, what you need to do is find a way of taking out the skewing factors. If the trust has a medical male worker they will dominate the higher pay groups and that is going to sway things. For future years the trust needs to work out what its pay gap is about, is it the trust paying different rates for doing the same job or is the shape of the workforce different? Until the trust knows that it cannot be sure.

Christine Brereton replied that the data will be checked and she wondered if one of the differentials could be the AfC uplift. In terms of the second question around the differential if you look at the percentage of workforce, which is predominantly female and in question 1 to 3 it is similarly represented. In quartile 4 there are more males which are not representative of the percentage of the workforce. In question 4 bonus payments are also skewed. Internal intelligence and more sophisticated analysis will help.

Claire Low asked Karl Portz if he wanted to add anything and she explained that Peter Reading's concern was about data being correct and if there looks like significant improvement has been made. He was questioning figures from one year to the next because they had gone up significantly and that may be skewing the figures which might be due to AfC uplift to pay grades. Karl Portz added that he is working on information provided by payroll and the change in figures is due to quartile 4. Peter Reading highlighted a pension payment that did not land in person's pockets and he asked for that to be checked with Brian Shipley.

Robert Pickersgill added that Quality and Safety reported last April on data that showed some national benchmarks, building on statistical refinement, provides interesting statistics nationally and shows trends from 1998 and the requirement changed in 2018. This is a first indication of how to explain anomalies. The national figures for the gender pay gap are lower than the trusts and he asked why there is such a differential. There is also a total of 80% of staff that are females and that also needs to be looked at.

The Chair asked Karl Portz if the way the information was presented reflects how it must be reported to commissioners, regulators and the outside world. The Chair asked Karl Portz to make sure that the trust can explain the difference.

Christine Brereton added that Robert Pickersgill is right; the report is somewhat meaningless if it has not got comparable data. The comparability can only be done when all trusts have submitted their data after October.

The Chair confirmed the Workforce Committee is happy to recommend the report to Trust

Board for approval subject to the data being checked and correct. Linda Jackson asked to make sure the correct data is available and the report is amended before going to Trust Board. The Chair agreed.

6.2 Modern Day Anti-Slavery Statement
This report will go to the Public Trust Board Meeting in April. The trust must comply legally with the report and statement. Prior to going to Trust Board the information out of the report will be put into a statement so that it is clear. The Chair agreed that should be done.

The trust submits an annual statement and it is a refresh from the previous year. This is linked with finance in the organisation and whilst no staff are working outside the country the main element links to supply chains within procurement. The Chair added it is around procurement and contracting which is really important. Linda Jackson made a plea that the committee should be presented with a tracked changes document to show the changes made as that would aid the speed of reading the documents. The Chair agreed with the suggestion to see what yearly changes are being made.

The Workforce Committee was happy to endorse the report.

7 Workforce Committee: review of working arrangements

The Chair stated that everyone is still in the middle of the pandemic and a lot of people directorate staff is working on the vaccination programme. He asked how the committee improves things such as mandatory training and PADRs going forward. The committee in a focused way needs to pick up the right issues and make sure progress has been made. Historically long reports have been tabled at meetings to focus the committee. There are some issues with data quality particularly around the workforce numbers. In terms of the assurance programme this committee plays an important role to have that level of assurance and to support the teams to achieve that. What is the key information and how do we move forward and support that.

Christine Brereton replied that it is fair to say that she has been with the trust six weeks now and is really keen to make sure that the right things are being talked about at the right committees with regard to workforce. There are huge amounts of data being provided in different ways to different committees and she is keen to try and understand the workforce metrics and the performance measures that are meaningful and presented at the right level to the right committee. She is looking at having a set of workforce data, doing some work with NHSI and looking at the IPR that was presented to Board in February to give assurance around workforce. At the Workforce Committee that information can be drilled down for areas of concern to address the problems and identify any issues. There are some concerns around data quality and the People directorate is trying to make sure the source data from ESR is correct and where it needs to be.

Christine Brereton would like to align other metrics to the NHS People Plan and align performance measures around the People Strategy by using FPC charts. This is high on Christie Brereton's priority list and she has also spoken to Peter Reading. A good place to start is perhaps to provide assurance on a small number of metrics, and she asked for everyone's patience whilst that gets up and running. Firstly, what is the purpose of this committee and how is it best to do that, having a detailed twenty page report may not give the committee what it needs to do. The committee will need to be assured on what it needs to be assured on and this also provides the link between the Workforce Committee and the right level of the Trust Board.

Linda Jackson stated that she fully supported the structure and focus of papers and is keen to capture the real purpose of the Workforce Committee. There are a few things going on firstly, there is an old work plan that needs to be reviewed with Christine's help. Secondly, with COVID

and the impact on staff, this has caused a lot of staffing issues that are going to be around for a while. Thirdly, in April the Trust Board will agree the business plan and priorities for the trust and the Workforce Committee can pick out of that what is key and what it needs to focus on. Fourthly, there are a number of consultations later in the year and a lot of workforce issues will be falling off the back of that. The Chair added that the key KPIs are recruitment and retention.

Robert Pickersgill felt that the workforce cut of the BAF is particularly relevant. On page 4 of the previous minutes Andrew Smiths refinement of risk analysis and link that to the BAF and you almost have a work programme falling out of that. He would expect that to appear in every meeting for consideration. Secondly, the Gender pay gap report, bonus payments and other observations around the CQC report, mandatory training and appraisal. He can see a link to issues around appraisal being linked to management issues and the committee could look at that in more detail. Those are two gigantic areas to enhance the role of the committee. The committee has already had the BAF, CQC and Audit Committee and it needs to take the time to say how the committee is addressing those in one way rather than having separate action plans. The Chair agreed with Robert Pickersgill the committee needs to do justice to the areas he mentioned and they also need KPIs.

Robert Pickersgill stated that resilience is the other side of risk analysis and you can build in resilience and make extra sure you are addressing those problems properly. Staff and wellbeing is also part of that. Tim Mawson added that one of the major issues on the shop floor nationally is the skill gaps in clinical areas which get worse during COVID with staff getting ill. It is about trying to keep staff on the ground and also being able to recruit them.

Neil Gammon thoroughly supported Linda Jackson reminding the committee of the importance of the work plan and a positive strategic element of that work plan. The Workforce Committee must offer assurance to the Trust Board and take a strategic view with the People Strategy and People Plan to ensure they are always on the front foot alerting the Trust Board who then need to take a view and action. The workforce is pervasive with everything that the trust does.

Christine Brereton asked Paul Bunyan to talk about the work with NHSI and their meeting with them. Paul Bunyan reported that NHSI had offered support to develop a suite of workforce metrics and they want to use that as an example for the whole of the UK. They are starting with areas where they are confident about the data and it is also about the message and how action focused the trust is. A further meeting was held this week with NHSI and then there will be a wider audience to look at metrics and this is steered by what Christine Brereton said previously about the NHS People Strategy.

The Chair stated that he is keen to get the committee back to some kind of business as usual and to be able to present information and discuss key areas. He is hoping that by the next meeting we will be in a better place to do that. The priority at present for the trust is to its patients and its staff and hopefully the committee will be as pragmatic as it can be and look at key areas and report to the Board. The Chair was pleased with the progress Christine Brereton and her team had made to date.

8 Any Other Urgent Business:
Nothing discussed

9 Date, time and venue of next meeting:
Tuesday, 27 April 2021 at 2.00 pm held virtually via Microsoft Teams

The meeting closed at 14:57

NLG(21)134

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors Public
REPORT FROM	Dr Kate Wood – Medical Director
CONTACT OFFICER	Jane Heaton – Associate Director – Strategic Medical Workforce
SUBJECT	Guardian of Safe Working ¼ report
BACKGROUND DOCUMENT (if any)	TCS 2016/2018 – Junior Doctors
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	GoSW/JDF Forum Joint LNC TMB
EXECUTIVE SUMMARY	The note the quarterly report – for information This report went to TMB on 19 April 2021. Exception reports for the quarter 1 January 2021 to 31 March 2021 saw an increase from 49 to 60 exception reports in this quarter. The majority of the exception reports submitted were in connection with working hours, with a small number also submitted around educational opportunities and work patterns for which the Director of Post Graduate Medical Education continues to oversee and discuss within the relevant Divisions/Directorates. There is still on-going work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared. Once refresher training has been carried out on the allocate system for exception reporting and Educational Supervisors reminded of their responsibilities the time spent by the Guardian of Safe Working in relation outstanding exception reports should reduce

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Quarterly Report

Jane Heaton
Interim Guardian of Safe Working
19 April 2021

Contents

1. Executive Summary

Exception reports for the quarter 1 January 2021 to 31 March 2021 saw an increase from 49 to 60 exception reports in this quarter.

The majority of the exception reports submitted were in connection with working hours, with a small number also submitted around educational opportunities and work patterns for which the Director of Post Graduate Medical Education continues to oversee and discuss within the relevant Divisions/Directorates.

There is still on-going work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared.

Once refresher training has been carried out on the allocate system for exception reporting and Educational Supervisors reminded of their responsibilities the time spent by the Guardian of Safe Working in relation outstanding exception reports should reduce.

2. Exception Reports

Current numbers of Doctors in Training within NLaG is as follows:

Number of Training Posts (WTE)	263
Number of Doctors/Dentists in Training (WTE)	247.47
Number of Less than full time (LTFT) Trainees (Headcount)	24
Number of Training post vacancies (WTE)	34.03
Number of Trainees by Site (Head Count)	
SGH	126.5
DPOW	103.8
Goole	0

Source Finance data

During the period of this quarterly report (January 2021 to March 2021) there have been a total of 60 exception reports submitted through the allocate exception report system.

This showed an increase of 18 exception reports from the last quarter (October 2020 to December 2020).

Of the 60 exception reports submitted, 54 of these were linked to hours. This showed an increase of 18 reports from the previous quarter.

The exception reports for this quarter relating to hours had been agreed by the Guardian of Safe Working (GoSW) for either payment or time off in lieu (TOIL).

These exception reports have now been closed on the system as they have been actioned appropriately.

The below table is a breakdown of the exception reports over the last quarter (January 2021 – March 2021)

Exception Reports Open (ER) between 1st January 2021 – 31st March 2021	
Total number of exception reports received	60
Number relating to hours of work	54
Number relating to pattern of work	2
Number relating to educational opportunities	4
Number relating to service support available to the Doctor	0
Number initially relating to immediate patient safety concerns	2*

*This number is not included in the total number of exception reports received – when completing an exception report there is an option to specify if the doctor feels there is an immediate safety concern and the system then flags this within the numbers.

Exception Report Outcomes (ER) between 1 January 2021 and 31 March 2021	
Total number of exception reports resolved as at 31/03/2021*	35
Total number of exception reports unresolved as at 31/03/2021*	25
Total number of exception reports where TOIL was granted	2
Total number of exception reports where overtime was paid	20
Total number of exception reports resulting in a work schedule review	0
Total number of exception reports resulting in no further action	7
Total number of exception reports resulting in fines	0

"Note:

* Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.

* Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.

* Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded."

3. Immediate Safety Concerns

During this quarter a total of 4 exception reports were submitted were the Doctors raised an immediate safety concern in addition to either a concern around working hours. Within the system, an exception report relating to hours of work, the work pattern, educational opportunities and service support has the option for the doctor of

specifying if they feel it is an immediate safety concern. An immediate safety concern is not an exception field on its own.

Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and progressed appropriately.

When investigating those exception reports that had a potential safety concern also attributed to them the outcome was:

- Inability to leave on time and a requirement by the doctors to complete tasks before handover. The doctors also flagged this as a safety concern, following investigation it was not categorised as an immediate safety concern.

4. Work Schedule Reviews

During this quarter there were no work schedule reviews required.

5. Trend in Exception Reporting

This quarter showed, as the previous ¼ report had, exception reports relating to educational opportunities were again due to service delivery, for example doctors have reported the inability to attend clinics either due to the clinic being converted to telephone consultations or the doctor required on the Ward due to service commitments.

6. Fines Levied against Departments this quarter

During this quarter there were no fines levied against a Department.

7. Communication and Engagement

Work continues to look at the communication and engagement with our Doctors in Training.

The Guardian of Safe Working/Junior Doctors Forum has been up and running now for 2 months, has formal terms of reference, agenda and notes.

8. **Support for the Guardian Role**

There is now dedicated administrative resource for the Guardian of Safe Working which sits within the Medical Director's Office.

The Trust's Guardian of Safe Working was advertised and Dr Liz Evans, Specialty Doctor in Anaesthetics at DPOW has been appointed to this role. Current pre-employment checks are being worked through in order to secure a start date, however in the meantime the interim arrangements will continue.

9. Key Issues and Summary

Exception reporting during this quarter demonstrated a small increase in comparison with the previous quarter.

Recruitment to the Guardian of Safe Working is now complete.

Engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to resolve most issues as and when they arise.

Further training requirements for the Educational Supervisors has been identified and it is planned this will take place during 2021.

In summary, it appears to be a positive position going forward.

Engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned so that we see the exception reporting on a downward trend still needs to be taken forward.

Compiled By:

Jane Heaton
Associate Director – Strategic Medical Workforce and Interim Guardian of Safe Working
Helen Fitzpatrick
Administrative Support to the Guardian of Safe Working

Date: 19 April 2021

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)135

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Andrew Smith, NED / Chair of ARG Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	Audit, Risk & Governance Committee Minutes from 21 January 2021.
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	ARG Committee – 22 April 2021
EXECUTIVE SUMMARY	Minutes of the Audit, Risk & Governance Committee held on 21 January and approved at its meeting on 22 April 2021.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Oversight of entire BAF process, completion and achievement.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

MINUTES

MEETING: Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**

DATE: **21 January 2021** via MS Teams

PRESENT:	Tony Bramley	Chair of ARG Committee / Non-Executive Director
	Andrew Smith	Non-Executive Director
	Michael Whitworth	Non-Executive Director
	Neil Gammon	Non-Executive Director
IN ATTENDANCE:	Stuart Hall	Associate NED, NLAG / Vice Chair HUTH
	Lee Bond	Chief Financial Officer
	Shauna McMahon	Chief Information Officer
	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)
	Rob Pickersgill	Lead Governor
	Steve Mattern	Associate Director of IM&T (For Item 6.1 and 13.1)
	Tonya Fredrickson	IT Data Security Manager (For item 6.1)
	Ivan Pannell	Head of Procurement (For Items 6.4; 6.5 and 6.6)
	Nicola Parker	Assistant Director of Finance – Planning & Control (For item 13.2)
	Alison Hurley	Membership Manager / Assistant Trust Secretary (For item 6.2)
	Sue Meakin	Data Protection Officer / Information Governance Lead (For Item 6.3)
	Anne Barker	Finance Directorate Administration Manager / PA to DoF

Item 1 01/21 **Apologies for Absence**

There were no apologies of absence received

Item 2 01/21 **Declarations of Interests**

There were no declarations of interest made.

Item 3 01/21 **Minutes of the previous meeting**

The minutes from the public meeting held on 22 October 2020 were reviewed and accepted as a true record.

The Highlight report for the Trust Board was also noted.

Andrew Smith noted as a point of order that whilst the minutes provided were excellent, in terms of the ICO regulatory actions which was discussed in depth at the last meeting, it had been agreed to raise at the Trust Board through the highlight report and was duly noted but asked what the next steps would be.

Andrew Smith also highlighted the Data Security item and Tony Bramley asked that this was raised as a concern when discussing items 6.1 or 6.3 on the agenda.

Item 5 01/21 **Matters Arising / Review of the Action Log**

5.1 Action Log

The Action Log was reviewed as follows:

7.1 (15.6.20) - A&E 4 hour breaches – Tom Watson advised that the meeting was due to take place on 26 January 2021 and the work would then be able to be completed. It was suggested rolling this item forward to April 2021 for sign-off.

5.3 (23.7.20) – Annual Security Report – Issue of violence towards staff to be referred to the Workforce Committee – Michael Whitworth advised that they had discussed this at the Workforce Committee meeting in October 2020 and was now on their action log, therefore this item can be **closed on the ARG Committee Action Log.**

11.1 (23.7.20) – Internal Audit Progress Report – Review of Establishment Control process to be referred to the Workforce Committee – Michael Whitworth advised that they had discussed this at the Workforce Committee meeting in October 2020 and was now on their action log, therefore this item can be **closed on the ARG Committee Action Log**.

11.1 (22.10.20) – Medical Staff Personnel Files Review – Stuart Hall had previously raised a question on the possible impact on the Trust's indemnity cover. Confirmation received from Medico Legal and was not considered to be a material consideration unless a contributory factor in claims and/or SIs. Therefore this item could be **closed on the Action Log.**

All other items on the action log were addressed through scheduled agenda items at the meeting and were therefore closed off.

Following the review the Action Log was noted.

Item 6 01/21 **Management Reports for Assurance – Items for Discussion**

The following items were taken out of sequence to allow for attendees to provide their update and leave the meeting.

6.1 Annual Review of Trust's Cyber Security Arrangements – CONFIDENTIAL – This item was discussed and minuted under a private agenda item.

13.1 Mobile Phone Policy – Review of document.

Steve Mattern briefly highlighted the changes to the document which included minor amendments to bring it up to date as well as a new section 6.7 on the Trust mobile phones contact numbers which would be published on the Hub by default unless requested not to do so by the mobile phone user.

The Committee noted the minor changes and approved the Policy.

6.3 IG Steering Group Highlight Report

Sue Meakin presented the report which was taken as read and highlighted specific issues to note, including a focus on ICO investigations. Sue Meakin drew the Committee's attention to section 4 within the report and the breakdown of all ICO reportable incidents since 1 April 2020. These had resulted in no further action by the ICO being deemed necessary. In terms of the staff accessing and allegedly disclosing information of a data subject, whilst no further action would be taken by the ICO the subsequent findings of the HR investigation would be shared with them.

Lee Bond queried what was being undertaken in respect of Trust Wide comms to discourage staff from viewing records inappropriately, following the incident of accessing information. Sue Meakin explained that it had been highlighted through a number of routes including the daily email from the CEO, a message on the HUB plus a lessons learnt newsletter and assured the Committee that this was being done on a continual basis.

Andrew Smith referred to point 1 of the highlight report relating to status of 'Standards Not Fully Met (Plan Agreed)' and stated that as a NED it did not fill him with comfort and queried when the Trust would execute the plan as there was a need to get traction as soon as possible.

Sue Meakin in response, stated that there was an improvement plan in place and the Trust must look at the outstanding actions, adding that the Data Security protection Toolkit return would be *standards not fully met* with plans agreed and the ICO could choose to do an audit if they deemed it necessary but they would expect work to be ongoing with a number of actions within the toolkit heavily reliant on digital so all interlinked. Tony Bramley stated that this was a moving feast but needs to get to a point where the Trust are comfortable with it.

10.18am Shauna McMahon left the meeting.

Neil Gammon referred to the data on pages six and seven of the report and queried if there was some information missing. It was agreed that Sue Meakin and Neil Gammon would discuss outside of the meeting and inform Sally Stevenson / Anne Barker for the purposes of the minutes if required.

Action: Neil Gammon / Sue Meakin

Tony Bramley commented that he had chaired the inappropriate access to WebV investigation which had now concluded, and that a number of staff had a right to access the information but not necessarily the need to do so, and there appeared to be a lack of clarity and therefore the emphasis should be on this going forward.

Following the review and subsequent discussions the report was noted and Sue Meakin left the meeting.

6.2 Quarterly Document Control Report

Alison Hurley attended the meeting to present the quarterly document control report. Following various changes requested by the Committee at the last meeting Alison Hurley stated that the report now showed detailed Divisional information and included (page five) a breakdown of the documents due for renewal in priority order.

Alison Hurley highlighted that a fixed term post had been recruited to address the backlog of overdue documents and they have written a business case to make the additional resource permanent. Alison Hurley went on to explain there had been a slight improvement overall and those areas with the highest number of overdue documents i.e. Medicine and Clinical Support Services have plans to address by March 2021, although there could still be slippage due to operational pressures.

Stuart Hall referred to the executive summary on page 1 of the document and the overall improvement noted which is a 0.3% decrease from the previous report yet there had been an increase of 29 documents either overdue or due to be out of date within the next three months and reiterated the points made at previous meetings in terms of going through the quick fixes in order to make progress.

Alison Hurley explained that she had met with Divisions and Directorates to determine the quick fixes by ensuring the documents were still appropriate.

Lee Bond commented that he was worried about the difficulty of managing 3,200 documents which seemed excessive, and suggested it was difficult to understand the scope of this. Tony Bramley commented that the documents are owned by multiple divisions and then referred to Appendix B and the list of overdue documents dating back as far as 2006 and suggested it is all about risk stratification. Tony Bramley added that as a Committee it was difficult to understand where there is a potential high risk to patient safety which is a primary concern. It was noted that this had been picked up by the CQC for a number of years and it was agreed to add to the highlight report. Tony Bramley posed the question of how the Committee made their involvement effective but did not want to just haul Divisions into the Committee but need to get the message out there.

Helen Harris agreed that it was a challenging issue and that there was a need to go back to the Divisions to review their overdue documents from a risk perspective. Helen Harris stated that she would work with Alison Hurley and Jonathan Darley on this. It was felt however that to get the assurance required it may be necessary to invite the Divisions to the Committee to respond to what actions they are taking.

Action: Helen Harris

Andrew Smith commented that he had a degree of frustration with this, as the risk issues had been discussed at the previous meeting of the Committee, but agreed with Tony Bramley that risk stratification was required and also a need to determine an organisation wide risk appetite statement if asking the Divisions to do a risk analysis.

Tony Bramley proposed adding the on-going concerns in this area to the Trust Board highlight.

Following the review and discussion the report was noted and Alison Hurley left the meeting.

6.4 Waiving of Standing Orders Report

Ivan Pannell attended the meeting to present the report and highlighted that 20 waivers had been received in the last quarter, which was a reduction on the previous quarter, and was happy to respond to any questions from the Committee.

Tony Bramley raised the issue of Amvale which had been rolling on for a number of years and never seemed to get resolved.

Ivan Pannell advised that it is expected to publish the tender for paramedic equipped ambulance for 24 hour discharge, which was the biggest portion of the contract. Estates and Facilities are currently reviewing the cross-site shuttle bus service and courtesy car function and it is hoped to be concluded in the next 2-3 months. Ivan Pannell assured the Committee that work was ongoing and hoped to be able to report progress at the next Committee meeting. Lee Bond advised that he had been reviewing the contracts position with Ivan Pannell, adding that this was nothing he doesn't see elsewhere, and that he would pick up the Amvale issue with Ivan Pannell outside of the meeting.

Action: Lee Bond / Ivan Pannell

Following the review the report was noted and the Committee await a progress update at the next meeting showing the Amvale contract being moved along.

6.5 Invoices without Purchase Orders Report

Ivan Pannell presented the report and stated that it had settled into a particular pattern with some peaks and troughs. He went on to state that around 10% of invoices were coming through without PO and whilst there had been no improvement, neither had there been any deterioration, other than to note certain peaks i.e. in December due to a huge number of invoices in relation to utility and rent invoices and some backlog of invoices for the Urgent Treatment Centre service.

Ivan Pannell highlighted the consistent outliers of Clinical Services and Estates with high numbers of invoices with no PO. Ivan Pannell added that capacity issues within the Procurement team had made it difficult to review and challenge these areas to improve compliance, but stated that it needs to become part of their normal work pattern.

Lee Bond stated that it was proposed to agree an improvement trajectory with Estates along with the Family Services and Medicine Divisions. Tony Bramley suggested that some of these could be the nature of the work and it would be helpful to identify those and the reasons suggesting a short statement in the next report on the issue and what was being done.

Action: Ivan Pannell

Following the review the report was noted.

6.6 400 Contracts Progress Report

It was suggested that the '400' should be removed from the report as this was an historic number.

Ivan Pannell referred to the analysis of the database which had been filtered to show higher value contracts of £40k and above, and those that had expired or due to expire within the next 15 months. Following this process there were 95 contract lines which was a slight decrease from 98 reported at the last meeting. The most significant in terms of importance, value and status were listed in the report which included the Amvale contracts. Other contracts were either out to tender or at the evaluation stage so no huge concerns as procedures were in place to take forward.

Stuart Hall referred to the Synergy Health Laundry Service and asked if there was anything to be done together with HUTH. Lee Bond agreed that those conversations could take place, as it would give increased resilience. Ivan Pannell advised that the current contract is done in collaboration with York and Harrogate.

Neil Gammon noted that the tables at the end of the paper indicated the significant number of year on year extensions to contracts. Ivan Pannell explained that this was partly due to the volume of work involved to deal with them, and also noting that the database is a live document and that some lines could be cleansed and taken out.

Rob Pickersgill noted that reasons do not feature alongside contracts within the report and asked if there were initiatives planned to improve the report to show this level of information. He also asked if was worth asking the Auditors if there was anything in their plans suggesting that lack of information may be due to some weaknesses.

Tony Bramley stated that Ivan Pannell was relying on areas to do their jobs, and it was clear that the Committee needed to put their support behind the Procurement team in order to keep the pressure on and enable Ivan Pannell to be able to do his job effectively.

Lee Bond noted that the report, when first requested, included hundreds of contracts but is now down to circa 100 and asked if the Committee still wished to see the report. Andrew Smith suggested that it was a useful report and a strong control mechanism giving the NEDs visibility of the contracts, and applauded it, adding that it should mature a bit more before eventually adopting an exception report to the Committee approach. Tony Bramley commented that he found the report very useful. Lee Bond suggested that there was an element of duplication as contracts were determined by PO's/contracts, and no greater assurance. However, Andrew Smith stated that contracts have a level of risk more than PO. Lee Bond suggested therefore to continue to produce the report for the Committee but suggested taking a view in the future as to its routine reporting nature. Tony Bramley explained that the PO issue was historic which was why the report was asked for and the contract report highlights the controls in place.

Following the review and discussion the report was noted.

6.7 Salary Overpayment Report

Sally Stevenson presented the report which showed a decrease in the value of overpayments for Q3 of 2020/21 from £197k in Q2 to £90k in Q3. However, Sally Stevenson noted the payroll error, highlighted at the last meeting, of transitioning of Band 1 staff to Band 2 as part of the national pay award arrangements totalling £95k. Therefore the true decrease in overpayments for Q3 was £12k. Sally Stevenson noted that it can take just one termination form being late that can have a significant effect on the figures, as had been the case in Q3.

Stuart Hall referred to the compliance letters and did not think that all those receiving the letters took them seriously noting one late termination form amounted to just under £24k. Sally Stevenson explained that the non-compliance letters have been working quite well, with various conversations with those receiving them, but they only go to repeat offenders. In this particular case it was late termination form for a Doctor and therefore a higher amount involved..

Tony Bramley asked about the escalation process as these are management failures and whilst there may be some valid reasons others are inexcusable. Sally Stevenson explained the escalation process which involved the first non-compliance letter to the manager concerned; the second letter is sent to the manager and their line manager and letter three to Executive Director for action as appropriate.

Rob Pickersgill asked what controls are in place to find these issues in the first place or is it reliant on late notification before they appear. He also asked about disbursements and control accounts. Lee Bond explained that the main control is within Management Accounts who would flag as a variance but the majority of reasons for overpayments were due to late notifications. Sally Stevenson added that control reconciliations did take place within the Financial Accounting team.

Lee Bond proposed speaking to Nicola Parker and pulling together a response to Rob Pickersgill's questions which would hopefully help with more detailed explanation.

Action: Lee Bond

Following the review and discussion the report was noted.

6.8 Declarations of Interest – Compliance with Policy

Helen Harris presented the report which outlined the compliance with the Standards of Business Conduct Policy. The report also outlined the current future approach to the management of declarations of interest which was anticipated to be implemented by April 2021. Helen Harris advised that it had been discussed by the Executive Team and she was currently working with IT to create an e-register, noting the biggest challenge would be the comms.

Andrew Smith noted that the comparison with other Trust was very useful, and that it was important to get traction and deadlines for this area. Tony Bramley endorsed this and was pleased to hear that an electronic system would be up and running from April 2021

Helen Harris stated that she had spoken with Tony Watson to propose that an Internal Audit is undertaken in 2022/23, which the Committee agreed.

The Committee requested a six monthly update on progress in this area. Tony Bramley also asked if this featured in the risk register which Helen Harris agreed to add.

Action: Helen Harris

Following the review the report was noted.

Item 7 01/21 Management Reports for Assurance

7.1 Hospitality and Sponsorship Declarations

Helen Harris presented the report which gives details of all hospitality, sponsorship and gifts declared by staff for 2020/21, as well as details of any interests and outside employment declared by staff.

Neil Gammon noted that his information was not shown on the report and Helen Harris stated that it is reported separately for Board members and should be in one register to bring together.

The report was noted subject to that comment.

Item 8 01/21 **Losses and Compensations Report**

Lee Bond stated that this is a standard agenda item for most Audit Committees and drew the Committee's attention to the table on page five in particular the loss due to pharmacy waste due to overstocking of fridge (£10.5k) and drugs left out of fridge (£3,600). Lee Bond advised that he would have a conversation with the Chief Pharmacist about this. Other issues in Section G e.g. hearing aid losses which unfortunately happens in hospitals.

Sally Stevenson also added that the value of bad debts was lower this year due to the level of write offs in previous years, as advised by Nicola Parker.

Stuart Hall noted the circa £2k payment supporting travel for a doctor and whilst he could understand some travel is involved within hospitals but given Covid-19 lockdown asked if this was expected and reasonable. Lee Bond agreed to investigate and provide an update.

Action: Lee Bond

Tony Bramley queried the pharmacy waste items in section D and some items from January and February 2020 were shown in the 202/21 report. Sally Stevenson advised that these were likely just due to a time lag in them being reported to Finance, etc, but agreed to confirm.

Post meeting note: The issue was confirmed as a time lag in reporting.

Tony Bramley referred to the ex-gratia payments narrative in section G v) on page two and understood that the RATs have in the past authorised non statutory payments but as far as he was aware had not been reported through the ARG Committee for historic reasons. He asked therefore where this happens whether it should fall within this report for accountability purposes in order that RATs are not exposed, and believed that it should be.

Following review the report was noted.

Item 9 01/21 **Review of Board Assurance Framework and Strategic Risk Register**

Helen Harris advised that a full presentation of the new layout of the BAF would be presented to the next Trust Board meeting on 2 February 2021, and that she did not intend to go through the BAF with the Committee stating that it belongs to the Exec Leads. The BAF continues to be reviewed with Exec Directors having ownership and oversight.

Tony Bramley referred to Risk 3 (Adverse Impact of external events i.e. Brexit), which currently sits with the ARG Committee and would need a Board level discussion on where that risk should sit. Andrew Smith agreed that a discussion is required and put on record.

Neil Gammon concurred with earlier remarks and noted that within the report it refers to the People Strategy to be launched but thought that that had already happened. Helen Harris explained that the People Strategy was approved but put on hold until Christine Brereton took up post, noting that the Trust Board development session on 2 February 2021 also included the People Strategy and its implementation.

Helen Harris also referred to Brexit and the Brexit Oversight Group (Page 44) which states that TMB are the oversight group with ARG as the Assurance Committee.

Tony Bramley reiterated his earlier remark that this needs a discussion at the Trust Board Development Session on 2 February 2021 for a simple resolution. It was also agreed to note it in the Trust Board Highlight Report.

Action: Tony Bramley

Following review the report was noted.

Item 10 01/21 **External Audit (Mazars)**

Mark Surridge presented the report which sets out the external auditor's scope of work and key area of focus and confirmed that they were sufficiently resourced to meet the deadlines with appropriate flexibility as required. 2020/21 draft and audited accounts submission dates have now been confirmed. External assurance on the Trust's Quality Report is once again not needed this year. This will see a fee saving for the Trust. Going forward this may be something that the Trust could commission from its Internal Audit service

In terms of expenditure, Mark Surridge expected that there would be additional testing in terms of Covid-19 costs reimbursement. Mark Surridge referred to the issue of Going Concern and the need to keep a watching brief as a Finance team.

In terms of the audit fees shown at section 6 of the report, Mark Surridge advised that there was a substantial increase in the annual fee for the statutory audit work, due to the increased scope of work and reporting requirements from the new Audit Code of Practice issued by the National Audit Office (NAO), particularly in relation to the VFM conclusion. Mark Surridge assured the Committee that this had been consistently applied across all of Mazars clients.

The Committee then heard that 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 VFM conclusion will end up in the public domain, so Mark Surridge stated that there was a need to ensure that the commentary wording was fair and mutually agreed.

Lee Bond commented that the update from Mark Surridge was helpful and referred to the cut off risk for revenue and asked if Mark Surridge could elaborate. Mark Surridge explained for revenue recognition it is necessary to consider what they see and most block contracts do not present a risk as they are very easily verifiable at year end but need to ensure that any deferred income is recorded in the correct year. Lee Bond stated that it was expected that block contracts would roll over into Q1 so should be quite straight forward.

In terms of the VFM exercise, Lee Bond commented that it felt like a fishing trip. Mark Surridge confirmed that the new code changes the way in which the External auditor will report their findings in relation to the Trust's VFM arrangements. There is an overarching guidance note then supplementary guidance so acknowledged the need for a lot of work with comprehensive reports required. Mark Surridge confirmed that they have the people and resources to deliver what is required. Lee Bond stated that the Trust and the External Auditor would need to plan sufficient time for this carefully as the auditing window is narrow.

Andrew Smith referred to last year's non-standard audit opinion and queried whether this was specific to NLAG or generic across all Trust's in similar circumstances.

Mark Surridge stated that they were expecting sector wide paragraphs for going concern limitations of scope. These impacted a few Trusts last year but it is expected to impact more this year due to valuation of land and buildings and Covid-19. Mark Surridge added that everything would be run through a national panel for consistency checks, and other organisations would be in the same position.

Andrew Smith stated that he would want to be quite comfortable and agree with any Going Concern reference and how this can be reconciled to the Board's conclusions in this area.

Reference was made by Neil Gammon to the Group audit approach which previously had included WebV Solutions and the Charitable Funds accounts. Mark Surridge explained that in 2021/22 this is not required as WebV Solutions Limited closed and the Trust's Charitable Funds and other related charities being immaterial as a whole.

Nicola Parker who had joined the meeting added that in terms of WebV they were still waiting for confirmation from HMRC that it was closed but they were still planning on consolidating the Charitable Funds accounts, adding that they had done M9 TAC and consolidated them.

Rob Pickersgill highlighted that the Governors were interested to hear about the affected changes in activity due to Covid and the effect on income reported in the accounts and wondered if these could be briefly outlined. Lee Bond explained that there would be no issues with change of case mix which is the idea behind the block contracts. Lee Bond stated that there would be no material exposure for the Trust as a result of Covid-19 and stepping down other activity, with the exception being Pathlinks but in terms of money from CCGs there is no risk.

Rob Pickersgill queried if that was why there was more interest in expenditure this year, and Lee Bond confirmed that this was probably the case.

Tony Bramley agreed to include the update in the Trust Board highlight report.

Following the discussion and review the report was noted.

Item 13 01/21 **Accounting Policies**

Nicola Parker presented the report and drew the Committee's attention to pages one and two which summarised the items of interest for this financial year and highlighted issues to note as follows:

A) Going Concern – The 2020/21 accounts will be prepared on a going concern basis as in previous year.

B) Injury Cost Recovery – A slight increase to 22.43% from 21.75% the previous year. The Trust will continue to provide for 25% based on experience, as in previous years.
C) Provisions – The discount rates for 2020/21 have been revised to -0.95% from -0.50% the previous year.
D) In-year Revaluations - A desktop revaluation for the year end 31 March 2021 has been commissioned with Cushmann Wakefield to review the land and buildings across all sites. Additional narrative is expected regarding "material valuation uncertainty" in the valuation report; it is understood this will come from the DHSC.
E) WebV Solutions Ltd – The Trust is waiting for final confirmation from HRMC relating to the tax clearance.
F) Covid-19 Income and Expenditure – Further standard narrative for all is expected around Covid-19 income and expenditure and will be incorporated into the Trust's accounts and accounting policies once available.

Rob Picksergill queried if the Apprenticeship Levy was fully utilised; Climate Change Levy which he thought charities were exempt from; and Public Dividend Capital (PDC) commitment in future years. Nicola Parker confirmed that the Apprentice Levy is fully utilised and the Trust's HR Department contact other partner organisations if we cannot fully utilise, to make best use of the funds. Charity is exempt in terms of the Climate Change Levy, just the Trust. PDC will increase going forward as the Trust substantially increases capital investment.

The review was noted. Nicola Parker was thanked for the report and update and she left the meeting.

Item 11 01/21 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 within the report noting that only one advisory audit report had been finalised since the last meeting. Work had progressed however on a number of audits.

Tom Watson referred to the last meeting and the need to escalate any ongoing engagement issues and a meeting was arranged with Peter Reading, CEO, to discuss further.

Tom Watson stated that the workload is usually weighted in Q4 and more so this year due to Covid-19 restrictions/operational pressures. Audit Yorkshire have considered the 'must do' audits in order to give a meaningful audit opinion at year end, and Tom Watson stated that there were no concerns in delivering these but as there was no contingency built in it would need the support of the Exec Team and operational staff involved in the audits to ensure they supported with the conclusion of the field work and sign off of the draft reports, etc. .

Tony Bramley suggested taking item 11.4 concerning the Head of Internal Audit Opinion (HoIA Opinion) paper at this point in proceedings.

Helen Kemp-Taylor stated that it was recognised this had been an unusual year with significant challenges but the focus had to be on the provision of enough assurance to provide a meaningful HoIA Opinion for the Trust's Annual Governance Statement (AGS). The must do's and should do's were set out in the paper and this was where focus would be given and reiterated Tom Watson's comments for support from the Executive Team and operational staff. Whilst it was acknowledged the challenges within the organisation Helen Kemp-Taylor assured the Committee that it was manageable and doable to be able to give a meaningful HoIA Opinion.

Tony Bramley acknowledged the challenge and stated that the Committee would support as needed to ensure that the work was completed.

Andrew Smith referred to the Client Briefing document (Item 11.4) and asked what the distinction was between must do's and should do's and should the Committee be concerned if not able to complete. Helen Kemp-Taylor stated that this was a subjective view in order to provide an opinion at the year end and that it was not an issue for NLAG as the audits were all planned and the intention was to complete all as necessary. Andrew Smith asked if they were all going to be done and Helen Kemp-Taylor confirmed they would.

Andrew Smith stated that the Trust Risk Appetitre has low tolerance for issues that threaten patient safety and asked if the audit work is skewed to assuring patient safety. Helen Kemp-Taylor stated that this was indicative of the current situation in terms of deferrals in clinical areas and was one of the reasons for flagging this to the Committee.

Tony Bramley stated that it was important that all NEDs and Executive Directors are sighted on the need to complete the 2020/21 audit plan and give the compliance needed. It was agreed that they can then focus on the 2021/22 plan at the internal audit planning workshop event being held on 4 March 2021.

Tom Watson advised that a number of requests had been received to move audits into Q4 with additional days used for mandated audits and four new audits added to the audit plan. Tony Bramley and Neil Gammon agreed that this was a fait accompli and therefore agreed as presented and to pick up the consequences at a later date.

It was agreed to flag the issue of internal audit progress with the plan and the impact on the HoIA Opinion to the Trust Board.

11.2 Insight Technical Updates Report

The Committee received the Insight Report for information. Tom Watson highlighted specifically the Integrating Care document. The Committee were not aware of this document and Helen Harris agreed to pick up with Peter Reading to review against guidance.

Action: Helen Harris

11.3 Internal Audit Recommendation Follow Up Report

Tom Watson presented the report and highlighted that reasonable progress had been made with implementing Internal Audit recommendations since the last meeting, although not as positive as in the past. Additional information was requested on the overdue recommendations more than 12-months old and Tom Watson proposed to discuss with the relevant Executive Directors and update at the next meeting, which was agreed.

Action: Tom Watson

Item 12 01/21 Counter Fraud

12.1 LCFS Progress Report

The paper was taken as read and Nicki Foley updated the Committee on key points to note.

- Counter Fraud Collaboration – A new LCFS had been appointed and commenced in post in December 2020, who would act as the nominated LCFS for LPFT and LCHS in the expanded counter fraud collaborative.
- Cabinet Office - Government Counter Fraud Functional Standards. The NHSCFA will transition to the new Functional Standard by the end of the financial year. Further guidance is awaited from the NHSCFA.
- Fraud Awareness Month – This did not happen in its usual format but there were postings on the HUB and also included within the CEOs regular Trust wide email. Awareness sessions were offered but none requested, but this was not unique to NLAG.
- Five new referrals received since the last meeting.

Tony Bramley thanked Nicki Foley for the comprehensive report as usual but was conscious that it never seemed to get the discussion it deserves at the end of the meeting and suggested moving it up earlier on the agenda in future.

Tony Bramley also suggested a reflection on how Covid-19 has impacted the Trust from a fraud perspective as well as any lessons to be learned.

Action: Nicki Foley

Item 13 01/21 (Cont'd) Policies for Review / Approval

13.3 Annual Review of Policy for Engagement of External Auditors for Non-Audit Work

Sally Stevenson presented the report and explained that since the first version of the Policy several years ago only minor amendments had been required annually, but this year a number of amendments had been required following updated guidance dealing with ethical requirements from the National Audit Office. Sally Stevenson advised that she had had a discussion with Mark Surridge from Mazars during the review process.

There were no comments received and the amended Policy was approved. Tony Bramley proposed adding to the Trust Board highlight report for information.

Item 15 01/21 Action Logs & Highlight Reports from other Board Sub-Committees

The action logs and highlight reports from other Board Sub-Committees had been included on the Sharepoint site for information as follows:

- Finance & Performance Committee
- Quality & Safety Committee
- Workforce Committee

The Health Tree Foundation Committee and the RATs Committee had not met since the last ARG Committee.

Tony Bramley noted that the Quality & Safety Committee highlight reports only related to August and September 2020 despite more recent meetings taking place. Anne Barker agreed to pick up with the PA's of the Committee's concerned to ensure up to date information is provided to the ARG Committee.

Action: Anne Barker

Item 16 01/21 **Any Other Business**

16.1 Results of ARG Committee Annual Self-Assessment Exercise 2021

The results of the ARG Committee Annual Self-Assessment Exercise 2021 was provided and agreed by the Committee. It was agreed to provide to the Trust Board along with an Addendum regarding adding the Ethics Committee and HTF in the ARG Committee's Terms of Reference to the list of Committee's with which the ARG Committee has a governance relationship.

Action: Sally Stevenson

16.3 Annual Review of ARG Committee Terms of Reference

The ARG Committee Terms of Reference were provided with only two minor changes proposed i.e. change of name from Director of Finance to Chief Financial Officer; and the addition of the Health Tree Foundation Committee and Ethics Committee as noted above.

The amendments were agreed and approval for submission to the Trust Board for final ratification.

Action: Sally Stevenson

16.4 Annual Review of ARG Committee Rolling Annual Work Plan 2021/22

The 2021/22 workplan was reviewed and agreed.

Item 17 01/21 **Matters for Escalation to the Trust Board**

The following items were agreed to highlight to the Trust Board:

- External Audit – year End Issues
- Internal Audit progress with 2020/21 Plan
- Overdue Controlled documents
- Board Assurance Framework
- Cyber Security
- Conflicts of Interest
- Annual Review of Policy for Engagement of External Auditors for Non-Audit Work

Lee Bond commented that it was a lot to highlight to the Board and should be prioritised accordingly, which Tony Bramley agreed to prioritise into those for action or further discussion and those for information.

Item 18 01/21 **Matters to Highlight to other Trust Board Assurance Committees**

Lee Bond referred back to the Quarterly Document Control Report (6.2) and noted that the vast majority were clinical documents and suggested referring to the Quality & Safety Committee through the Medical Director.

Helen Harris agreed to liaise with Mike Proctor as Chair of the Quality & Safety Committee, which was agreed.

Action: Helen Harris

Item 19 01/21 **Review of ARG Committee Workplan**

The workplan was reviewed and noted.

Item 20 01/21 **Review of the Meeting**

Tony Bramley noted that the meeting had overrun by 15 minutes and asked for any thoughts/observations from the Committee.

Neil Gammon took the opportunity to comment that this was Tony Bramley's last Committee meeting before he leaves NLAG for pastures new and said that life wouldn't be quite the same again in ARG Committee meetings. . Neil Gammon added that as a long standing colleague it fell to him to thank Tony Bramley for everything he had done for this Committee and the Trust in general during his time as a Non-Executive Director.

Tony Bramley thanked Neil Gammon for his kind comments which he appreciated.

Rob Picksergill commented that he was pleased and proud that he had been on the interview panel that appointed Tony Bramley as a NED at the Trust.

Tony Bramley said he would have a fondness for NLAG long after his departure.

Item 21 01/21 **Date and Time of the next meeting**

Thursday, 22 April 2021 – 9.30am-12.30pm – via Teams Meeting

NLG(21)136

DATE OF MEETING	01/06/21
REPORT FOR	Trust Board of Directors Public
REPORT FROM	Adrian Beddow, Associate Director of Communications
CONTACT OFFICER	Charlie Grinhaff, Communications Manager
SUBJECT	Communications Update
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	
EXECUTIVE SUMMARY	This report covers April 2021 and highlights activity and developments of the Communications team in relation to internal and external communications activity. Key points include: Building our Future communications has had a potential reach of nearly 8 million. 100% of media coverage in April was positive or neutral. The team has 100% compliance with mandatory training.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within	

the BAF or state not applicable (N/A)					
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

May 2021

Kindness • Courage • Respect

April update 2021

Key developments and projects

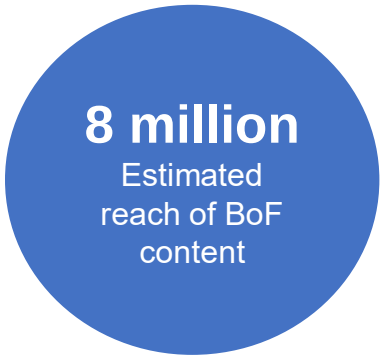
As the number of media enquiries, internal communication requirements and meeting commitments due to COVID-19 decrease the team is transitioning from a mainly reactive way of working to a more proactive one. Forward planning is underway for the year ahead and both the teams and individuals' objectives are now aligned and focused on the Trust priorities. The team are receiving many requests for support from other teams across the Trust as projects are started/resumed following the pandemic. Mandatory training compliance within the team is at 100%.

Humber Acute Services: our intention is to start an on-going comprehensive comms and engagement campaign both internally and externally.

Building our Future (BOF): The estimated potential audience for all the BoF content – including coverage by our local media - to the end of April is in excess of 7,992,394. During April, there were 409 unique visitors to the internal microsite site, generating 709 hits. The external site was visited by 1405 unique users, generating 1546 hits. Posts around parking and our plans to preserve the heritage of SGH generated the greatest interest

Other **Projects/campaigns** we are supporting include:

- CQC planning
- Discharge to Assess
- Recruitment adverts – started mid month
- Launch of the new Trust strategies
- Heart Failure@home
- The Green Agenda including encouraging staff to recycle



Internal Communications

Ask Peter – This continues to be a very popular forum for staff to raise concerns and questions about literally anything. We responded to 91 Ask Peter's in April. Parking was the most popular topic, followed by pigeons, training, staffing and soup bowls.

Staff Facebook Group – the group continues to grow. The most popular post highlights staff appreciate the fun elements of the group as well as the practical

Top posts on the group in April:
Photo of ducks at DPoW (see below): "Just another mum on her way home from the maternity unit."
Experience of Care Week 2021 – staff awarded certificates
Thank you post from a leaving staff member: "It's been an honour to work for the Trust."

91
Ask Peter responses in April

84
Staff attended the last SLC briefing

3,300
Staff use our closed Facebook group

External Communications - media

There was no negative media coverage in April.

Recent media interviews:

- Leanne Ellis on perinatal mental health – Viking FM, That's TV, and BBC Radio Humberside
- Jug Johal on free parking for blue badge holders – BBC Radio Humberside
- Jug Johal on the DPoW A&E planning approval
- Staff doing a charity sky dive for the Health Tree Foundation – That's TV, BBC Radio Humberside, Viking FM

Top media releases views on website (April)

- Visiting restrictions ease in maternity services
- Visiting restrictions being eased on wards
- Free parking for disabled drivers

24
Media enquiries dealt with (88% within deadline)

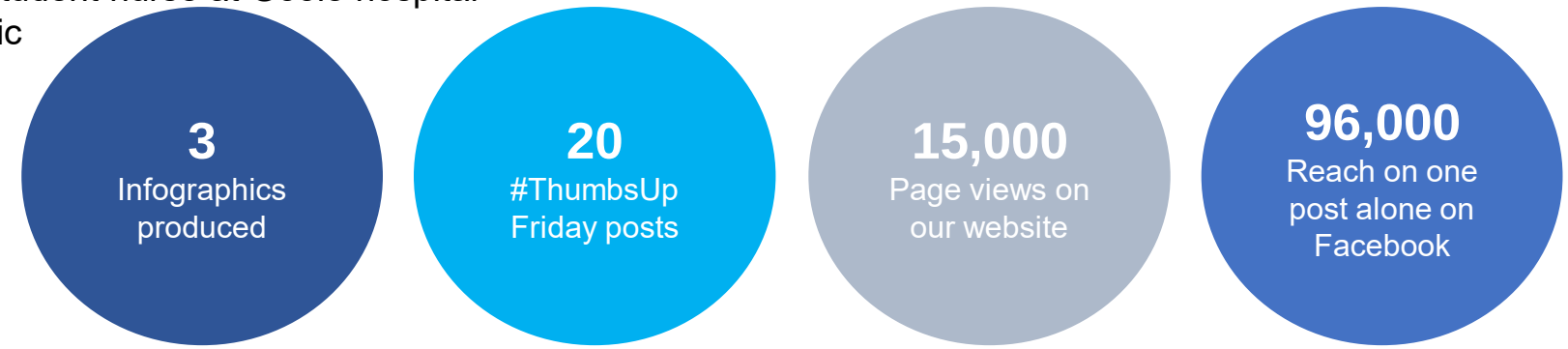
6
Proactive media releases issued in April

100%
Of media coverage was positive or neutral

Social Media and Website

Top social media stories in April:

- Just a mum taking her little one's home (duck photo from staff Facebook group) – 96,000 reach and more than 12,000 engagements
- Video of the longest ventilated patient being clapped out of ICU
- #ThumbsUpFriday to Jon, a student nurse at Goole hospital
- A year in numbers - infographic
- Visiting restrictions to ease



Most popular website pages in April:

- Lateral flow testing
- Vaccination booking page
- Grimsby hospital home page

NLG(21)137

DATE OF MEETING	1 June 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Helen Harris, Director of Corporate Governance
CONTACT OFFICER	As above
SUBJECT	Documents Signed Under Seal
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The report below provides details of documents signed under Seal since the date of the last report (February 2021 – NLG(21)056).

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

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

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

Use of Trust Seal – June 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**
268	Sale of Land at DPOWH	09.04. 2021

Action Required

The Trust Board is asked to note the report.