Northern Lincolnshire and Goole NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 5 April 2022, by MS Teams
Time – 9.00 am – 12.30 pm
(Lunch 12.30 pm – 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 & Nicola Crook, Highly Specialist Speech & Language Therapist	Note	09:00 hrs	Verbal
2.	**Business Items**			
2.1	**Chair's Opening Remarks** Sean Lyons, Chair	Note	09:10 hrs	Verbal
2.2	**Apologies for Absence** Sean Lyons, Chair	Note		Verbal
2.3	**Declarations of Interest** Sean Lyons, Chair	Note		Verbal
2.4	**To approve the minutes of the Public meeting held on Tuesday, 7 December 2021** Sean Lyons, Chair	Approve		NLG(22)028 Attached
2.5	**To approve the minutes of the previous Public meeting held on Tuesday, 1 February 2022** Sean Lyons, Chair	Approve		NLG(22)029 Attached
2.6	**Urgent Matters Arising** Sean Lyons, Chair	Note		Verbal
2.7	**Trust Board Action Log - Public** Sean Lyons, Chair	Note		NLG(22)030 Attached
2.8	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note	09:20 hrs	NLG(22)031 Attached
2.8.1	**Trust Priorities – 2022/23** Dr Peter Reading, Chief Executive & Lee Bond, Chief Financial Officer	Approve		NLG(22)032 Attached
2.9	**Integrated Performance Report (IPR)**	Note		NLG(22)033 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Key Issues – Quality & Safety** Dr Kate Wood, Medical Director & Ellie Monkhouse, Chief Nurse	Note	09:35 hrs	NLG(22)033 Attached

3.2	**Quality & Safety Committee Highlight Report and Board Challenge** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	Note	09:45 hrs	NLG(22)034 Attached
3.3	**Ockenden Update** Ellie Monkhouse, Chief Nurse & Jane Warner, Associate Chief Nurse, Midwifery	Note	09:50 hrs	NLG(22)035 Attached
3.4	**Key Issues – Performance** Ab Abdi, Deputy Chief Operating Officer	Note	10:00 hrs	NLG(22)033 Attached
3.5	**Finance & Performance Committee Highlight Report and Board Challenge – Performance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	10:10 hrs	NLG(22)036 Attached
4.	**Strategic Objective 2 – To Be a Good Employer**			
4.1	**Key Issues – Workforce** Christine Brereton, Director of People	Note	10:15 hrs	NLG(22)033 Attached
4.2	**Workforce Committee Highlight Report and Board Challenge** Michael Whitworth, Non-Executive Director & Chair of the Workforce Committee	Note	10:25 hrs	NLG(22)037 Attached
4.3	**Gender Pay Gap** Christine Brereton, Director of People	Note	10:30 hrs	NLG(22)038 Attached
4.4	**Modern Slavery Act Statement** Christine Brereton, Director of People	Note	10:35 hrs	NLG(22)069 Attached
	BREAK – 10:40 hrs – 10:50 hrs			
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Key Issues – Finance – Month 11** Lee Bond, Chief Financial Officer	Note	10:50 hrs	NLG(22)068 Attached
5.2	**Finance & Performance Committee Highlight Report & Board Challenge – Finance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:00 hrs	NLG(22)039 Attached
5.3	**Key Issues – Estates & Facilities** Jug Johal, Director of Estates & Facilities	Note	11:05 hrs	NLG(22)040 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Key Issues – Strategic & Transformation** Ivan McConnell, Director of Strategic Development	Note	11:15 hrs	NLG(22)041 Attached
6.2	**Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – March 2022** Gill Ponder, Non-Executive Director	Note	11:25 hrs	NLG(22)042 Attached
6.3	**Annual Review of the Health Tree Foundation Trustees' Committee Terms of Reference** Gill Ponder, Non-Executive Director	Approve	11:30 hrs	NLG(22)043 Attached
6.4	**Humber Acute Services Development Committee Highlight Report & Board Challenge** Sean Lyons, Chair	Note	11:35 hrs	NLG(22)044 Attached
6.5	**Strategic Development Committee Highlight Report & Board Challenge** Linda Jackson, Vice Chair	Note	11:40 hrs	NLG(22)045 Attached

7.	**Strategic Objective 5 – To Provide Good Leadership**			
7.1	**Leadership Strategy** Christine Brereton, Director of People	Note	11:45 hrs	NLG(22)046 Attached
8.	**Governance**			
8.1	**Audit Risk & Governance Committee Highlight Report & Board Challenge – February 2022** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	Note	12:00 hrs	NLG(22)047 Attached
8.2	**Annual Review of the Audit, Risk & Governance Committee Terms of Reference** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	Approve	12:05 hrs	NLG(22)048 Attached
8.3	**Board Assurance Framework – Quarter 3** Alison Hurley, Assistant Director of Corporate Governance	Note	12:10	NLG(22)049 Attached
9.	**Approval (Other)**			
	None			
10.	**Items for Information / To Note (please refer to Appendix A)** Sean Lyons, Chair	Note	12:20 hrs	
11.	**Any Other Urgent Business** Sean Lyons, Chair	Note		Verbal
12.	**Questions from the Public**	Note		Verbal
13.	**Date and Time of Next meeting** **Board Development** Tuesday, 3 May 2022, Time TBC **Public & Private Meeting** Tuesday, 7 June 2022, Time TBC	Note		Verbal

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

- In accordance with Standing Order 14.2 (2007), any Director wishing to propose an agenda item should send it with 8 clear days' notice before the meeting to the Chairman, who shall then include this item on the agenda for the meeting. Requests made less than 8 days before a meeting may be included on the agenda at the discretion of the Chairman. Divisional Directors and Managers may also submit agenda items in this way.
- In accordance with Standing Order 14.3 (2007), urgent business may be raised provided the Director wishing to raise such business has given notice to the Chief Executive not later than the day preceding the meeting or in exceptional circumstances not later than one hour before the meeting.
- Board members wishing to ask any questions relating to those reports listed under 'Items for Information' should raise them with the appropriate Director outside of the Board meeting. If, after speaking to that Director, it is felt that an issue needs to be raised in the Board setting, the appropriate Director should be given advance notice of this intention, in order to enable him/her to arrange for any necessary attendance at the meeting.
- **Members should contact the Chair** as soon as an actual or potential conflict is identified. **Definition of interests -** A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold." Source: NHSE - Managing Conflicts of Interest in the NHS.

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 – December 2021** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(22)050 Attached
	Quality & Safety Committee	
10.2	**Quality & Safety Committee Minutes** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(22)051 Attached
10.3	**Patient Experience Report – incorporating Annual Inpatient Survey Result and Action** Ellie Monkhouse, Chief Nurse	NLG(22)052 Attached
10.4	**Guardian of Safe Working Hours – Quarter 3** Dr Liz Evans, Guardian of Safe Working Hours	NLG(22)053 Attached
	Workforce Committee	
10.5	**Workforce Committee Minutes – November 2021** Michael Withworth, Non-Executive Director & Chair of the Workforce Committee	NLG(22)054 Attached
10.6	**Freedom to Speak Up Guardian (FTSUG) – Quarter 3** Liz Houchin, FTSUG	NLG(22)055 Attached
	Audit, Risk & Governance Committee	
10.7	**Audit, Risk & Governance Committee Minutes – October 2021** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(22)056 Attached
10.8	**Results of the Audit, Risk & Governance Committee Self-Assessment Exercise 2022** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(22)057 Attached
	Health Tree Foundation Trustees' Committee	
10.9	**Health Tree Foundation Trustees' Committee Minutes – November 2021** Neil Gammon, Chair of the Health Tree Foundation Trustees' Committee	NLG(22)058 Attached
	Other	
10.10	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(22)059 Attached
10.11	**Clinical Strategy Reporting Framework** Ivan McConnell, Director of Strategic Development and Kerry Carroll, Deputy Director of Strategic Development	NLG(22)060 Attached

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 7 December 2021 at 9.00 am
Tennyson Suite, Forest Pines, Ermine Street, Broughton

For the purpose of transacting the business set out below:

Present:

Linda Jackson	Acting Chair
Dr Peter Reading	Chief Executive
Lee Bond	Chief Financial Officer
Dr Kate Wood	Medical Director
Simon Parkes	Non-Executive Director
Gillian Ponder	Non-Executive Director
Michael Proctor	Non-Executive Director
Michael Whitworth	Non-Executive Director

In Attendance:

Ab Abdi	Deputy Chief Operating Officer
Adrian Beddow	Associate Director of Communications
Christine Brereton	Director of People
Mick Chomyn	Associate Director of Pathology (for item 2.5.1)
Elaine Criddle	Deputy Improvement Director
Dr Nicola Crook	Highly Specialist Speech & Language Therapist (for item 1)
Stuart Hall	Associate Non-Executive Director
Helen Harris	Director of Corporate Governance
Jenny Hinchliffe	Deputy Chief Nurse (representing Ellie Monkhouse)
Liz Houchin	Freedom to Speak Up Guardian (for item 4.3)
Paul Holmes	Quality Improvement Academy Manager (for item 3.3)
Jug Johal	Director of Estates & Facilities
Jo Loughborough	Senior Nurse – Patient Experience (for item 1)
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Fiona Osborne	Associate Non-Executive Director
Maneesh Singh	Associate Non-Executive Director
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Trust Secretary (note taker)

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

1. Patients' Story and Reflection

Jo Loughborough advised Dr Nicola Crook was at the meeting to present to the Board examples of what was being done well and what lessons had been learnt from patients to do better in the future within Speech Therapy.

Dr Nicola Crook advised three problems had been identified within the service. These were in relation to patients on a long wait list for which some had waited more than a year. Some of the back log related to staffing and COVID-19 issues but some patients had not been contacted to review the progress and identify any issues. There was also an issue with more rapid discharges from the Stroke Unit at Scunthorpe General Hospital (SGH) as some patients had been sent home instead of a transfer to the Diana, Princess of Wales Hospital site (DPOWH). This impacted on the team due to the number of community visits required without the amount of staff to support this.

Work was undertaken around capacity and demand along with process mapping to see where patients were with regard to recovery. A Stroke Clinic was re-started at both sites which enabled the team to clear the long wait list. The service was re-structured to provide more intensive therapy which included the treatment of patients with two therapists and one assistant, the treatment was for four hours a week over a number of weeks.

One patient that had had a stroke three years previously still struggled to speak, but with the extensive therapy over an eight week period, improvements had been made. The communication rating at the start of the therapy by the patient was three out of ten, but this had increased to seven out of ten after the eight week period, with an additional word increase by the patient of 20 words during this time. This had also improved the psychological side for the patient with increased personal confidence. The patient was now able to have a conversation but had avoided this in the past. Although this service was offered in North East Lincolnshire (NEL), North Lincolnshire had not received the same uplift, so the service was not offered in that area. There was a hope that this would be the case going forward.

Linda Jackson was pleased to see a solution had been found for the patients and found this one an uplifting story.

Gill Ponder found the story a real example of making a difference to a patients' life and queried whether this could be promoted in any way to inspire other teams to look at how work was undertaken within the teams. Dr Nicola Crook agreed this was a unique idea to share and had been shared at the Quality & Safety Group for Community & Therapies. It would be welcomed to share in other settings as required.

Dr Kate Wood queried whether there had been support from the Quality Improvement (QI) team or if this was undertaken due to Dr Nicola Crook's undertaking a Doctor of Philosophy (PhD). Dr Nicola Crook explained it had been a combination of both and there had been support from the QI team around the collection of data.

Jenny Hinchliffe advised that with the launch of the QI Strategy it would hopefully initiate a piece of work going forward and wanted to pass on thanks and congratulated Dr Nicola Crook on the piece of work.

Linda Jackson thanked Dr Nicola Crook for attending the meeting and sharing the story.

2. Business Items

2.1 Chair's Opening Remarks

The Trust Board were advised that Sean Lyons, the new Chair at Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) would start on the 1 February 2022 but as this would be the first day Linda Jackson would Chair the Board meeting that day. Before Sean Lyons started in post one to one meetings would be put in the diary with Board members.

2.2 Apologies for Absence

Apologies for absence were received from Ellie Monkhouse, Jenny Hinchliffe representing and Shaun Stacey, Ab Abdi representing. Simon Parkes attended the meeting but due to technical issues with MS Teams had to leave during the meeting.

2.3 Declarations of Interest

No declarations of interests were received.

2.3.1 Update Register of Directors' Interests – NLG(21)246

Linda Jackson asked for approval of the paper.

The Trust Board agreed to the approval.

2.4 To approve the minutes of the Public Meeting held on Tuesday, 5 October 2021 – NLG(21)247

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

- Fiona Osborne referred to page 10 and advised the wording should be altered to read "Fiona Osborne referred to the balance sheet increasing by 10%".

2.5 Urgent Matters Arising

Linda Jackson invited Board members to raise any urgent matters that required discussion which were not captured on the agenda. No items were raised.

2.5.1 Mortuary and Body Store Assurance – Trust Board response to NHS England / Improvement – NLG(21)248

Linda Jackson advised this item had been discussed at the Trust Board meeting held on the 2 November 2021, following on from this an Ad Hoc Sub-Group meeting had been held on the 15 November 2021 to provide assurance to the Board. Mick Chomyn advised that previous Human Tissue Authority (HTA) Guidance only applied to Scunthorpe and Grimsby but new guidance released on the 25 October 2021 meant there was aspects of non-compliance which had now either been resolved or worked through. New guidance had been received by the HTA on the 25 October 2021 in respect of the long-term storage of bariatric bodies. This had meant NLAG were not compliant, this would be rectified and a business case was being carried out in terms of this. A further requirement was for all mortuary and body stores to have secure swipe card access to facilities. Both SGH and DPOWH were compliant, however, this was not the case at GDH. Following on from this, swipe card access had now been installed and was operational from the 1 December 2021. NHS England / Improvement (NHSE/I) had now updated their records to reflect the change.

A further issue was around Closed Circuit Television (CCTV) coverage as again GDH did not have this in place, this has been installed and was fully operational from the 18 November 2021. This had also been updated with NHSE/I. There was now a need for regular review of the CCTV which had meant the implementation of a Standard Operating Procedure (SOP) included within the paper. The first monthly audit of this would take place this month and monthly going forward. Arrangements for GDH was still to be finalised, responsibility for this would reside with Community & Therapy Services. The oversight for actions would be provided by the Audit, Risk & Governance Committee (AR&GC).

The risk assessments of the mortuary and body stores were now completed and were awaiting formal governance approval through the Community & Therapy divisional governance meeting. The Disclosure and Barring Service (DBS) checks were required for all staff in those areas, in particular those that accessed the mortuary and these had been undertaken. Further guidance was expected in respect of DBS checks.

Michael Whitworth referred to the review of the CCTV coverage by staff and whether this would be included in job descriptions including support to those staff due to the nature of this. Mick Chomyn advised the original letter received made reference to the CCTV being inside the mortuary, however, it had since been identified that the footage would be outside the mortuary and would be in respect of what access staff had in this area.

Fiona Osborne referred to the bariatric bodies requirement and queried how long it would be before NLAG would be compliant. Mick Chomyn advised NLAG had storage for bariatric bodies but the requirements being put in place was for freezer storage for longer term requirements. The guidance stated that bodies that were kept longer than 30 days would require freezer storage, which was incredibly rare. The Trust had looked into the supply of such freezers and there did not appear to be manufacturers that supplied them, so this was being worked through.

Linda Jackson referred to the possibility of further DBS changes and queried how NLAG would control the list of authorised personnel moving forward for new staff. A further query was in respect of the responsibility being held by the AR&GC to monitor any outstanding actions and gain the necessary assurance as they currently met quarterly and whether this would be regular enough to monitor requirements. Mick Chomyn advised in respect of the DBS checks a wider discussion would be required in the Trust to agree what would be required going forward. In respect of the oversight if it was not the AR&GC it would be for the Board to decide who would be best placed to have oversight.

Linda Jackson thanked Mick Chomyn and the team for all the hard work undertaken but wanted to note there was still some outstanding actions to keep oversight and this would be by the AR&GC.

Action: Simon Parkes

Dr Peter Reading referred to DBS checks and explained they were of limited value due to the time frame in-between them being undertaken. Further discussion would be required on whether certain staff required checks to be undertaken more frequently but this would incur costs that would need to be provided by the Trust. Linda Jackson felt that the list of staff that required access to this area would need to be monitored.

Due to technical issues with MS Teams, Simon Parkes had to leave the meeting at this point.

2.6 Trust Board Action Log – Public by exception NLG(21)249

Linda Jackson invited Board members to raise any further updates by exception in relation to the Trust Board Action Log. All actions to be updated at the meeting today were noted and would be closed.

Christine Brereton referred to item 4.1 from the October 2021 meeting. The reporting at divisional level was now being produced through Power Business Intelligence. Due to work with Shauna McMahon's team in respect of the Integrated Performance Report (IPR) teams had been able to identify which staff had not undertaken the training. This had then fed into the Performance Review Improvement Meetings (PRIMs) report. The Human Resources (HR) Business Partners had also been provided with the information to enable them to support staff.

2.7 Chief Executive's Briefing – NLG(21)50

Dr Peter Reading advised the paper summarised detail from the Integrated Care System (ICS) on recruitment. A paper had also been shared with Board members from Stephen Eames, Chief Executive-designate of the Integrated Care Board (ICB) for Humber Coast & Vale (HCV). This was the first proposal and the Partnership Board would meet the following day being Wednesday, 8 December 2021. Point two of the report emphasised the challenges NLAG faced. The national imperative around recovery was strong, as at a recent Chief Executive Officer (CEO) and Chair event it highlighted a regional review of ICS by ICS

performance, and NLAG had been able to show that performance was stronger than some partners in the ICS.

During a meeting with Richard Barker it had been mentioned there was emphasis on patient safety due to current back logs and risk to patients with elective work being delayed and that it was imperative this was looked at. A further review on additional capacity had been discussed and elective care would continue to be reviewed on a daily basis. Linda Jackson advised the meeting had highlighted the need to address –

1 Deliver elective waits – zero 104 day waits, no 52 week waits, maintain cancer performance and reduce 62 day backlog.
2 Do as much activity as possible in the next three months.
3 2022/23 planning guidance would require activity growth above pre-covid levels and to start working towards this now.

Mike Proctor queried whether there were any thoughts that when other posts at ICS level were appointed if it would impact those people in similar roles in the existing organisations. Dr Peter Reading advised contact had been made to Stephen Eames to indicate there would be a strong case to have a Chief Digital Officer at ICS level. Time would tell if the Medical Director and Chief Nurse roles at ICS level would have real authority as these roles were duplicated at Regional and Trust level. There would need to be clarity on where the power / decision making would sit.

Michael Whitworth explained that there were a number of patients that were on waiting lists going to General Practitioners (GPs) to request face to face appointments to have assurance which had added more strain on GPs.

2.8 Integrated Performance Report – NLG(21)251

Shauna McMahon advised the IPR was for noting at the meeting. All Executive and Non-Executive Director (NED) reports shared at the meeting were based around the report.

3. Strategic Objective 1 – To Give Great Care

3.1 Executive Report – Quality & Safety - NLG(21)252

Dr Kate Wood referred to the ongoing mortality work. One issue to highlight was the disparity between in and out of hospital Summary Hospital Mortality Indicator (SHMI) and work remained ongoing with commissioning colleagues. The Trust had been assured that there had been £200,000 earmarked for specialist palliative care within NEL. Other work was in respect of structured judgement reviews, where a number had been left unreviewed for a few months. The Medicine team and Mortality Improvement Group are working on making improvements and identifying any learning.

Venous Thromboembolism (VTE) reporting was being rectified as the denominator was calculated with patients who should not have been included.

The Trust currently had a marked increase of Serious Incidents (SIs), there had been 18 in September for which 12 were pressure ulcers. One of these had now been de-logged, however, until a Root Cause Analysis (RCA) had been undertaken it was not known the outcome as to whether this was an issue that would be ongoing and as a result of current operational pressures.

The Clinical Commissioning Group (CCG) had provided funds for community staffing which would be implemented from April onwards, this would no longer be 'red' on the action tracker. The rating for mandatory training and appraisal compliance should also improve.

Maneesh Singh referred to the out of hospital SHMI performance at NEL and queried when the report would be due. Dr Kate Wood advised this was discussed at the Quality & Safety Committee (Q&SC). Lee Bond referred to the staffing fill rates as it advised 15 wards had less than 50% fill rates. It was queried whether when this was calculated if it was after agency and bank nurses had been added. Jenny Hinchliffe advised this was not the overall fill rate as it related to those on the ward. Lee Bond queried whether the community nurse staffing tool to measure workload was in place and whether this was recording data. Jenny Hinchliffe advised this had been purchased and had just been rolled out which would provide more data around capacity and demand.

3.2 Quality & Safety Committee Highlight Report and Board Challenge – NLG(21)253

Mike Proctor explained the committee had looked at patient wait times in the Emergency Department (ED) and that he had had the opportunity to spend some time in ED. Mike Proctor had been really pleased to see staff had prioritised patients by clinical need and not the wait time. Practice due to COVID-19 had changed as patients were not able to be treated in corridors as previously done which was a positive for patient experience. The experience was not what NLAG wanted but it meant patients were kept safe due to being seen by clinical need. Gill Ponder had recently taken part in '15 steps' within ED and patients that were spoken to could not speak highly enough of the care received. Those that had waited still praised staff in the area and understood the priorities of others. Ab Abdi advised NHSE/I had that morning asked about performance of the previous evening in ED and the indicators had been there for patient safety which NHSE/I had been pleased to hear.

Linda Jackson referred to the issue around ophthalmology in the highlight report and the fact that the committee had lack of assurance for those high risk patients. Mike Proctor confirmed that there had been significant progress and out of around 700 high risk patients the Trust had reviewed 50%. There had been no harm to those patients reviewed to date. Progress would continue to be reviewed by the committee.

3.3 Quality Improvement Strategy – NLG(21)254

Paul Holmes advised the Quality Improvement (QI) Strategy had been shared with the Q&SC and the Trust Management Board (TMB) before sharing with the Trust Board. It had been written in consultation with the wider QI community within the

Trust, including those that had previously engaged in the wider QI agenda. The Strategy focussed on empowering change through QI and looked at methods to do with individuals. Paul Holmes went through the different approach that was being used in respect of the Strategy.

Mike Proctor advised the Q&SC had recommended approval of the Strategy by the Board, the format was very user friendly and it would be easy for people to read. Dr Peter Reading felt it was a well put together strategy, he had been invited to hear presentations at the consultant development programme, where four consultants had presented on QI projects undertaken. The enthusiasm had been very impressive about the work carried out and the support from the QI team.

Christine Brereton was interested in the implementation plan and how this would come “alive”. The Strategy was clear on what would be achieved, but a plan would be required to support this and what projects would be in place next year on how to use the methodology and engage with staff. Christine Brereton would be interested to see the plan for next year so this could be monitored through the Q&SC and Trust Board to see the development of this. Linda Jackson was pleased that traction had been achieved and that this was now moving.

The Trust Board approved the QI Strategy.

3.4 Establishment Reviews – NLG(21)255

Jenny Hinchliffe presented the nurse establishment review on behalf of Ellie Monkhouse who was on leave. Jenny Hinchliffe explained the annual safe staffing review was a mandatory requirement of all Trust Boards. The methodology used was in line with guidance from the National Quality Board and 31 wards across the organisation had been reviewed during March and April 2021 by the Chief Nursing Officer. The process had been scrutinised at the Q&SC the previous month and a discussion had also taken place at TMB. It was acknowledged that the review had been more complex due to the pandemic. Some themes had been identified as referred to in the report. It had identified that there was a high amount of activity in an evening and overnight when staffing was reduced and the skill mix was not meeting national guidance consistently. Feedback from ward managers was that there was insufficient time for supervisory parts of the role. It had been shown nationally that this impacted on patient experience as it gave ward managers time to help develop staff.

The team were mindful of costs and current financial pressures so had risk rated the recommendations to enable plans to be put in place, these had also been split into sections. High risks had been enacted immediately to address the activity into an evening to ensure patient safety with bank and agency staff, however, this did remain a cost pressure. The recommendation, therefore, was to fund the posts substantively. It had been recommended that the two clinical education posts within the EDs currently funded non-recurrently were also made substantive posts. Work continued with the finance department on costings.

Dr Peter Reading congratulated the Chief Nurse team on the thorough process that had been undertaken along with the engagement of ward managers. It was felt the recommendations did make sense to be put in place. It was recognised

that the model hospital data indicated the Trust nurse staffing was more expensive when benchmarked with peers but after discussion this was probably due to the high level of bank and agency staff used to fill shifts. Linda Jackson felt it was the best report to date on nurse staffing establishment process as it showed the issues which were flagged very clearly and prioritised.

Mike Proctor felt as a Board member there would be a need to see what level of investment would be required, over what period and how this would impact on other Trust priorities, as one of those was the long term financial sustainability of the organisation. Dr Kate Wood wanted to note that patients that came into hospital had a higher acuity than before which caused a real challenge. This was a national issue so there would be a need to have a national conversation regarding staffing in hospitals. Staffing was a risk that had been identified and would need to be managed by NLAG. Fiona Osborne queried what the timing would be for the business planning in respect of H2 or 2022/23. Lee Bond advised that NLAG were expecting guidance for 2022/23 and from that clear guidance parameters would be set. Proposals for investment would then go through the business planning process in quarter four.

Stuart Hall felt there was a need to look at nursing costs over the last five years as there had been an increase of 30% and queried if this was due to paying premium rates or whether this was due to the need to increase the nursing workforce. Jenny Hinchliffe advised that over the last five years there had been a significant number of nursing vacancies so this would impact on agency staffing costs. Work was being carried out with colleagues to look at strengthening the recruitment and retention of staff. Data was now available so this would be benchmarked against other trusts. There were numerous factors that required review which included the number of bed moves out of hours and ward layouts due to Covid restrictions.

There would also be a need to look at the level of increased supervision for ward managers. Ward manager supervisory time did have an impact in respect of the number of vacancies along with pressures on the wards which meant the managers had to provide operational nursing support. International nurses and newly qualified nurses also required more support so this impacted on ward manager time. Ab Adi referred to Stuart Hall's point in respect of ward manager time and advised that the national recommendation was to have the ward manager as supernumerary but this had not happened as they were providing direct patient care. Jug Johal advised that current ward refurbishments in respect of additional side room areas would also impact on the required number of nurses.

A detailed discussion followed about the need to increase the establishments to meet the professional recommendations of the Chief Nurse versus the practical ability of the Trust to recruit to them, either by the use of substantive appointments or through additional bank and agency staffing. Dr Reading felt there was a need to staff the wards safely and that might mean the use of additional agency staff in the short term. Lee Bond advised this might be an issue as recent data suggested that the local bank and agency market was effectively saturated. Dr Peter Reading advised this was an operational issue and the baseline had to be correct. If NLAG were unable to staff with agency it would be the decision of the site manager to decide whether to close beds at particular times.

The Finance & Performance Committee (F&PC) would have oversight on the financial implications of the review moving forward, and Q&SC would have oversight of the quality and safety implications coming out of the business planning process. Linda Jackson asked for clarity as to the current status of the top priority areas. Jenny Hinchliffe confirmed that the top priority areas were all being covered by agency so the immediate risk was addressed. This would then be reported back to the Trust Board. Linda Jackson thanked Jenny Hinchliffe for the report.

The board noted the nurse establishment review. Linda Jackson clarified that the paper would now go through the Trusts business planning process, the outcome would form part of an investment proposal for the Trust which would be considered at TMB and then come back to Trust Board.

3.5 Executive Report – Performance – NLG(21)256

Ab Abdi referred to the main points of the report and explained the challenges that ED faced in relation to staffing. Inappropriate attendances had been particularly high across all sites and capacity had been challenged due to the increased number of COVID-19 cases. The Board were advised the dedicated triage ambulance consultant was now on the “shop floor” which ensured a dedicated consultant in charge of delay.

Linda Jackson appreciated everything that was being done to address the challenges, however, queried in terms of ED when everything would be put in place to show an improved position with regards to performance. Ab Abdi advised there had been some reporting challenges with patients being seen by Same Day Emergency Care (SDEC) and once they were addressed it would show an improved position but would not achieve the targets set due to the complexity of the multiple challenges. It was agreed there would be further focus on actions in this area within the Trust Board Executive Performance report for February.

Action: Shaun Stacey

Dr Kate Wood wanted to highlight that Hull University Teaching Hospital (HUTH) had significant oncology challenges that NLAG had been made aware of due to a fragile staffing position of Oncologists. This was particularly in respect of breast oncology which would impact on NLAGs performance. This challenge may cause a risk to patients but this was not fully understood at the moment. Dr Peter Reading wanted to give credit to HUTH in respect of transparency of raising the concerns experienced. Stuart Hall advised there were some solutions but there would be a need to see how they would work. Dr Peter Reading advised the solutions would be joint with HUTH and this may have an impact on where patients were treated. It may also accelerate some of the Humber Acute Services Review (HASR) joint working in those areas. Linda Jackson was pleased to see both Trusts were working well together. It was felt there may be an issue around communications of how widely this message was communicated and this must be addressed when reviewing the options available moving forward.

3.6 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(21)257

As the operational issues had been discussed under an earlier item Gill Ponder advised it would not be discussed again under this item.

Gill Ponder explained the committee had received assurance on the low voltage (LV) and high voltage (HV) electrical supply and had undertaken a deep dive on the estates infrastructure which had highlighted a risk of 20. A plan to review operational risks would be put in place to address this. Some positive news was that NHSE/I had given a substantial rating for the Emergency, Preparedness, Resilience and Response (EPRR) self-assessment.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Executive Report - Workforce – NLG(21)259

Christine Brereton referred to the risks in the highlight report around retention and how this was to be reviewed through putting in place exit questionnaires. A time out session was held in November to look at bringing together different workstreams to enable the team to focus on the key focus areas. Work had been undertaken in terms of the exit questionnaire which would be shared with staff who were leaving. There would be more focus on those staff that wanted to leave to try and alleviate this happening. Other areas of risk were around job evaluation panels due to the significant back log, training events had now been put in place to allow NLAG panels to be staffed.

The Trust had received guidance in respect of mandatory COVID-19 vaccines, however, this needed to have approval from parliament to be implemented fully by 1 April 2022. This would mean staff that were subject to CQC regulatory activities would be required to be vaccinated by 1 April 2022. This process was already in place within Community Services for staff that entered patient homes.

Lee Bond referred to the vaccination programme in terms of the update stating 67% of staff had been double vaccinated and whether it was known what areas those staff worked in to identify where the risk was. Christine Brereton advised the 67% was in relation to staff that NLAG were aware of being double vaccinated. There would be further staff that may have had the vaccines outside of the Trust and those numbers were not identified, this would mean the percentage would be higher than 67%, medical and dental staff were currently at 40% but it was believed this would be higher due to those members of staff having the vaccine before NLAG had offered this. Part of the planning would be to reach out to staff to share the information of being vaccinated. Lee Bond queried whether the new guidance was taking the stance to encourage staff to receive the vaccines or whether it stated that if staff did not, they would not be able to remain in current positions. Christine Brereton advised the current stance was to encourage staff to have the vaccine at this moment in time as this had to be agreed through parliament first. It was agreed a further update would be given in the Executive report on Workforce in the February board meeting.

Action: Christine Brereton

4.2 Workforce Committee Highlight Report and Board Challenge – NLG(21)260

Michael Whitworth advised the committee had recently undertaken a number of deep dives. The committee had been assured by the direction and progress made in respect of leadership. The sickness data had been discussed, particularly how the data was being used and the work that linked in with Occupational Health.

4.3 Freedom to speak up Guardian (FTSUG) – Quarter 2 – NLG(21)261

Liz Houchin advised the number of concerns raised during 2021/22 quarter two had been the same as the previous year. The main themes had been around behaviour and worker safety. There had been an increase in open concerns although one anonymous concern had been received. The outcome of the anonymous concern was to be published on the hub page as there was no other way of sharing the outcome. Linda Jackson highlighted the walk arounds personally undertaken with Liz Houchin had been received well by staff. Liz Houchin advised monthly meetings were being held with Angie Legge as patient safety lead to link issues together.

Linda Jackson wanted to thank Liz Houchin for the progress made. Dr Peter Reading observed that the number of concerns raised were constant but highlighted that staff had also used the “Ask Peter” to raise other concerns. This had also increased and was around 250 a month. Christine Brereton advised the purpose of the Cultural and Transformational Board was to gather this information to enable NLAG to see how to address the issues.

4.4 Overview on NHSE/I Future of HR and OD Development Report – NLG(21)262

Christine Brereton explained the paper was different to the People Plan as the priorities were more focussed on the future direction of the HR and Organisational Development (OD) profession. It focussed more on the OD element which was what the Trust were trying to put in place. Further work would be required and some of this may be with the provider collaboratives or ICS. Work would be shared with the Workforce Committee and then the Board when fully digested.

Mike Proctor queried whether this would mean two teams going forward to enable the work to be completed. Christine Brereton advised that the restructure put in place earlier in the year had created this to enable teams to focus on the separate requirements. Stuart Hall felt the Trust should support staff that wanted to enter a different part of the National Health Service (NHS) or move away and how the Trust would keep in contact in case those staff wanted to re-enter again in the future. Christine Brereton agreed with the point made and explained that it was difficult to obtain a role within the NHS if people did not currently work there. This would need to be focussed on moving forward to ensure it was more accessible and work would be undertaken within the ICS to widen the workforce. Fiona Osborne queried how much the People Strategy and this paper informed one another as the ICS People Strategy was to be released on the 9 December 2021, as this report was released in November, which could cause a delay. Christine Brereton advised the ICS People Strategy was in respect of how the Trust worked

across the system in terms of workforce so had a different focus. The report shared today was more focussed on the future of OD.

5. Strategic Objective 3 – To Live Within our Means

5.1 Executive Report - Finance – Month 07 (including Financial Special Measures & H2 Planning) - NLG(21)263

Lee Bond highlighted there had been major movements in month as the funds had been received for the national pay rise. The Trust did not receive any additional Elective Recovery Funding (ERF) income in the month as the target had not been met. NLAG did meet the target in Month eight but as Hull, Harrogate and York did not, the system could not achieve the ERF income. In respect of COVID-19 spend this had reached £8 million to date. There was concern in respect of the table on page five as it showed there was three areas that could be impacted upon if the income for COVID-19 was reduced. The team would work with Ellie Monkhouse and Jenny Hinchliffe to try and reconcile the current level of spend the Trust. Creditors at this time were currently being paid on time although there were issues with agency creditors.

Lee Bond referred to the H2 plan which required NLAG to be in a breakeven position by the end of the year. There was an element of risk within this and discussion had taken place at F&PC. Money was available for elective recovery and it was felt there was still money available within the Clinical Commissioning Groups (CCGs) and system. The Trust had worked with colleagues across the ICS to understand the position of all organisations involved. Lee Bond was confident the Trust would reach the H2 plan in respect of achieving what was required in terms of financial special measures (FSM). The letter received in respect of FSM in November 2020 advised the Trust would continue to have some supervision for up to 12 months. A number of items were required from the Trust in terms of governance assessments along with NHSE/I observing governance meetings. All requests made had been achieved at the end of the 12 month period. After a conversation with NHSE/I it was hoped written confirmation would be received after the Christmas period to say the Trust had met all criteria laid down and could exit FSM.

5.2 Finance & Performance Committee Highlight Report and Board Challenge – Finance - NLG(21)264

Gill Ponder advised the F&PC had discussed the high level spend on temporary staffing and had reviewed the draft long-term plan to address the deficit of the Trust. The Trust would underspend on the grant funded energy efficiency spend as agreement had not been reached to roll the funds into the next financial year. This would mean less work would be undertaken than anticipated. The committee supported the proposal of the new Patient Administration System (PAS) to enable collaboration with HUTH. There had also been good assurance in respect of the Digital Strategy.

5.3 Emergency Care Centre Update and Ambulance Handovers – NLG(21)265

Linda Jackson advised that as performance issues in respect of this item had been discussed earlier in the meeting and this update covered the same issues, no further update would be provided at this point. It was noted further discussion would take place during the private meeting.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Executive Report – Strategic & Transformation – NLG(21)266

Ivan McConnell advised the Trust were substantially engaged in the HASR review and a range of workshops had been held. The interim clinical plan was expected to be completed by the end of March 2022 as per the agreed plan and handed over to the HUTH/NLaG Joint Development Board for implementation. There would be an early draft PCBC for core service change available by the end of December. This would be minus two sections, one being the evaluation and the second the finance section. This would be available for stress testing and consistency checking. There would be an NHSE/I Gateway Review in April and there may be some risks identified within this.

There had been some developments in terms of capital funding being available, with three potential schemes in the region and the Trust may be one of the three, but confirmation had not been received as yet.

Dr Peter Reading referred to slide six of the report as it stated the Chairman was a member of the HCV Partnership Board and this was not the case. The second point did not mention that the Trust were part of the community collaborative as well as being part of the acute collaborative.

Gill Ponder hoped that the Trust were successful in the Capital expression of interest bid but queried what would be put in place if this was not achieved and whether there was a parallel workstream happening as an alternative. Ivan McConnell confirmed there was an emerging parallel workstream, some of this would potentially be a smaller amount of money meaning something would need to be decamped. Secondly there would be a need to think of alternative funding and what this would be.

6.2 Health Tree Foundation Trustees' Committee (HTFTC) Highlight Report & Board Challenge – July 2021 – NLG(21)267

Gill Ponder advised the committee discussed the contract for Smile that would come to an end on the 31 March 2022. A new post had been approved by the charity for one year for Community & Therapies, with this person joining the two others in the delivery and roll out of the End of Life Programme. The ReSPECT post had also raised some concerns as there was an expectation from NHSE/I for the post holder to work across other Trusts for the remaining eight months. This had not been envisaged when the post was originally funded by HTFTC. Dr Kate Wood advised a meeting had been held with Neil Gammon subsequent to the committee meeting and they would now be looking at how to include additional information to posts that are subsidised to ensure it was more clear as to the roles

and responsibilities and any limitation of use outside of NLAG. This would be discussed at the next meeting of the committee.

6.3 Humber Acute Services Development Committee Highlight Report & Board Challenge - NLG(21)268

Linda Jackson took the paper as read and advised Humber Acute Services Development Committee (HASDC) members discussed when Programme one would leave the oversight of the committee, it was agreed that the oversight of these programmes would sit with the Joint Development Board (JDB) which had representatives from both HUTH and NLAG. The JDB would provide a highlight report through to HASDC and would flag any risks and areas for concern. Stuart Hall felt that due to the dynamic environment the Trusts were already working earlier than anticipated due to circumstances.

6.4 Strategic Development Committee (SDC) Highlight Report & Board Challenge – NLG(21)269

Linda Jackson advised the first meeting had taken place, where it had been agreed that Shauna McMahon would join the committee in respect of the strategic digital aspect. Following a recent meeting it was agreed a matrix of responsibilities would be produced showing what responsibilities F&PC, SDC and AR&GC had on certain workstreams to avoid any duplication and provide the necessary clarity. The draft workplan currently ran until the end of March 2022. There had been a request to incorporate some horizon planning in the workplan. The committee had discussed the issue around the Trust not being able to spend capital funds on the energy performance schemes in time. Jug Johal explained conversations were taking place to see if the funds could be rolled-over but the outcome had not been received as yet. Linda Jackson advised the delays had been taken out of the Trusts control.

7. Strategic Objective 5 – To Provide Good Leadership

There were no items listed under this item for discussion.

8. Governance

8.1 Audit, Risk & Governance Committee (AR&GC) Highlight Report & Board Challenge – NLG(21)270

Michael Whitworth explained there had been productive discussions around internal and external audit around the outstanding actions and the Trust were in a more positive position than initially thought. It was not included within the report but discussion had taken place on good examples of the wider work of the committee. It was noted that further information would be put in the report going forward. Lee Bond felt the approach being taken by Simon Parkes to streamline the workplan was refreshing as some reports no longer required reporting to the AR&GC.

8.2 Board Assurance Framework (BAF) - NLG(21)271

Helen Harris advised the report shared was in relation to quarter two and had been considered at sub-committee level during November. The Board were asked to review the ratings and advise if assurance was received.

Linda Jackson referred to SO1 - 1.2, this was currently at a rating of 20 with a target of five, this showed it would not be achieved for the year and so what would be agreed in respect of those risks. SO2 was also at 20 with a target risk of eight which again would not be achieved. Gill Ponder queried that if the risks were not to be achieved could the report include an interim score that stated what was hoped to be achieved. Linda Jackson agreed as it was currently unachievable as it stood. Helen Harris explained they referred to a target date of 31 March 2026 as stated on the spreadsheet, this would also be the case for the workforce objective as the date related to the strategies. Helen Harris did support Gill Ponder's point of the addition of a target achievement for the year.

Christine Brereton explained that within the workforce objective there was so much that required completion, one suggestion had been to have a look at including sub-categories within the objective to enable this to be more achievable. It was agreed this would be further reviewed by Christine Brereton, Helen Harris and Ellie Monkhouse to make this more achievable. Ab Abdi felt there was a difference between the targets and the safety side although the target was not being met there was evidence to show the safety of patients was in place. Linda Jackson agreed with the objectives being broken down more in the sub-committees as felt this would work better and highlight what work was being completed. Elaine Criddle advised the BAF was there to provide assurance to the board and if that was not what it was doing it may need to be revisited. Jug Johal felt the new format had been a vast improvement from where the Trust had been previously. It was agreed to add the additional column for yearly target dates moving forward.

Action: Helen Harris, Christine Brereton and Ellie Monkhouse

9. Approval (Other)

There were no items of approval.

10. Items for Information

The following items were shared at the December 2021 meeting:

- F&PC Minutes - August & September 2021
- Q&SC Minutes - September & October 2021
- Guardian of Safe Working Hours - Quarter 2
- Workforce Committee Minutes - September 2021
- AR&GC Minutes - July & August 2021
- HTFTC Minutes - July, September, October 2021
- Communications Round-Up
- Timetable of Board & Sub-Committee Meetings
- Document Signed Under Seal

11. Any Other Urgent Business

There were no items of any other urgent business.

12. Questions from the Public

No members of the public were in attendance at the meeting.

13. Date and Time of the next meeting

Formal Trust Board Meeting

Tuesday, 1 February 2022, Time: TBC
Forest Pines, Broughton

Board Development

Tuesday, 2 March 2022, Time: TBC
Forest Pines, Broughton

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

Linda Jackson closed the meeting at 12:00 hours.

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

Name	Possible	Actual	Name	Possible	Actual
Terry Moran	2	2	Ellie Monkhouse	5	4
Dr Peter Reading	5	5	Fiona Osborne	2	2
Lee Bond	5	4	Simon Parker	2	1
Christine Brereton	5	5	Gillian Ponder	4	4
Neil Gammon	1	1	Michael Proctor	5	5
Stuart Hall	5	4	Maneesh Singh	4	4
Helen Harris	5	5	Andrew Smith	3	2
Linda Jackson	5	5	Shaun Stacey	5	4
Jug Johal	5	5	Michael Whitworth	5	5
Ivan McConnell	5	5	Dr Kate Wood	5	5
Shauna McMahon	5	4			

NLG(22)029

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 1 February 2022 at 9.00 am
Via Ms Teams

For the purpose of transacting the business set out below:

Present:

Linda Jackson	Vice Chair (Chair of meeting)
Sean Lyons	Chair
Dr Peter Reading	Chief Executive
Lee Bond	Chief Financial Officer
Ellie Monkhouse	Chief Nurse
Shaun Stacey	Chief Operating Officer
Dr Kate Wood	Medical Director
Simon Parkes	Non-Executive Director
Gillian Ponder	Non-Executive Director
Michael Proctor	Non-Executive Director
Michael Whitworth	Non-Executive Director

In Attendance:

Adrian Beddow	Associate Director of Communications
Christine Brereton	Director of People
Elaine Criddle	Deputy Improvement Director
David Cuckson	Governor
Nicky Foster	Deputy Head of Midwifery (for item 3.3)
Stuart Hall	Associate Non-Executive Director
Helen Harris	Director of Corporate Governance
Jordan Howard	Acacium Group
Jug Johal	Director of Estates & Facilities
Jo Loughborough	Senior Nurse – Patient Experience (for item 1)
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Shiv Nand	Governor
Fiona Osborne	Associate Non-Executive Director
Ian Reekie	Lead Governor
Mr Kishore Sasapu	Deputy Medical Director
Maneesh Singh	Associate Non-Executive Director
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Trust Secretary (note taker)

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

1. Patients' Story and Reflection

Jo Loughborough advised the patient story was in relation to restoration of faith for a lady who had attended the Scunthorpe General Hospital (SGH). The lady was called Pat and the complaint raised related to a few services that Pat had used as a patient. Part of the complaint action was to meet with Pat and the family after the formal response was completed. This was to explain projects and processes that had been put in place to provide Pat and the family with some insight and assurance. Jo Loughborough went through the concerns that had been raised by Pat which included bad communication between teams, dismissive behaviour amongst other issues. There had been numerous admissions during the care provided and during this time the wrong medications had been prescribed and medication that should have been prescribed had not been. Pat was also discharged back to the General Practitioner (GP) whilst still being unwell. The persistent complaining was the only thing that resolved the issues. A further condition was diagnosed whilst being an inpatient but the information had not been provided on the discharge letter so the GP was unaware of this. Some staff had stood out, one in particular was Dr Hussain and Dr Banerjee who had telephoned to apologise to Pat personally. A junior doctor had also stood out that worked in the Emergency Care Centre (ECC) who had introduced himself and put Pat at ease.

Jo Loughborough advised the team had agreed to meet with Pat face to face in the hope this would provide more assurance of issues that had been resolved. This was addressed as a formal complaint, however, part of the resolution was to meet the individuals to talk through issues directly and look at processes and procedures that were in place on how to manage patients. The ECC Sister had acknowledged some issues with processes which would also be changed. The team had linked in with Dr Hussain to resolve issues in that area and these were resolved within 24 hours which had helped with Pat's anxiety. The work around discharge processes and quality had also been explained to offer reassurance. The impact the Patient Experience Strategy would have once it was introduced was also explained and how this would see the person and not just the patient. The meeting had made Pat and the family feel issues were being resolved and improvements were being made for the patient experience. Linda Jackson thanked Jo Loughborough for sharing the story and for explaining the processes that were now in place.

Dr Kate Wood thanked Jo Loughborough for sharing a good news story and showing how the Trust was learning from them. It was important to highlight where the organisation did not always do well. When looking at individual services the Trust sometimes looked how to make those better, however, it was also important to look at how teams should also work together as there are many patients that use multiple services. This was part of the work that was already being reviewed. Ellie Monkhouse felt the story demonstrated how the Trust was moving forward and it enabled the Trust to show what work was being done. In respect of the Patient Experience Strategy, communication would be at the core of developing this. There was also a huge piece of Quality Improvement work being undertaken around discharges which would compliment the needs of the Operations team. There had been positive feedback from complainants due to face to face meetings being held.

Linda Jackson was pleased to hear the quality improvement processes were being used to improve discharge processes. Stuart Hall queried whether learning was cascaded down to staff and whether staff who had been identified as being a positive experience for Pat had been advised of this.

2. Business Items

2.1 Chair's Opening Remarks

Linda Jackson advised the meeting was to be held virtually due to the increased Covid cases locally.

Linda Jackson welcomed Sean Lyons to the meeting as the new Joint Chair of Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospital (HUTH). It had been agreed Linda Jackson would Chair the meeting due to it being Sean Lyon's first day in the role. It was noted Mr Kishore Sasapu was in attendance should the need arise in the future to deputise for Dr Kate Wood.

2.2 Apologies for Absence

There were no apologies received for the meeting.

2.3 Declarations of Interest

No declarations of interests were received.

2.3.1 Fit & Proper Persons Annual Declaration – NLG(22)001

Linda Jackson referred to the paper and went through the process that had been undertaken. The files were held by the Chief Executive's Personal Assistant and Helen Harris, Director of Corporate Governance had a role in reviewing the files. The conclusion from the checks undertaken was that all Fit and Proper Files were up to date and within compliance. The second part of the paper related to the annual review of the updating of the Directors' of Interest.

The board were asked if anyone had anything to be raised in respect of changes or further declarations. The following changes were noted.

- Fiona Osborne requested a title change as it should read Associate Non-Executive Director.
- Lee Bond's partner was employed as Deputy Chief Nurse at HUTH. A further addition was the Finance Lead on occasion for the Integrated Care System (ICS).

Dr Peter Reading wanted to note thanks to Heidi Forster due to the amount of work that had been undertaken for the files to be where they were now. The files were now at a standard to comply with the Care Quality Commission (CQC). Linda Jackson wanted to also note thanks to Heidi Forster. It was noted the real rigour would be required going forward to ensure the files remained compliant.

Although it was not a requirement for Sean Lyons to be included in the paper for the meeting that day, declarations of interest would be Joint Chair of NLAG and HUTH and the Chair of West Nottinghamshire College for further Education College. It was again noted by Sean Lyons the importance of correct files being in place.

The Trust Board approved the paper.

2.4 To approve the minutes of the Public Meeting held on Tuesday, 7 December 2021 – NLG(22)002

The minutes of the meeting held on the 7 December 2021 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made.

- Simon Parkes was to be added to the attendance as apologies had to be sent during the meeting due to a technical issue with MS Teams.
- Fiona Osborne referred to page 3, section 2.3.1, the paper in relation to this item had spelt Fiona Osborne's surname incorrectly so needed to be amended, this had been omitted from the minutes.
- Dr Kate Wood referred to page 4, section 2.5.1 this should read "Mick Chomyn advised that previous HTA Guidance only applied to Scunthorpe and Grimsby but new guidance released on the 25 October 2021 meant there was aspects of non-compliance which had now either been resolved or worked through". Gill Ponder who had chaired the meeting was happy to support the change.
- Dr Kate Wood referred to page 6, section 3.1, the words "of work" should be removed from the first paragraph.
- Dr Kate Wood referred to page 6, section 3.1, the second paragraph should read "was being rectified".
- Dr Kate Wood referred to page 7, section 3.1, the first paragraph should read "The Clinical Commissioning Group (CCG)" and not the CQC. This should also state the funds had been identified for community staffing.
- Linda Jackson referred to page 9, section 3.4. It would need to be added that the paper was noted and was very comprehensive, a lot of good work had been undertaken on the paper. The paper would now go through the business planning process and would then be deliberated at the Trust Management Board. Further clarification would be added to show that the Finance & Performance Committee would have the role to oversee financial implications of what would and would not be agreed as part of the business planning process. The Quality & Safety Committee would have involvement in the quality and safety aspects of the decisions being made. It would also be noted that Jenny Hinchliffe had done a sterling job in presenting the paper to the Trust Board. The amendments for this section would be made outside of the meeting, approval would then be sought at the April 2022 meeting.
- Dr Kate Wood referred to page 10, section 3.6. An amendment would be required in respect of the Emergency Preparedness, Resilience and Response.
- Gill Ponder referred to page 10, section 3.6. It had been noted in the meeting that the operational issues had been discussed earlier under another item so

Gill Ponder had advised this would not be again highlighted during this section, it was agreed to add this to the minutes.

- Gill Ponder, referred to page 13, section 5.2, the wording should be changed to state “agreement had not been reached”.

Linda Jackson confirmed the minutes would be shared for approval at the April 2022 meeting.

2.5 Urgent Matters Arising

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

Linda Jackson advised Alistair Brooks had attended the Trust Board meeting in January 2020 to request formal approval from the board for NLAG to dissolve the Web V Solutions Company. The Trust Board had agreed to this at the time. Linda Jackson confirmed the company had been dissolved as at the 11 January 2022. A thank you was noted to all those who had been involved in the process.

2.6 Trust Board Action Log – Public by exception NLG(22)003

Linda Jackson invited Board members to raise any further updates by exception in relation to the Trust Board Action Log. It was noted that those highlighted in green would be removed to closed actions. The following updates were received.

- Point 2.5 – Simon Parkes confirmed this action would be added to the Audit, Risk & Governance Committee (AR&GC) Workplan going forward.
- Point 3.5 – Linda Jackson advised the new report was to be shared at the meeting that day, the board would be asked to raise any further concerns in relation to this.
- Point 4.1 – An update would be provided on this item during the meeting as part of the Executive Update.
- Point 8.2 – Helen Harris advised a meeting was due to be held that week with Christine Brereton. It had also been agreed that the safe staffing element of this would be moved to Strategic Objective 1.1 so this could be closed.

2.7 Chief Executive’s Briefing – NLG(22)004

Dr Peter Reading advised the implementation of the ICS across England had been delayed by three months subject to legislation. The recruitment to key roles continued on the Humber Coast and Vale (HCV) Integrated Care Board (ICB) and development of the architecture of the ICS also continued.

Point three of the report was now out of date as the CQC had confirmed inspections would restart as of today being Tuesday, 1 February 2022. It had been advised that a decision in respect of Financial Special Measures (FSM) had been delayed. Lee Bond would continue to attend a monthly meeting in respect of this.

2.8 Integrated Performance Report (IPR) – NLG(22)005

Linda Jackson advised the IPR was for noting at the meeting. All Executive and Non-Executive Director (NED) reports shared at the meeting were based around the report and the report would be referenced throughout the Executive updates It was noted the report was evolving very nicely in respect of the summary information and the sections on the sub-committees. The report would have also been shared at the relevant sub-committees and would have been reviewed in detail.

3. Strategic Objective 1 – To Give Great Care

3.1 Executive Report – Quality & Safety - NLG(22)006

Dr Kate Wood advised key risks had been articulated in the paper and had also been triangulated to the IPR. One point to mention was that the paper mentioned Quality Special Measures but this should state Recovery Support Programme so this would be amended. Jug Johal referred to the risk in relation to facilities at the Scunthorpe site and advised a bid had been unsuccessful two years' previously for the Changing Places Bathroom, a further bid had also been submitted in September 2021 to North Lincolnshire Council. This had been followed up two weeks previously but no further update had been received. The same bid would also be submitted to the Capital Investment Board (CIB) at the next meeting.

Fiona Osborne was pleased to see the progression with the CQC work but felt the report underestimated the amount of good progress completed to date. The Q&SC had noted the thoroughness of monitoring and checking. Lee Bond referred to the staffing and fill rates within the report and advised a meeting would be held with Ellie Monkhouse to discuss this further. In reference to the timelines of incident investigations it was queried how far behind the Trust were with this. Dr Kate Wood advised that in respect of Serious Incidents (SIs) this was a multi-disciplinary process and did not involve single individuals, in light of this timescales were allowed to be extended in certain situations. In light of the pandemic clinical staff had been required to be taken away to review clinical issues so this caused some delays. Dr Kate Wood did not have exact numbers but agreed to report this back. Lee Bond queried whether the Trust was falling behind in terms of learning due to the delays with SIs. Dr Kate Wood advised an update could be provided for the minutes outside of the meeting. Sean Lyons referred to the sepsis performance and whether this was of concern due to it being really low in relation to indicators. Dr Kate Wood advised part of this was in relation to how it was reported as it was taken from the electronic reporting system. The Trust currently had staff on the wards to support teams on electronic reporting to ensure work was appropriate at patient status level.

Post Meeting Note: Following the meeting Dr Kate Wood confirmed the Trust had 34 SIs, 16 of those had been delayed. The percentage would again increase as staff had been redeployed due to significant operational pressures. However, the Trust was would recover this within a few months. The issues will delay have been due to operational pressures.

3.2 Quality & Safety Committee Highlight Report and Board Challenge – NLG(22)007

Linda Jackson referred to the paper and highlighted this included the quality priorities for approval for 2022/23. A query was raised as to what involvement the Governors and CCGs had had in respect of the quality priorities to ensure relevant people had been involved.

Mike Proctor advised the Quality & Safety Committee (Q&SC) had supported the Continued of Carer plan at the meeting as it was due for submission by Monday, 31 January 2022. This would be a huge undertaking and would mean substantial change in the current workforce, the change for this must not be underestimated. The committee had not looked at the resource implications required for this, however, they may also be significant.

In relation to the recent major incident a suggestion was made that the monitoring of actions would be allocated between board sub-committees, a piece of work in respect of this was now being undertaken. The committee continued to review the priorities and how they had developed. It was highlighted that sepsis was one of the priorities. Mike Proctor wanted to note that Angie Legge had done a fantastic job of progressing the work required.

Linda Jackson referred back to the query around governor involvement with the annual quality priorities. Dr Kate Wood advised that due to issues around face to face meetings Survey Monkey was undertaken and 197 responses had been received, this had been sent to key stakeholders and governors. It was advised that 197 responses had been received but the number of Governor responses was unknown. It was agreed further analysis needed to be undertaken outside of the meeting regarding the level of governor involvement this year and if any further action was required

Gill Ponder queried whether the ambition to hit 90% was enough in respect of Deteriorating Patients. A second query was in relation to the reference to medication safety around the reduction in admissions without a valid reason and how this would be defined in what would be a valid reason. Dr Kate Wood referred to the Governor query and advised there was attendance from a Governor at every meeting which had been part of the governor consultation but accepted there may be a need for more interaction. In response to the 90% this was very challenging so would not want to go any higher than that percentage. In relation to the query of omitted medications, when medication was omitted a reason of why could be added, an omission with a reason could also be added. Stuart Hall referred to the cross over between the committees in relation to some issues, for example the safety of discharge metrics and whether discussion of this should also take place during the Finance & Performance Committee (F&PC) meeting to resolve issues. The overlay of such issues should be discussed across the sub-committees. Simon Parkes referred to the metrics detailed and understood the reason for them was to drive behaviour, however, there was quite a few of them that were not being met. A query was raised as to how confident the Trust were as to them being driven by a strong clinical lead.

Simon Parkes queried whether everything was being done in respect of achieving safeguarding training as the Executive Report and Committee report did not tie together. Dr Kate Wood referred to the metrics query, the previous year the metrics supervision had been transferred to the F&PC due to the duplication. Once these were completed further discussion would take place on which would then be the appropriate committee for oversight. One of the issues around this was again around effective handover and work between teams to ensure discharge letters were robust. Simon Parkes referred back to this point as the metrics referred to the issue of it and not the quality of this. The patient story earlier in the meeting also referred to the quality of letters being issued. Mike Proctor advised further development was required in respect of the metrics and a good discussion regarding this had taken place at the committee. The outcome of this was that further discussion would take place outside of the committee about how the metrics could be refined further. It would be an ongoing issue for the committees to measure performance against relevant priorities and how to understand them. In relation to safeguarding this related to the Ofsted North Lincolnshire Report, the committee had discussed whether the Trust was doing everything that could be done to support. This had been highlighted due to the number of high-profile cases recently. The point made did not relate directly to the training.

Sean Lyons referred to the Friends & Family Test and queried whether the 60% PALS concerns managed in five days was ambitious enough and how this compared to other Trusts. Ellie Monkhouse advised there had been a significant amount of work undertaken at the Trust in respect of complaints. The same process was now being put in place to respond to PALS concerns, a quality improvement approach would also be developed to support this. The team unfortunately relied on Trust leadership to manage concerns raised, however, due to the pandemic this had caused issues. Sean Lyons queried whether the patient experiences being 5% was low and if this was normal. Ellie Monkhouse agreed they were low compared to some trusts. It had taken a while to procure a process for this but the Trust was now working with “I want great care”. There had also been a technical issue in November which had meant a “dip”. Feedback given in relation to the IPR was that response rates would be required and not just the performance of outcomes. Patient experience data was collected in other ways which included the 15 Steps process and the Family Liaison teams this was also captured within the Nursing Dashboard.

Linda Jackson was still not convinced there had been enough engagement with Governors in respect of the quality priorities, it was agreed Helen Harris would seek further clarification on this in respect of wider Governor involvement. It was further agreed this would then be addressed between Helen Harris, Dr Kate Wood and Mike Proctor. Mike Proctor agreed to clarify this with Angie Legge further.

Action: Helen Harris, Dr Kate Wood, Mike Proctor

Linda Jackson asked for approval of the priorities for the next 12 months. The Trust Board agreed to approve the Quality Priorities.

3.3 Delivering Midwifery Continuity of Carer at Full Scale – NLG(22)008

Ellie Monkhouse advised part of the implementation required the Trust Board to have oversight of the plan which was required for submission by the 31 January. Due to the timings of the board meeting the responsibility was given to the Q&SC to approve the paper for submission. Ellie Monkhouse advised the template submitted was a national requirement. Through each part of implementation the LMS would agree when NLAG were able to go forward to the next stage, there would also be various milestones to go through. A mechanism would be in place for the Q&SC to review this each quarter. It did not mean the Trust were signing up to anything in respect of financial aspects it was to show how NLAG would endeavour to deliver at full scale. The Trust Maternity Improvement Advisor from NHS England / Improvement (NHSE/I) had also supported the development of the plan.

Lee Bond queried what the realistic timescale was for this as the plan referred to it being in place for most women rather than all women. Ellie Monkhouse advised a Project Plan was at the back of the paper but the Trust would be working towards March 2023. It had been acknowledged there may be issues along the way. Fiona Osborne advised that although the committee did not look at staffing overall it did query the critical timing of this. The delivery target was March 2023 but the delivery was to be May due to the national staffing issue and this was one of the biggest risks that had been discussed at the meeting.

Linda Jackson clarified the requirement of the board was the acceptance of the plan. The plan was robust and it had been noted there was wider implications that would need to be shared at TMB and through the Business Planning process in terms of costs and workforce issues.

Stuart Hall queried where the staff would come from and whether NLAG was thinking “out of box” in terms of the upscaling current roles. Ellie Monkhouse agreed this would be the case.

Nicky Foster went through the paper and highlighted key points. The Plan detailed what would be required going forward. The implementation of the plan would support the Trust Strategic Plan 2019/2024 and the Trusts Objectives. The successful implementation of the plan would ensure all maternity services were high performing and well led.

Lee Bond wanted to note the funding from Ockenden was non-recurrent which meant there would be no guarantee it would be received again. There was still work to be done in this area going forward across the Integrated Care System (ICS).

Linda Jackson clarified that a considerable amount of work had been completed to put the plan together which had then been reviewed robustly at the Q&SC, this was then approved for submission by the deadline. The Trust Board were being asked to approve the plan on the basis of the review of the Q&SC. It was understood it would need further review in terms of finances and workforce implications.

The Trust Board agreed the plan on the principle provided.

Mike Proctor advised there was a huge amount of work required around maternity services and was concerned about the capacity of the management team to deal with this at the same time as other priorities. The board would need be mindful of this in terms of support to the team. Ellie Monkhouse confirmed there had been a number of national requests being asked of the Trust and these were required in short timeframes, governance arrangements were being used in terms of this. A request was made to be mindful of this in light of the significant amount of pressure within that area at the moment.

Linda Jackson thanked Nicky Foster for attending the meeting and for the comprehensive update.

3.4 Executive Report – Operational Performance – NLG(22)010

Shaun Stacey advised that despite improvements within the Emergency Department (ED) the Trust continued to struggle with performance on majors type one activity. The principle challenge was sustainability of flow which was the major concern. Currently there was also 47 stranded patients for North Lincolnshire (NL) which had impacted on patient flow. The report highlighted the delay in ambulance handover and Shaun Stacey reminded board members of NLAG's responsibility to ensure this was minimised. There had been some improvements but this had not been significant enough. There was a suggestion that the issue for East Midlands Ambulance Service (EMAS) was quite significant but was not necessarily caused by NLAG but by the overall numbers for EMAS, this did mean the small number of delays did contribute to the overall issues for EMAS. The Trust, therefore, needed to keep review of this and work continued to progress this.

A further ongoing challenge was around cancer particularly in breast which had been due to workforce challenges that HUTH continued to experience. This was a contribution to a delay in treatment for patients requiring those services. It was noted there was some positives within the report.

Linda Jackson had recently visited ED at Grimsby to see how the newly implemented Emergency Care Centre (ECC) was operating it was felt the reporting for the next board in light of this may see some changes in performance as a result of the new initiatives in that area. Fiona Osborne referred to discharge to assess and queried whether the new rules in care homes would support the discharge of patients. Shaun Stacey advised there was currently over 57 care homes closed due to outbreaks of Covid plus a further three due to other outbreaks of infectious diseases. There was also a further two domiciliary providers that were not open to access due to CQC actions. The Trust discharge was not the issue in respect of performance as it was in the top 10 performers for Discharge to Assess, the issue was around the care homes not being open to patients discharged from NLAG. Work was ongoing with care homes to improve the current issues. If care homes could adopt the same infection control procedures as hospitals it would allow a more efficient use of space to allow a better transition of care.

Gill Ponder referred to one of the low lights in the report in respect of the long delays in resuscitation this explained it was due to there not being sufficient beds in the High Dependency Unit (HDU), and Intensive Therapy Unit (ITU), it was queried whether there may be improvements in those areas to increase capacity. Shaun Stacey advised this did not necessarily impact on NLAG patient flow as some of the patients in ED had to be referred to specialist care at HUTH, this was where the delay was as they also had capacity issues. This issue was being managed internally as the ITU network reviewed patients when it was at maximum capacity to see if patients could be moved to an alternative bed, those patients were reviewed three times a day. This was unfortunately not always a simple issue to resolve. Maneesh Singh queried whether quality and safety was being jeopordised by discharging patients too early and whether this had contributed to the reason for some patients being readmitted. Shaun Stacey advised the readmission rate for NLAG was not above the national average. It was not felt NLAG was putting patients under pressure to go home. Patients were gaining the correct access to diagnostics and treatment they required which had meant they could be followed up at home.

Stuart Hall queried how the issues with the discharge of patients would be addressed in the longer term and whether a plan would be put in place. Shaun Stacey explained work was being undertaken in an integrated way and meetings were being held regularly on how to progress this. The key would be to work closely with Public Health England going forward to resolve issues. The Trust were in a fairly strong position due to good relationships already being in place. Further information on options would be shared at a future meeting of the F&PC. Linda Jackson agreed a deep dive at the F&PC would be helpful.

3.5 Executive Report – Digital - NLG(22)011

Shauna McMahon highlighted points from the report. The initial work undertaken by the team was to build on the project management of digital as this was not initially in place. The road map on page seven showed progress to date along with the tracking of this being referenced. The report detailed the high number of projects being undertaken by the team and how they were being managed. The update provided to the board going forward would focus more on patient and clinical benefits through digital transformation. More information would also be provided around the Humber Acute Services Review (HASR) and the ICS. There had also been more clinical engagement with physicians that had been keen to move the digital systems forward.

Linda Jackson was pleased to see there had been more clinical engagement. It was noted a board development session was to be held in respect of Digital on the 1 March with NHS Providers. Gill Ponder felt on reading the report it highlighted what the team had achieved and wanted to offer congratulations on the fantastic progress. Fiona Osborne felt that although the project team was now in place the Trust should not underestimate the scale of projects that would need to commence, the team and Shauna McMahon would need continued support with forward planning. Shauna McMahon appreciated the positive comments and wanted to highlight this had been a team effort.

Sean Lyons noted the great work achieved so far. One query was in respect of clinical coding and what the impact of this would be with collaboratively working in terms of income and mortality figures due to Covid. A further question was in respect of a new PAS system and whether this was to be put in place and if risks for this had been mitigated. Shauna McMahon explained the new PAS system was currently being worked through with HUTH as this would be linked to the Lorenzo system currently used there. The Trust was also working with an external company who had experience with data migration. Shauna McMahon was confident the risks were being mitigated in respect of this. With respect to the clinical coding query this was a challenge across the country with regard to employing trained clinical coders. As this was an issue the Trust had introduced a Trainee Clinical Coder role to enable training to be undertaken for the role. There had been good clinical engagement with staff early on but due to Covid this had not been as good lately, however, it was hoped this would now improve again. The Summary Hospital Level Mortality Indicator (SHMI) was as expected overall but there was hope there would be some improvements with the collection in respect of this. One of the biggest areas to improve on would be the proposal for an Enterprise Document Management System which would move everything to an electronic format. This would also significantly improve clinical coding.

Dr Kate Wood highlighted the relationships between coders and clinicians was key and there would be a need to ensure they were maintained with moving to cross site working with HUTH. The clinicians were sighted on the importance of coding and this would mean the Coding team would need to continue being flexible to support clinicians going forward. The Electronic Prescribing Medication Administration system (EPMA) still needed more work in respect of information reporting. The detail in the report referenced this being completed but further work was still required. Dr Kate Wood wanted to highlight that Jug Johal had been the initial driver behind ensuring clinicians and coders worked together so wanted to note thanks for the initial work undertaken with this.

3.6 Finance & Performance Committee Highlight Report and Board Challenge – NLG(22)012

Gill Ponder advised she would not go over points in respect of performance and cancer due to earlier discussions. The Trust was now taking patients from other Trust waiting lists as part of the levelling up process across the ICS, this would clearly impact on performance numbers at NLAG. There had been considerable improvements with diagnostic performance, however, it would be a further couple of months before improvements would be seen in non-obstetric ultrasound. Outpatient transformation continued with good results but it had been disappointing that non-patient face to face consultations had declined. However, a recent patient survey had shown patients found them convenient and effective. Dr Kate Wood asked if the survey could be shared with clinicians to ensure they were sighted on the results.

4. Strategic Objective 2 – To Be a Good Employer and Strategic Objective 5 – To Provide Good Leadership

4.1 Executive Report - Workforce & Leadership – NLG(22)013

Christine Brereton advised the main focus had been in respect of Vaccination as a Condition of Deployment (VCOD), however, following an announcement by the Secretary of State the previous day being Monday, 31 January the regulations would now be reconsidered. As a result this had removed the urgency to have those staff in scope to be vaccinated or to have received the first vaccine by the 3 February 2022. The activity for this would now be stepped down and the changes would be communicated to staff. There would still be a request to submit data through to the national team so this would be concentrated on in the first instance.

Further work by the team had been the management of sickness absence due to the high increase which had impacted on operational pressures, this had now levelled off. One other area of work focussed on was the development of the Leadership Strategy, this was being socialised at the moment through the Executive team and at TMB. This would be shared at the Public board in April 2022. Work had commenced on a review of statutory and mandatory training although there had been some improvements made some were still below what they should be. This would also be a highlighted area for the Care Quality Commission (CQC). The team were undertaking a review of training to ensure all training was what would be required. There was a National Framework which detailed what was required so this would be used to ensure staff were not being asked to complete training that was not relevant. Linda Jackson was encouraged that the mandatory training work continued as this was overdue.

5. Strategic Objective 3 – To Live Within our Means

5.1 Executive Report - Finance – Month 09 - NLG(22)014

Lee Bond advised the Trust would finish the year in line with the plan. The performance in month was slightly ahead on the income but this was due to the Trust receiving money for the elective recovery fund (ERF) for the period October – December 2021. The pay for the month was £0.49 million overspent due to costs around medical staff, nursing and other variances. The nursing spend had been offset due to the number of vacancies which was a concern. Non-pay had been underspent in month due to independent sector outsourcing underspends which had been partly offset by additional ERF activity in a theatres, orthopaedics and ophthalmology.

One key area of concern was around Covid due to the amount of expenditure, this was approaching around £11 million after nine months and was slightly higher than anticipated. It was still within the overall funding for Covid but the expenditure would be cut by 57% next year. The business planning process would look at where this money was being spent to try and address anything required. One of the headlines for the report was that the Trust had almost spent £51 million on temporary staff in the nine months ending 31 December 2021. This was an increase of 24% from last year. Almost £4 million of this was in respect of medical

staffing. Covid had also impacted on this due to the ward reconfiguration and infection control measures.

One of the biggest challenges within cost improvements would be the reliance on non-recurrent monies as this impacted into next year. This had also been raised by the Financial Special Measures team at a recent meeting as there was some concerns. This would need to be addressed going into next year.

One major issue to highlight in respect of Capital was the programme that related to Salix funding. The Trust had been in discussion with the Department of Health and Business Energy and Industrial Strategy (BEIS) to ask for a relaxation of grants on funding over the year end but this was not possible. This would mean the energy systems that was to be put in at the Scunthorpe site would not be completed in line with the original submission. Some of the work would be completed by the end of March but in order to complete this there would be a further application submitted for subsequent phases.

The current position was a deficit of around £20 million, however, it was expected to change now work was being undertaken with local commissioning colleagues that were transitioning into the ICS. The allocations for the next year have been released but where still being interpreted. The income and expenditure assumptions would also then be clear, the process would be completed in the next month.

Linda Jackson summarised that the Trust was on track but there was no scope for any level of complacency.

Christine Brereton advised that in respect of the recruitment plan, work had started on this prior to Christmas and a Nursing Recruitment Project Group had been formed. It would look at the different streams of how the Trust recruited nurses. This was suspended due to VCOD but had now recommenced. Some of the same principles for this would also be applied to medical staff recruitment. This would then form a larger project as it would need to be looked at with the bank and agency spend to provide assurance to the board.

Shaun Stacey referred to the agency expenditure in the report and felt a further deep dive was required to review what was being used as the Trust was not currently going off contract. The Trust was seeing that Holt Agency were demanding a higher rate of pay based on demand which meant the Trust could then not attract clinical staff due to the demand being high. The existing joint contract in the region also did not allow flexibility around this so it had meant the authorisation of higher payments. This issue needed to be reviewed further and Shaun Stacey would be in support of this. In respect of nursing the Trust mainly used the lower cost agency. A review of what was being used would also better assure the board going forward. Lee Bond agreed with Shaun Stacey and referred to the table on page eight which suggested the Trusts significant amount of spend was within the framework.

Stuart Hall referred to the Covid expenditure in respect of the non-recurrent funds and queried what the implications would be if the Trust did not receive the funding. Lee Bond advised a discussion had taken place with Ellie Monkhouse in order to

understand that if the establishment was funded at the rates requested within the previous establishment paper, whether, it would mean the removal of some of the spend on agency staff. Due to the relaxation of the infection control aspects it was felt some of the controls introduced two years ago may not be required. One of the biggest issues in respect of Covid funding was the 57% that would be taken away from the ICS. Ellie Monkhouse advised now was a good opportunity to invest in the development of the workforce in relation to future generations. The Trust were looking at apprenticeships, nurse practitioner roles along with roles that transfer from nursing associate roles to a registered nurse. There was a need to be in line with other Trusts across the ICS as they were offering those opportunities. Funding for this would be supported through Health Education England. There was a need to staff the wards due to the opening of wards and additional beds to keep the wards working in a safe way. Ellie Monkhouse wanted to highlight that although Covid rules were easing from a health perspective this would not change at the Trust. There would still be a need for isolation facilities at the Trust which was not currently available, this was being put in place through redirooms which was not a long term option. There would be a need to take into account that the requirement of red areas and the need for ITU areas being accommodated in other wards had been one of the issues in respect of the need for the increase in staffing.

Linda Jackson thanked Ellie Monkhouse for the additional update and wanted to note nervousness for the challenges ahead balance of safe care , wider workforce availability and financial pressures for Trusts in 2022/23.

5.2 Finance & Performance Committee Highlight Report and Board Challenge – Finance - NLG(22)015

Gill Ponder advised the committee was due to receive a paper that would explain the financial framework for 2022/23 which would be considerably different to previous reports. The Committee had undertaken a deep dive into Strategic Risk One – 1.5, which related to the risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources. This had reduced from rating 16 to 12 as the committee had been assured due to the ongoing work in this area. It had been acknowledged that the team had difficulties in respect of centralising contracts along with an accurate register of devices and ownership of this. As part of the committee self-assessment earlier in the year the committee wanted to ask the Board if the highlight reports being received on one page was providing assurance. If the board had any feedback on this it could be sent to Gill Ponder.

5.3 Annual Accounts – Delegation of Authority - NLG(22)016

Lee Bond advised the Trust draft accounts would be submitted by the 21 April 2022, this would then be shared with Audit to undergo the correct process. In order to ensure timely sign off of the accounts on the 22 June 2022 it was requested that the Audit, Risk & Governance Committee (AR&GC) be given delegated formal authority to sign off the accounts at the meeting due to be held on the 10 June.

The Trust Board agreed to the delegated authority of the AR&GC.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Executive Report – Strategic & Transformation – NLG(22)017

Ivan McConnell advised there had been significant progress on the delivery of all three parts of HASR. This particularly related to the production of a draft consultation business case that would be finalised by the end of March. This had been subject to external review by NHS England, along with five overview and scrutiny committees that had all agreed to this. The report included some areas of good practice and there was a need for this to be recognised.

There was a plan to progress on a timeline with an NHS England Gateway review in June and a Clinical Senate review in April. Those would be subject to the Trust gaining capital. An expression of interest had been submitted for £720 million of capital in part share with HUTH and the ICS on the 9 September 2021. The decision on this had previously been delayed and would now be delayed further by another week. If the Trust was not on the short list for funding further plans would be put in place.

There had been active engagement in the Place Boards, great work had been done in this area which had been recognised by Stephen Eames and colleagues.

Dr Kate Wood wanted to note the great progress to date. It was noted there was a risk of programme one moving forward, this was a collaborative approach so it may cause issues with moving forward in terms of the operational delivery. It had been agreed that the strategies of the specialities within Programme One would be viewed by both Trust Management Board structures at both Trusts. This would be before they moved forward with the Joint Development Board which comprised of HUTH and NLAG Executives to ensure all divisions were sighted on potential changes. Ivan McConnell agreed there was a risk on the transition, however, there would be a joint plan for the handover process and this would be reviewed by the relevant committees and boards. It had been agreed that the two leads would also support this to ensure continuity.

7. Governance

There were no items of Governance presented at the meeting.

8. Approval (Other)

There were no items of approval.

9. Items for Information

The following items were shared at the February 2022 meeting:

- Finance & Performance Committee Minutes – October and November 2021
- Quality & Safety Committee Minutes – November and December 2021
- Communication Round-Up
- Documents Signed Under Seal

- Trust Board Development 2021/22 and 2022/23

10. Any Other Urgent Business

There were no items of any other urgent business.

11. Questions from the Public

Linda Jackson asked members of the public for any questions.

David Cuckson, Governor asked Lee Bond for clarification in respect of the heating. It stated the funding for this would not be taken forward to the next financial year and so queried what the implication of this would be for the scheme and whether this would be cancelled. Lee Bond advised that by the end of March the Trust would be aware of whether the temperature of the water was of a sufficient quality and temperature to sustain the heat pumps. Unfortunately the funds were not available to progress the installation of the kit. The Trust, however, would be in a position at this point to see if this was feasible, there would then be a need to apply for the grant for the Trust. It was hoped that if the water was of the right quality the bid would be received favourably. If this was not the case there would be a need to look at whether the Trust could continue to support the Scunthorpe site until a solution was found. Until then Jug Johal and the teams would continue with the current infrastructure.

12. Date and Time of the next meeting

Board Development

Tuesday, 2 March 2022, Time: TBC
Forest Pines, Broughton

Formal Trust Board Meeting

Tuesday, 5 April 2022, Time: TBC
Venue to be confirmed

The Private Trust Board meeting was due to follow at 12:00 hours.

Linda Jackson closed the meeting at 11:45 hours.

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

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	1	1	Shauna McMahon	6	5
Terry Moran	2	2	Ellie Monkhouse	6	5
Dr Peter Reading	6	6	Fiona Osborne	3	3
Lee Bond	6	5	Simon Parker	3	3
Christine Brereton	6	6	Gillian Ponder	5	5
Neil Gammon	1	1	Michael Proctor	6	6
Stuart Hall	6	5	Maneesh Singh	5	5
Helen Harris	6	6	Andrew Smith	3	2
Linda Jackson	6	6	Shaun Stacey	6	5
Jug Johal	6	6	Michael Whitworth	6	6
Ivan McConnell	6	6	Dr Kate Wood	6	6

NLG(22)030

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2022/2023

Kindness · Courage · Respect

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Public Meeting
2022/23

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
2.5	07/12/2021	Mortuary & Board Store Assurance - Trust Board response to NHS England / Improvement		It was agreed the Audit, Risk & Governance Committee would be responsibility for the oversight of actions being undertaken.	Simon Parkes	Feb-22	An update was to be provided at the February 2022 meeting. It was confirmed at the February 2022 meeting this would be added to the AR&GC workplan.		AR&GC workplan	
3.5	07/12/2021	Executive Report - Performance		It was agreed more focus would be included within the report going forward to highlight actions for specific areas.	Shaun Stacey	Feb-22	An updated report would be provided at the February 2022 meeting. An updated report was shared at the February 2022 meeting.		Minutes - February 2022 Board Meeting	
4.1	07/12/2021	Executive Report - Workforce		Update to be provided on the current position in respect of mandatory Covid vaccines for staff within the Executive Report - Workforce.	Christine Brereton	Feb-22	An update was to be provided at the February 2022 meeting. An update was provided at the February 2022 meeting.		Minutes - February 2022 Board Meeting	
8.2	07/12/2021	Board Assurance Framework (BAF)		A meeting to review the requirement of sub-categories within Strategic Objective 2 was to be held.	Helen Harris / Ellie Monkhouse / Christine Brereton	Feb-22	An update was to be provided at the February 2022 meeting.			
3.2	01/02/2022	Quality & Safety Committee Highlight Report & NED Challenge		Update to be provided on Governor Engagement in respect of the Quality Priorities approval process.	Helen Harris / Dr Kate Wood / Mike Proctor	Apr-22	An update was to be provided at the April 2022 meeting.			

Key:

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

Kindness · Courage · Respect

ACTION LOG & TRACKER

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Board Public Meeting

2022/23

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?

Key:

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

NLG(22)031

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	5 April 2022	
Director Lead	Peter Reading, Chief Executive	
Contact Officer/Author	Peter Reading, Chief Executive	
Title of the Report	**Chief Executive's Briefing**	
Purpose of the Report and Executive Summary (to include recommendations)	To brief the Board on major issues of interest, some of which are covered in more detail elsewhere on the agenda.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Pandemic Response ✓ Quality and Safety ☐ Estates, Equipment and Capital Investment ✓ Finance ✓ Partnership and System Working	✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

***Board Assurance Framework (BAF) Descriptions:**

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

Chief Executive's Briefing

1. Development of Humber Coast and Vale Integrated Care System (ICS)

   The implementation of Integrated Care Systems across England continues, with further executive and non-executive appointments (designate) to the Integrated Care Board, and also the appointment of Place Directors (designate) for both North and North East Lincolnshire, and further development of the Place Partnership Boards for North Lincolnshire and East Riding of Yorkshire.

2. Key areas of ExecutiveTeam focus

   Key areas of focus in February and March:

   - Urgent and emergency care, and patient flow;
   - Elective recovery;
   - Continued pandemic response in light of local resurgence of high levels of Covid;
   - Staffing (including managing high levels of absence due to Covid, and supporting staff wellbeing);
   - Continuation implementation of the Trust's extensive investment programme in estates, equipment and infrastructure, and digital;
   - Developing operational and financial plans for 2022-23, against a backdrop of very high levels of urgent and emergency pressure, the need to pursue elective recovery very energetically, and a tight financial settlement for the NHS in 2022-23 .

3. CQC inspection

   The CQC resumed hospital inspections in February 2022, but has not yet inspected NLaG.

4. National Covid-19 Pandemic Enquiry

   This Inquiry is expected to examine the UK's pandemic response and ensuring that lessons were learned for the future. The Trust has established an internal Inquiry working group, made up of key individuals which would meet on a regular basis to discuss and action the information coming from the national team, with the regional steering group meeting monthly. Draft Terms of Reference have recently been published and these set out the aims of the Inquiry, namely to examine the COVID-19 response and the impact of the pandemic; to produce a factual narrative account in relation to central, devolved and local public health decision-making and its consequences; the response of the health and care sector across the UK; the economic response to the pandemic and its impact, including government interventions; and to identify the lessons to be learned from the above, thereby to inform the UK's preparations for future pandemics. It is not expected that hearings will commence until 2023.

5. National Staff Survey

   The results of the National Staff Survey for 2021 were published on 30th March 2022. NLaG's response rate at 38% (2,553) was 2% higher than the previous year, but still well below the national average.

   Good progress had been made in some areas with staff telling us they feel secure raising concerns about unsafe clinical practice, as well as managers providing clear feedback and

allowing staff to use their own initiative. However, fewer staff would recommend NLaG as a place to work, or as a place for friends and relatives to be treated compared to the 2020 results. This is obviously very disappointing, but this score has deteriorated everywhere in country – a sad reflection on the enormous pressure the NHS has been under over the last two years.

6. ‘Mutual aid’ to neighbouring trusts

Because NLaG’s elective delivery position (particularly with respect to long waits) is substantially stronger than some of its neighbours (particularly, Hull University Teaching Hospitals - HUTH), the Trust is making available some of its surgical capacity (mostly at Goole) to provide ‘mutual aid’ to help other trusts reduce their numbers of long waits. This will inevitably reduce the performance of NLaG with respect to its own local catchment area, but it is entirely consistent with the collaborative principles now applying in the NHS.

7. Integrated Acute Assessment Business Case

In February the Trust received Full Business Case approval to invest £24.86 million in building Integrated Acute Assessment Units at Grimsby and Scunthorpe hospitals.

8. Joint Clinical Information Officer

The Boards of HUTH and NLaG have appointed Shauna McMahon (NLaG’s Chief Information Officer) to be Joint Chief Information Officer for both trusts with a (non-voting) seat on both Trust Boards, with effect from 1st April 2022.

9. Changes to divisional management arrangements for Clinical Support Services

Following the retirement at the end of March of Dr Steve Griffin, Divisional Medical Director for Clinical Support Services and a careful option appraisal of options, the Trust Management Board has decided to change the management arrangements for the services within that division substantially.

The Division will be disestablished and the majority of its services and departments redistributed across Operations (Central), Estates & Facilities, and the clinical divisions of Medicine, Community & Therapies, and Surgery & Critical Care divisions.

Pathlinks will be managed separately, reporting to the Chief Operating Officer (COO), through a new post of Medical (Clinical) Director for Pathlinks. This post will be advertised internally and externally, and open to clinical scientists as well as doctors. The appointee will have a seat at TMB.

NLaG and HUTH will appoint a Joint Cancer Divisional Medical Director. This has been an ambition of the Humber Cancer Board as agreed by the 2 trusts in 2019. Nursing leadership for Cancer has already been provided this way since October 2021. Supporting the Joint post will be an NLaG Cancer Clinical Lead role. The two Trusts work together to provide cancer services across the Humber and the role will strengthen collaborative working as the Humber Cancer Board continues to streamline services at both Trusts.

Pharmacy will report to the COO through the Chief Pharmacist, who will retain his seat on TMB. Radiology, Endoscopy, Medical Physics and Nuclear Medicine will move to Surgery with its Clinical Leads and Associate Director of AHP Diagnostics

and current managers. It is a self-sufficient department and will not need extra resources. Medical Engineering will move to Estates & Facilities Directorate. Audiology will move to Surgery alongside ENT services, linking their diagnostics with the clinical service.

Patient Services will move to Operations (Central). Outpatient clinics will be disassociated from Patient Services and put back into the divisions of Surgery, Medicine and Community. This mirrors the format of Family Services who currently retain the management and clinical leadership of their clinic areas. This has the advantage of releasing a Matron post for redeployment into Medicine division.

The Resource Centre and Site Management will remain with Operations (Central) directorate. Bank staff recruitment, agency contract management and e-roster training and audit roles will be retained in Operations (Central) under the current 8D post. The coordinators for medical rota, bank and agency will be divided into the divisions of Surgery, Medicine, Community & Therapies to support better rota and bank allocations and management by the divisions.

Peter Reading
Chief Executive

NLG(22)032

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	5 April 2022
Director Lead	Dr Peter Reading, Chief Executive & Lee Bond, Chief Financial Officer
Contact Officer/Author	Dr Peter Reading, Chief Executive & Lee Bond, Chief Financial Officer
Title of the Report	**Trust Priorities – 2022/23**
Purpose of the Report and Executive Summary (to include recommendations)	This paper presents for Board discussion and approval the Trust Priorities proposed for 2022-23. This have been developed through extensive discussion within the Executive Team and their teams, together with advice from the Non-Executive Directors. These 'headline priorities' will be supported with more detailed metrics and implementation plans in the Trust's business plan and in the individual objectives of Executive Directors.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Pandemic Response ✓ Quality and Safety ✓ Estates, Equipment and Capital Investment ✓ Finance ✓ Partnership and System Working ✓ Workforce and Leadership ✓ Strategic Service Development and Improvement ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
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Financial implication(s) (if applicable)	Applicable through the Trust's business planning processes.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Objectives to further equality, diversity and inclusion, and to reduce health inequalities are included.
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance ☐ Information ☐ Review ☐ Other: Click here to enter text.

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Trust Priority 1 – Our People

- We will further develop how we seek to **attract and recruit** new staff by:

    - Developing an overall Recruitment Plan to attract staff to a range of roles across the trust, including hard to fill clinical roles, resulting in less reliance on bank and agency staff
    - Reviewing our **recruitment practices** to ensure that they are fair, inclusive, responsive and provide a positive candidate experience.
    - Developing **new roles** (including nurse apprenticeships) to attract staff and support existing workforce shortages.
    - Increasing **flexible and hybrid working** opportunities clinically and non-clinically for our new starters.

- We will **develop and care** for our own staff by**:**

    - Implementing a **nursing career pathway** which offers development opportunities for new and existing staff utilising our apprenticeship levy wherever possible
    - Exploring opportunities with partners, to introduce **new clinical roles** that would enhance our clinical workforce.
    - Reviewing our approach to **flexible, hybrid and retire and return** to meet individual needs in order to retain key staff wherever possible.
    - Continuing to raise awareness of and expand access to **health and wellbeing services** for staff.

- We will continue to improve our **culture and staff engagement** within the Trust by:

    - Conducting a culture diagnostic exercise to understand better what matters to our staff, and build actions to address these needs, overseen and monitored through the introduction of a **Culture Transformation Board.**
    - Further embedding **Just and Learning Culture** practices into how we address adverse events that affect our staff.
    - Designing and implementing a 3-strand **Leadership Development Strategy** focused on developing our emerging and existing leaders which includes: Leadership Core Skills, Career Development, and a Values Based Leadership programme centred on Kindness, Courage and Respect.
    - Strengthening our efforts to increase and celebrate the **diversity** of our workforce, developing strong staff networks to ensure an inclusive employee experience for all staff.

Trust Priority 2 – Quality and Safety

- We will improve safety on the following six **Trust Quality Priorities**:

    - **Mortality Improvement** - focusing on care at the end of life, we will reduce the number who die within 24 hours of admission and reduce emergency admissions for those in the last 3 months of life.
    - **Deteriorating Patient** - in line with the CQUIN to improve safety, we will ensure we observe NEWS2, escalate when it is high, and respond with treatment.
    - **Sepsis** - we will focus on improving sepsis six screening and the response within 1 hour.
    - Medication safety – we will improve the recording of patient weights, reduce medication omissions and improve appropriate antibiotic prescribing.
    - **Friends and Family Test and PALS** - these are key to patient experience so we

will aim to respond to 70% of PALS in 5 days by the end of the year and improve response rates in the Friends and Family test so we better understand what our patients want.
    - **Safety of Discharge** - focusing on seamless safety across organisation boundaries, by improving the timeliness of discharge letters and helping ensure hospital beds are for those who need them by improving the speed of discharge once a patient is well.

- We will continue to implement and embed actions flowing from CQC inspection in 2019 and take all necessary action in response to any further inspection(s) in 2022-23.

- We will improve safety by **sharing key learning** through multiple routes to enable the messages to become embedded.

- We will continue to participate in **national audit** and act on national and outlier alerts, and ensure we keep our services up to date by reviewing and changing practice based on best practice guidance from NICE.

- We will continue to develop and implement our Trust-wide **Quality Improvement (QI)** collaborative approach, with a particular focus on the use of the discharge lounge, document reassessment of pain, the safe storage of medicines and the number of staff trained in QI methodology.

- We will meet the seven actions following the **Ockendon** Report Part 1 and new actions following the publication of Part 2. We will also support the planning and delivery of the full-scale implementation of **Maternity Continuity of Carer** by March 2023, and support delivery of all the Clinical Negligence Scheme for Trusts (CNST) standards for Maternity services.

- We will prepare the organisation for the changes to statutory **Liberty Protection Safeguards** (due summer 2022).

- We will continue to ensure compliance with **Safe Staffing** requirements in line with national workforce safeguards.

- We will continue to maintain the highest standards of **Infection Prevention and Control**.

Trust Priority 3 – Restoring Services

- We will **increase the number of people we can diagnose, treat, and care for in a timely way** through doing things differently, accelerating partnership, and making effective use of the resources available to us, across health and social care. This will include offering our facilities to provide ‘mutual aid’ to neighbouring trusts if their waiting times are longer than ours.

- By keeping our patients safe, offering the right care, at the right time and in the right setting we will deliver **10% more activity** in 2022/23 when compared to levels of activity in 2019/20

- Reduce the backlog of patients waiting for care in the Trust from 28,000 to 9,000 and reduce the number of patients waiting above 40 weeks to 400 by March 2023. In addition, **reduce long waits** for treatment by reducing patients waiting above 52 weeks to zero by June 2022.

- By March 2023, increase **Patient Initiated Follow-Ups** (PIFU), Advice and Guidance (A&G) services and support the reduction of unnecessary Follow Up appointments by 25%

- Improve performance against **cancer waiting times** standards

    - 62-day performance – make a 3% improvement in each quarter from April 2022
    - 31days performance and Faster Diagnosis Standard – meet the standard consistently by March 2023
    - Joint Clinical Director for cancer HUTH/NLAG to be recruited by July 2022, and single management structure in place by September 2022
    - Join cancer services with HUTH by March 2023 for lung, upper gastro-intestinal, head and neck, skin, and oncology

- Cease having any **patients waiting for 12-hours** or more in our emergency departments by March 2023.

- Significantly improve the number of patients waiting to be admitted to wards from the emergency department within one hour.

- Maintain utilisation of **Same Day Emergency Care** (SDEC) above national average and at 40%

- Significantly reduce the time **ambulances** wait in our current emergency departments to **handover** care to achieve the following
    - 65% of handovers in under 15 minutes
    - 95% of handovers in under 30 minutes
    - No handovers waiting more than an hour

- Open our **new Emergency Departments** in July 2022 for DPOW, and in early 2023 for SGH

- Improve the responsiveness and increase the capacity of **community care** to support timely hospital discharge

    - Achieve full geographic coverage urgent community response - 8am to 8pm, 7 days a week and cover all 9 clinical conditions or needs of the national 2-hour guidance
    - Improve productivity and reach more patients under 2 hours to exceed the minimum 70% threshold of people seen within 2 hours by December 2022
    - Complete the comprehensive development of virtual wards (including hospital at home) towards a national ambition of 40-50 virtual beds per 100,000 population by December 2022

Trust Priority 4 – Reducing health inequalities

- We will work at system level to reduce pre-pandemic and pandemic related Health Inequalities, using related waiting list data that is embedded within performance frameworks to measure access, outcomes and experience for

BAME populations and those in the bottom 20% of IMD (Index of Multiple Deprivation) scores.

- We will improve the length of stay for patients who have **alcohol dependency** from North East Lincolnshire (identified as an area of additional need) and provide support to manage and improve their health in the long term.

- We will provide additional support and treatment to **tobacco** dependent inpatients, high risk outpatients, and pregnant women under our care.

- Our **maternity services will prioritise those women most likely to experience poorer outcomes**, including women from BAME backgrounds and women from the most deprived areas, and place them on a Maternity Continuity of Care (MCoC) pathway by March 2022. Then we will develop an enhanced model of MCoC that provides extra support for women from the most deprived areas, for implementation from April 2023.

- We will focus on ensuring that **patients with learning disabilities or autism** suffer no additional disadvantages in accessing care.

Priority 5 – Collaborative and system working

- We will develop and implement plans to align further our organisations and services with those of Hull University Teaching Hospitals (HUTH). This will include the Humber Acute Services Review (HASR).

- We will play a full part in the work of the **Humber and North Yorkshire Health and Care Partnership**, including the Humber Partnership Board, the Acute Collaborative, the Community Collaborative, the three Place-based partnerships of North and North East Lincolnshire, and the East Riding of Yorkshire, and associated clinical and 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.

- We will work together with partners across the integrated care system (ICS) to develop our approach to **population health management and prevention**. This will allow our population to play a more proactive role in promoting good health, targeting interventions at those groups most at risk, supporting health prevention and treatment.

Trust Priority 6 – Strategic Service Development and Improvement

With partners in the **Humber Acute Services Review**, we will:

- submit a **Pre-Consultation Business Case** (PCBC) to NHS England in May 2022 for the delivery of new models of care for Urgent & Emergency Care, Maternity, Neonates & Paediatrics, and Planned Care & Diagnostics;

- gain approval to launch a **Statutory Public Consultation** during Quarters 2 & 3 of 2022-23;

- deliver a **Decision-Making Business Case** based upon Consultation Outcomes by Dec. 2022;

- commence implementation of the **planned models of care** in Q4 2022/23.

Trust Priority 7 - Finance

- We will achieve the **Trust's 2022/23 Financial Plan**.

- We will achieve the 2022/23 Humber Coast and Vale HCP **system financial control total**.

- We will leave the **Financial Special Measures** element of the Recovery Support Programme.

- We will work as part of the HCV ICS to agree a **3-year plan** starting in 2022/23.

Trust Priority 8 – Capital Investment

- We will invest **c.£100 million in estates and equipment**, including new Emergency Departments, Same Day Emergency Care and Acute Assessment Units at both DPOW and SGH, and Ward 25 (Scunthorpe) refurbishment.

- We will continue to pursue (with Hull University Teaching Hospitals) our £720m Expression of Interest to be part of the **National Hospitals Programme**, including Strategic Outline Case and Outline Business Case, if we are shortlisted for this Programme. Our proposal includes the long-term development of a new hospital for Scunthorpe and redevelopment of DPOW.

Trust Priority 9 – Digital

We will implement the second phase of our **Digital Strategy**, including:

- Completing **digital projec**ts initiated in 2021-22 – Patient Administration System (PAS), Data Warehouse and implementation, Robotic Process Automation (RPA) of Single Sign On (SSO), internal system integration and WebV enhancements.

- Digitising **Health Records** as a priority, followed by corporate paper processes to support paper-lite/paperless working (including introducing an Enterprise Document Management System during 2022-23 and 2023-24).

- Working with national and regional teams to implement **mandated system level digital solutions** (e.g. Maternity IT system, Eye Referral System, Diagnostic Hubs, ICS Electronic Patient Record).

- Collaborating with acute partners in the ICS to improve access for clinicians to clinical information through **digital interoperability between trusts** and by supporting digital processes.

- We will improve **digital literacy** through a focused communications and education approach engaging with end-users to foster a culture that embraces technology and leverages digital champions to support sustained digital transformation.

Trust Priority 10 – The NHS Green Agenda

- We will promote, develop and embed the **NHS Green agenda** into the Trust, specifically, procurement policies, staff energy champions, Net Zero Heroes, travel, waste and recycling, including continuing to move towards the removal of single use plastics where clinically possible and energy reduction.
- At Scunthorpe General Hospital we will explore funding to provide **energy conservation** schemes to include a new energy centre.
- At DPoW we will continue to work with North East Lincolnshire council to explore and develop a **district heating network** across the locality, including a new energy centre coupled with energy conservation measures such as LED lighting.

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	05 April 2022
Director Lead	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Medical Director Christine Brereton, Director of People
Contact Officer/Author	Shauna McMahon, Chief Information Officer
Title of the Report	**Integrated Performance Report (IPR)**
Purpose of the Report and Executive Summary (to include recommendations)	**1. Introduction** The IPR aims to provide the Board with a detailed assessment of the performance against the agreed indicators and measures and describes the specific actions that are under way to deliver the required standards. **2. Access and Flow** The executive summary of the Access and Flow section is provided over on page 4. **3. Quality and Safety** The executive summary of the Quality and Safety section is provided over on page 5. **4. Workforce** The executive summary of the Workforce section is provided over on page 6. **5. Appendix** a) Appendix A National Benchmarked Centiles b) Appendix B Extended Scorecards as presented to each respective Sub-Committee **6. The Trust Board is requested to:** a) Receive the IPR for assurance. b) Note the performance against the agreed indicators and measures. c) Note the report describes the specific actions which are under way to deliver the required standards.
Background Information and/or Supporting Document(s) (if applicable)	Access and Flow – IPR (February Data) Quality and Safety – IPR (January/February Data) Workforce – IPR (February Data)
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Pandemic Response ✓ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable

Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

1. ACCESS & FLOW – Shaun Stacey

Highlights: (share 2-3 positive areas of progress/achievement)

- Percentage of Patient Discharged Same Day As Admission (excluding daycase) – 38.7% for February 2022
- Number of Incomplete RTT Pathways 52 Weeks – 296 for February 2022 (unvalidated)
- Diagnostic Procedure Waiting Times – 6 Week Breach Rate (DM01) – 18.4% for February 2022 (unvalidated)

Lowlights: (share 2- 3 areas of challenge/struggle)

- Cancer Waiting Times – 62 Days GP Referrals – 65.1% for February 2022 (unvalidated)
- Emergency Department Waiting Times (4 Hour Performance) – 64.4% for February 2022
- Number of Decision to Admit (DTA) 12 Hour Waits – 307 for February 2022

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Emergency Department Waiting Times (4 Hour Performance) – 64.4% for February 2022	UTC went live in DPoW on the 18th January 2022	All patients attending DPoW UTC in January and February were seen within 4 hours
Cancer Performance	Upper GI consultant led straight to test commenced at SGH 1st February 2022	Decrease in time taken for diagnostic tests on Cancer Upper GI pathways

2. QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

Highlights: (share positive areas of progress/achievement)
HSMR and SHMI remain within as expected.
NEWS observations continues to achieve.

Lowlights: (share areas of challenge/struggle)
Out of Hospital SHMI is above target, and NEL has a significantly higher score than NL.
There are 7 remaining Structured Judgement reviews outstanding for 2021 from Medicine Division.
Compliance for VTE remains below the 95% target.
Escalation of NEWS continues to give limited assurance.

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
1) OOH SHMI high and outstanding SJRs	1) Monitoring by Mortality Improvement Group. Further reviewers trained in ORIS system for SJRs	1) Continued reduction in OOH SHMI and completion of 2021 SJRs by 1 May 2021
2) VTE compliance below 95%	2) Coding error which gives an inaccurately poorer position being rectified this month.	2) Rebased figures on VTE position will show improved performance
3) Lack of documentation to retrospectively evidence escalation/responses of deteriorating patients.	3) Escalation via WEB V systems explored with Trust's WEB V lead	3) Significant increased performance on escalation once electronic escalation goes live

3. WORKFORCE – Christine Brereton

Highlights:

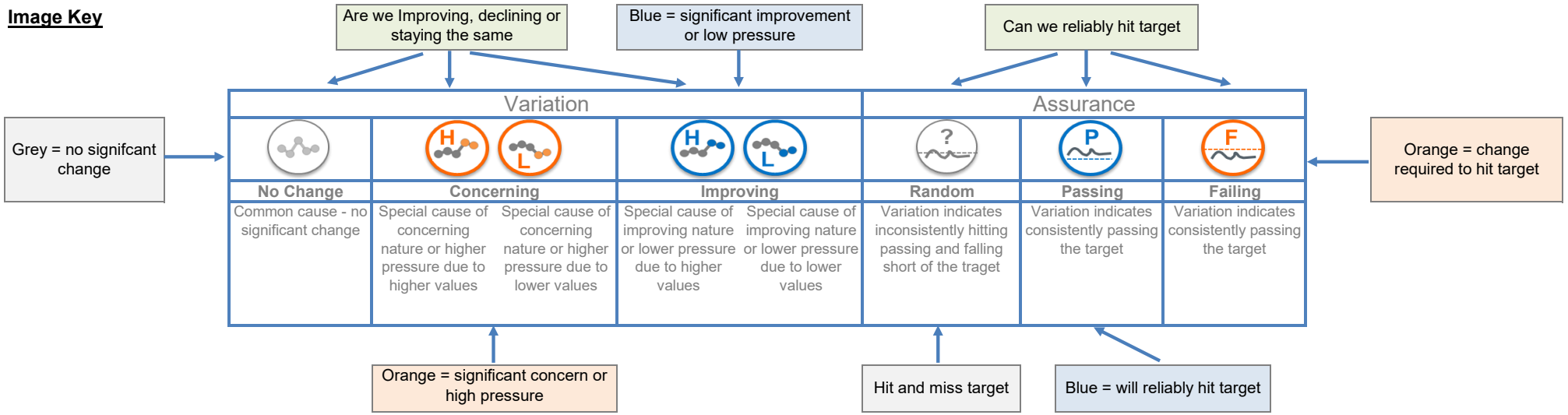
- The Core Mandatory Training position overall currently stands at 93%, Compliance continues to be above the Trust target of 90%
- The Registered Nursing vacancies position is 7.28% this continues to be below target of 8%
- The Role Specific Mandatory Training position currently stands at 80%. This continues to be in line with the Trust target of 80%

Lowlights:

- Hotspot areas of low compliance for Statutory /Mandatory training in medical workforce
- Turnover continues to be above target. The latest turnover data point 11.2%
- Unregistered Nursing vacancy positions continues to increase to 11.6% against a target of 2% (proposal to increase target)
- Sickness peaked in January due to a sharp increase in Covid-19 absence with a sickness rate of 7.9%

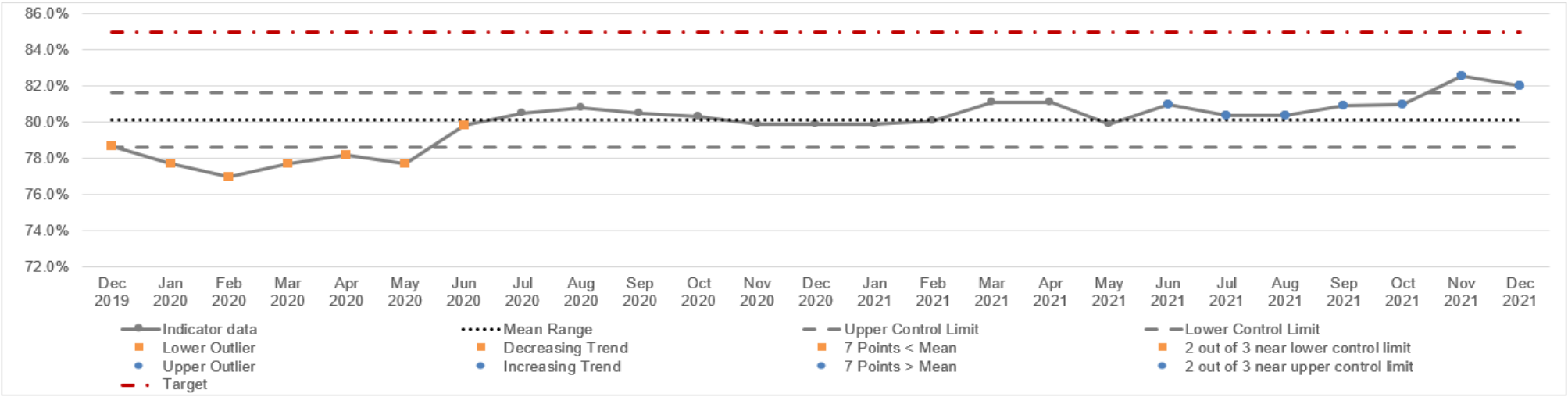
Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Deep dive of leavers data in March 2022 to identify hotspot areas with focused interventions. A bid has been successful to secure additional funding to support recruitment. focussing on materials & diversity, to support a more robust induction process containing a supernumerary period. Following ratification of a revised sickness absence policy, a suite of training will rolled out to line managers this will include greater levels of online content, in person training, and sectional guides that allow managers to refresh on parts of the sickness process as and when needed.	Planned earlier intervention in relation to known leavers. Creation of talent pools. Strengthen engagement levels; proactive health and wellbeing plan to address common themes affecting wellbeing-related retention. An increased emphasis on prevention of avoidable leavers by improving culture (mid to long term goal) and strengthening leadership capability and behaviours where required. Creation of talent pools for high frequency leaver areas to ensure a quicker recruitment turnaround.	Greater understanding of reasons for leaving. With this additional information we will be able to deploy targeted interventions to reduce turnover and the vacancy rates. An increased emphasis on prevention of avoidable leavers by improving culture (mid to long term goal) and strengthening leadership capability and behaviours where required. Creation of talent pools for high frequency leaver areas to ensure a quicker recruitment turnaround A funding bid has been successful for further funding to support recruitment, with £360,000 awarded to support the arrival of 120 international nurses between January and December 2022.

Image Key



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

SPC Key - example SPC chart

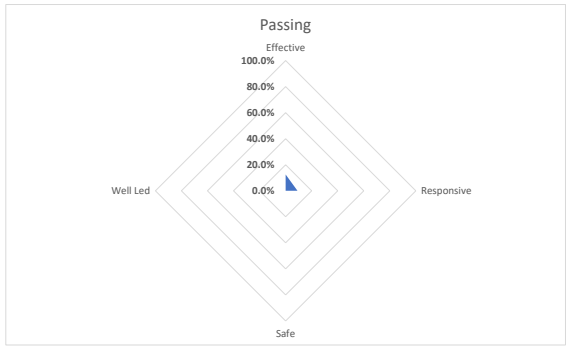


Orange Squares = significant concern or high pressure

Blue Circles = significant improvement or low pressure

Consistently Passing

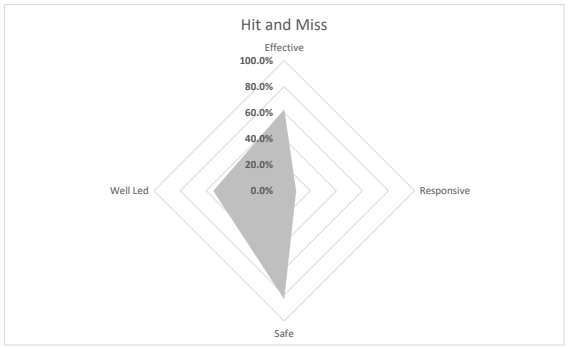
Total: 2



% Patients Discharged On The Same Day As Admission (excluding daycase)
Total Inpatient Waiting List Size

Hit and Miss

Total: 17



% Discharge Letters Completed Within 24 Hours of Discharge
Bed Occupancy Rate (G&A)
Core Mandatory Training Compliance Rate
Decision to Admit - Number of 12 Hour Waits
Number of E Coli Infections
Number of Gram Negative Infections
Number of MRSA Infections
Number of MSSA Infections
Number of Trust Attributed C-Difficile Infections
Role Specific Mandatory Training Compliance Rate
Turnover Rate
% of Extended Stay Patients 21+ days
Inpatient Elective Average Length Of Stay
Inpatient Non Elective Average Length Of Stay
Registered Nurse Vacancy Rate
Medical Vacancy Rate
Trustwide Vacancy Rate

Consistently Failing

Total: 17

% Inpatient Discharges Before 12:00 (Golden Discharges)
Ambulance Handover Delays - Number 60+ Minutes
Cancer Request To Test In 14 Days*
Cancer Waiting Times - 104+ Days Backlog*
Cancer Waiting Times - 62 Day GP Referral*
Combined AfC and Medical Staff PADR Rate
Emergency Department Waiting Times (% 4 Hour Performance)
Medical Staff PADR Rate
Number of Incomplete RTT pathways 52 weeks*
Number of Overdue Follow Up Appointments (Non RTT)
PADR Rate
Patients With Confirmed Diagnosis Transferred By Day 38*
Percentage Under 18 Weeks Incomplete RTT Pathways*
Venous Thromboembolism (VTE) Risk Assessment Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
Unregistered Nurse Vacancy Rate
Sickness Rate

			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement	H	% Patients Discharged On The Same Day As Admission (excluding daycase)	Inpatient Non Elective Average Length Of Stay	Number of Incomplete RTT pathways 52 weeks*
				Number of Trust Attributed C-Difficile Infections	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
		L		Number of MSSA Infections	
				Core Mandatory Training Compliance Rate	
				Registered Nurse Vacancy Rate	
	Common Cause		Total Inpatient Waiting List Size	% Discharge Letters Completed Within 24 Hours of Discharge	Number of Overdue Follow Up Appointments (Non RTT)
				Bed Occupancy Rate (G&A)	Cancer Request To Test In 14 Days*
				Inpatient Elective Average Length Of Stay	Cancer Waiting Times - 104+ Days Backlog*
				Number of MRSA Infections	Patients With Confirmed Diagnosis Transferred By Day 38*
				Number of E Coli Infections	Percentage Under 18 Weeks Incomplete RTT Pathways*
				Number of Gram Negative Infections	PADR Rate
				Role Specific Mandatory Training Compliance Rate	Medical Staff PADR Rate
				Medical Vacancy Rate	Combined AfC and Medical Staff PADR Rate
					Unregistered Nurse Vacancy Rate
	Special Cause Concern	H		% of Extended Stay Patients 21+ days	% Inpatient Discharges Before 12:00 (Golden Discharges)
				Decision to Admit - Number of 12 Hour Waits	Ambulance Handover Delays - Number 60+ Minutes
		L		Turnover Rate	Cancer Waiting Times - 62 Day GP Referral*
				Trustwide Vacancy Rate	Emergency Department Waiting Times (% 4 Hour Performance)
					Venous Thromboembolism (VTE) Risk Assessment Rate
					Sickness Rate

Scorecard - Access and Flow

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Note 'Action Required' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Planned	% Under 18 Weeks Incomplete RTT Pathways*	Feb 2022	69.4%	92.0%	Action Required		F
	Number of Incomplete RTT pathways 52 weeks*	Feb 2022	296	0	Action Required	L	F
	Total Inpatient Waiting List Size	Feb 2022	10,340	11,563			P
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Feb 2022	18.4%	1.0%	Action Required	L	F
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Feb 2022	27,859	9,000	Action Required		F
	Outpatient Did Not Attend (DNA) Rate	Feb 2022	9.7%	No target			n/a
	% Outpatient Non Face To Face Attendances	Feb 2022	31.0%	No target			n/a
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Feb 2022	65.1%	85.0%	Action Required	L	F
	Cancer Waiting Times - 104+ Days Backlog*	Feb 2022	25	0	Action Required		F
	Cancer - Patients With Confirmed Diagnosis Transferred By Day 38*	Feb 2022	30.8%	75.0%	Action Required		F
	Cancer - Request To Test In 14 Days*	Feb 2022	84.6%	100.0%	Action Required		F
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Feb 2022	64.4%	95.0%	Action Required	L	F
	Number Of Emergency Department Attendances	Feb 2022	11,265	No target			n/a
	Ambulance Handover Delays - Number 60+ Minutes	Feb 2022	651	0	Action Required	H	F
	Decision to Admit - Number of 12 Hour Waits	Feb 2022	307	0	Action Required	H	?
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Feb 2022	38.7%	92.0%		H	P
	% of Extended Stay Patients 21+ days	Feb 2022	12.5%	12.0%	Action Required	H	?
	Inpatient Elective Average Length Of Stay	Feb 2022	2.3	2.4			?
	Inpatient Non Elective Average Length Of Stay	Feb 2022	3.7	4.1		L	?
	Number of Medical Patients Occupying Non-Medical Wards	Feb 2022	114	No target			n/a
	% Discharge Letters Completed Within 24 Hours of Discharge	Feb 2022	89.3%	85.0%			?
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Feb 2022	15.2%	30.0%	Action Required	L	F
	Bed Occupancy Rate (G&A)	Feb 2022	91.0%	92.0%			?
COVID	Number of COVID patients in ICU beds (Weekly)	Feb 2022	1	No target		L	n/a
	Number of COVID patients in other beds (Weekly)	Feb 2022	56	No target		L	n/a
	% COVID staff absences (Weekly)	Feb 2022	12.2%	No target		L	n/a

Scorecard - Quality and Safety

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

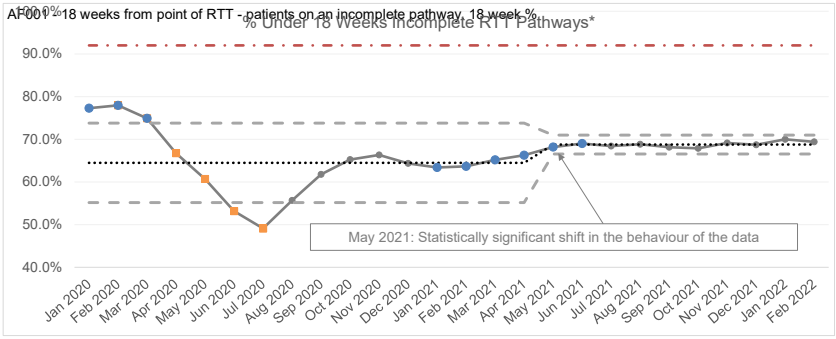
Infection Control	Number of MRSA Infections	Jan 2022	0	0			
	Number of E Coli Infections	Jan 2022	4	9			
	Number of Trust Attributed C-Difficile Infections	Jan 2022	0	3			
	Number of MSSA Infections	Jan 2022	0	0			
	Number of Gram Negative Infections	Jan 2022	7	12			
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dec 2021	100.0	As expected			As expected
	Summary Hospital level Mortality Indicator (SHMI)	Sep 2021	107.1	As expected			As expected
Safe Care	Patient Safety Alerts actioned by specified deadlines	Jan 2022	100%	100%			n/a
	Number of Serious Incidents raised in month	Dec 2021	6	No target			n/a
	Occurrence of 'Never Events' (Number)	Dec 2021	1	0		n/a	n/a
	Duty of Candour Rate	Nov 2021	100%	No target			n/a
	Falls on Inpatient Wards (Rate per 1000 bed days)	Jan 2022	4.9	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate per 1000 bed days)	Jan 2022	5.3	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Jan 2022	73.2%	95.0%	**Action Required**		
	Care Hours Per Patient Day (CHPPD)	Jan 2022	8.3	No target	**Action Required**		n/a
	Mixed Sex Accommodation Breaches	Feb 2022	4	0		n/a	n/a
Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Jan 2022	7.8	No target			n/a
	Complaints Responded to on time	Dec 2021	70.0%	85.0%			
	Friends and Family Test (FFT)						
	Number of Positive Inpatient Scores	Jan 2022	449 out of 465	No target		n/a	n/a
	Number of Positive A&E Scores	Jan 2022	274 out of 374	No target		n/a	n/a
	Number of Positive Community Scores	Jan 2022	134 out of 146	No target		n/a	n/a
	Number of Positive Outpatient Scores	Jan 2022	10 out of 13	No target		n/a	n/a
	Number of Positive Maternity Antenatal Scores	Jan 2022	0 out of 0	No target		n/a	n/a
	Number of Positive Maternity Birth Scores	Jan 2022	100 out of 104	No target		n/a	n/a
	Number of Positive Maternity Post-Natal Scores	Jan 2022	2 out of 2	No target		n/a	n/a
	Number of Positive Maternity Ward Scores	Jan 2022	38 out of 40	No target		n/a	n/a

Scorecard - Workforce

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

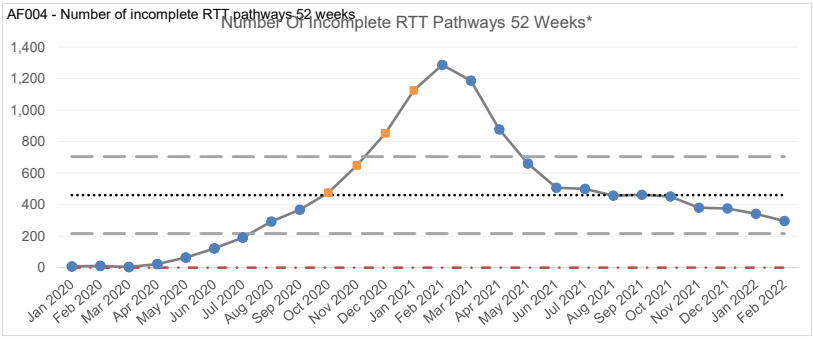
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate	Jan 2022	11.6%	2.0%	Action Required		F
	Registered Nurse Vacancy Rate	Jan 2022	7.2%	8.0%		L	?
	Medical Vacancy Rate	Jan 2022	12.1%	15.0%			?
	Trustwide Vacancy Rate	Jan 2022	9.3%	7.0%	Action Required	H	?
Staffing Levels	Turnover Rate	Feb 2022	11.2%	9.4%	Action Required	H	?
	Sickness Rate	Jan 2022	7.9%	4.1%	Action Required	H	F
Staff Development	PADR Rate	Feb 2022	80.0%	85.0%	Action Required		F
	Medical Staff PADR Rate	Feb 2022	77.0%	85.0%	Action Required		F
	Combined AfC and Medical Staff PADR Rate	Feb 2022	78.7%	85.0%	Action Required		F
	Core Mandatory Training Compliance Rate	Feb 2022	93.0%	90.0%		H	?
	Role Specific Mandatory Training Compliance Rate	Feb 2022	80.0%	80.0%			?

AF001 - 18 weeks from point of RTT - patients on an incomplete pathway, 18 week %



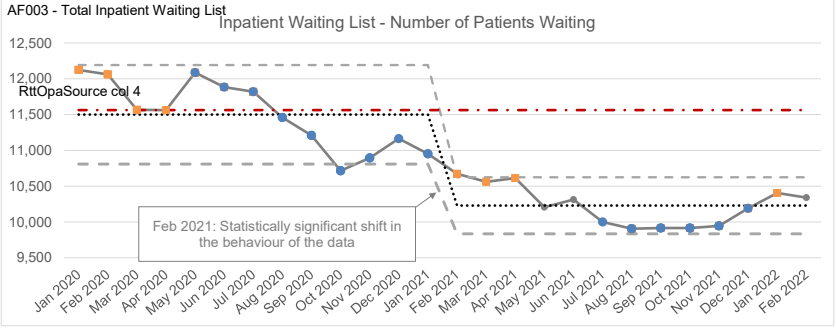
Feb 2022	Target	Variance	Assurance
69.4%	92.0%	Common cause - no significant change	Variation indicates consistently falling short of the target

AF004 - Number of incomplete RTT pathways 52 weeks



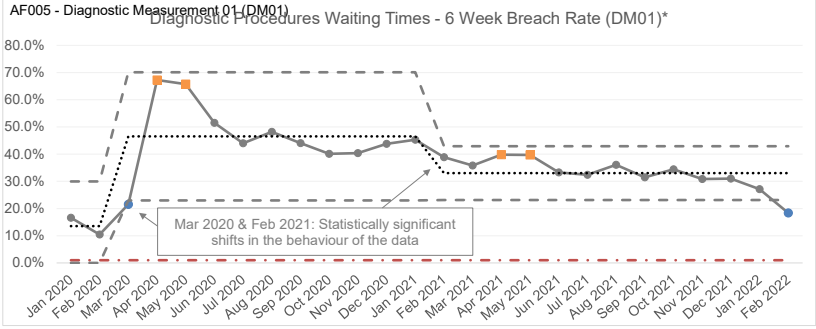
Feb 2022	Target	Variance	Assurance
296	0	Special cause of improving nature or lower pressure due to lower values	Variation indicates consistently falling short of the target

AF003 - Total Inpatient Waiting List



Feb 2022	Target	Variance	Assurance
10,340	11,563	Common cause - no significant change	Variation indicates consistently passing the target

AF005 - Diagnostic Measurement 01 (DM01)



Feb 2022	Target	Variance	Assurance
18.4%	1.0%	Special cause of improving nature or lower pressure due to lower values	Variation indicates consistently falling short of the target

Data Analysis:

Under 18 weeks incomplete*: Performance has stabilised following the onset of the pandemic last year, this is reflected in the process limit recalculation. However, the target of 92% will not be achieved without process re-design.
Incomplete 52 weeks*: The number of 52 week waits has decreased over recent months and shows early signs of stabilising following the spike caused by the pandemic. Although the numbers remain higher than those seen pre-pandemic. The target will not be met without process redesign.
Inpatient waiting list: There has been a significant reduction in the size of the inpatient waiting list over the course of the pandemic, hence the recalculation of the process limits. Based on the data, the indicator can reliably be expected to achieve the target of 11,563.
Diagnostics 6 Week Wait (DM01)*: There has been a significant improvement in this indicator following the impact of covid, however the figure of 18.4% is unvalidated. Process re-design is required in order to meet the target.

Challenges:
• Medicine division performance has increased slightly when compared to previous month. The division has 6/12 specialties above 92% threshold.
• Surgery continue to reduce the number of patients waiting 52+ weeks however they are not on track to deliver zero patients
• Mutual aid for HUTH and York is creating new long RTT waits that need treating - numbers are coming through for Urology and commencing Orthopeadics. We are also discussing how we can support vascular day case with HUTH.
• Theatre capacity affected by short notice sickness, issues with theatre estates and an influx of acute activity causing elective activity to be converted.

Key Risks:
• Across most specialties in medicine there remains some capacity risks in the coming weeks due to annual leave being taken reducing clinic capacity as clinicians are sometimes required to cover inpatient services due to colleagues being on leave. Time waited for diagnostics has an impact on ability to achieve RTT
• Potential further COVID waves
• Carry over of annual leave - clinician availability
• Vacancy rate; Gastroenterology: 33.3%. Cardiology 75%.
• Non-Obstetric Ultrasound is a low performing area although is now showing improvements
• CT is low performing
• High vacancy rate of Consultant Radiologists
• Unable to mitigate the activity gaps of tenders not being realised - ENT and Ophthalmology
• Ongoing management of high levels of acute activity impacting elective work
• Echo DM01 waiting times have increased as insuffiecient capcity in core - IS provider secured but need continuation into 2022/23

Actions:
• Medicine Division Activity Recovery Plans for 2021-22 for every specialty are in place
• Surgical division have active recovery plans alligned to the H2 planning in place and working for all specilties. Focus continues on the long waiting patients along with ensuring P2, urgent and cancer patients are also managed
• St Hugh's continues to be utilised for Ophthalmology, Orthopaedics and General Surgery . Urology continue to have support from trent Cliff and Ophthalmology continue to mitigate some capacity shortfall by Medinet.
• External Providers sourced for Gastroenterology, Respiratory, Cardiology, Endocrinology, Rheumatology and Echo. Additional sessions being delivered by internal consultants also.
• Extra capacity has been sourced for Non Obstetric Ultrasound and the DM01 is expected to improved from November 2021 onwards.
• Plan in place for extra capacity for CT on ad hoc basis until the new EDCT scanner(s) go live
• Business cases are being written to appoint more substantive staff in Diagnostic departments to bridge the gap between demand and capacity
• Audiology recovery plan
• Endoscopy Recovery Programme

Mitigations:
• Medicine and Surgical Division continue with recovery with additional sessions by NLaG clinicians. Working with various external providers to provide additional clinic capacity and reduce the time patients wait to receive treatment.
• Surgery & Critical Care have a robust structure in place to regularly review waiting lists and focus on long waiting and high risk patients. Risk stratification programme continues across all specialities, with additional support afforded to Ophthalmology to monitor and track high risk overdue follow up patients.

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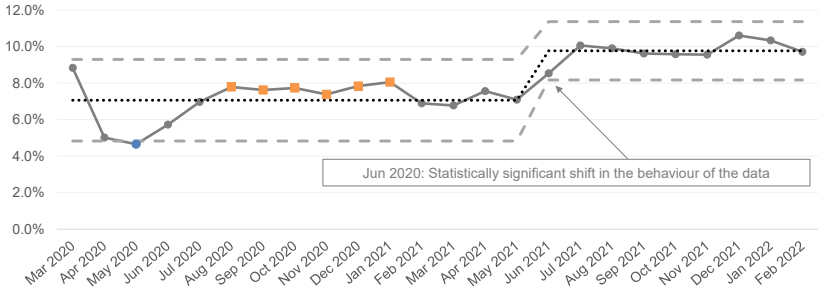
Feb 2022
27,859
Target
9,000
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Feb 2022
9.7%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Feb 2022
31.0%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:
Outpatient Overdue follow up: For the past 2 years performance has been alternating between improvement and concern. Over this period the indicator has consistently failed the target of 9,000 by some margin and can be expected to continue to do so without process re-design.
Outpatient DNA rate: Process limits were recalculated from June 2020 to reflect the statistically significant shift in the behaviour of the data. From this point DNA rates are as expected.
Non Face To Face Outpatient Attendances: Performance has been stable and as expected for the past 11 months from the date of the latest process limit recalculation

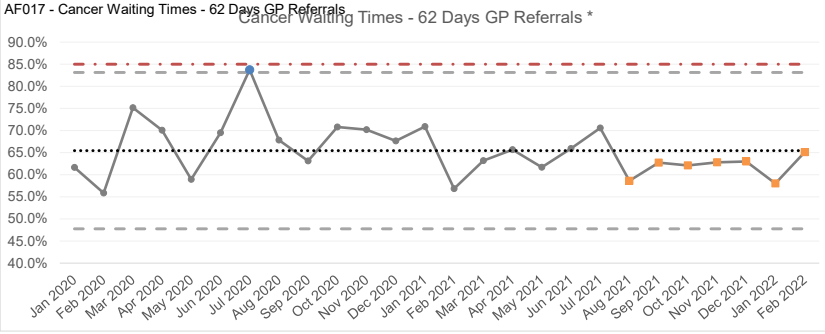
Challenges:
• Although the DNA rate has slightly improved it remains an area of focus
• Surgery are experiencing a high DNA rate within some specialties, particularly ophthalmology which is significantly affecting performance.
• The number of patients on the follow-up list has improved slightly, although sustainability is not guaranteed without transformation changes taking effect
• The PIFU target was achieved in December, although we are not expecting to hit the March 2% target due to clinical take-up
• CHN has gathered some momentum, but maintaining clinics due to unplanned care and ward priorities remains a challenge

Risks

Actions:
• Targetted workcontinues to increase the number of patients on a PIFU pathway in line with planned Trajectory
• CHN continues with cardiology seeing reduction in overall waiting list position. Clinics are plannedin March for Diabetes, ENT, Cardiology and Rheumatology
• Work has commenced with Gynaecology in relation to Post Menstrual Bleeding and a one stop clinic to reduce 2WW into NLAG - quotes are being sourced on equipment
• Heart Failure at home being trialled as part of PKB in Cardiology.
• Inital analysis of DNAs identifies a link to non face to face appointments, and loss of reminderservices. Text reminder service being reintroduced from March 2022
• Clinical Divisions finalising Business Plans to include the trajectories for achieving a reduction in the backlog of overdue follow ups, increasing PIFU numbers and improved response times to A&G
• TIF Funding has been secured to fund a 2 yr licence fee for Attend Anywhere (virtual consultations)
• Clinicians engaged with following the access policy with regards to DNAs
• Continue to work with the IS to improve response times on A&G requests across Medicine specialties, to increase GP requests

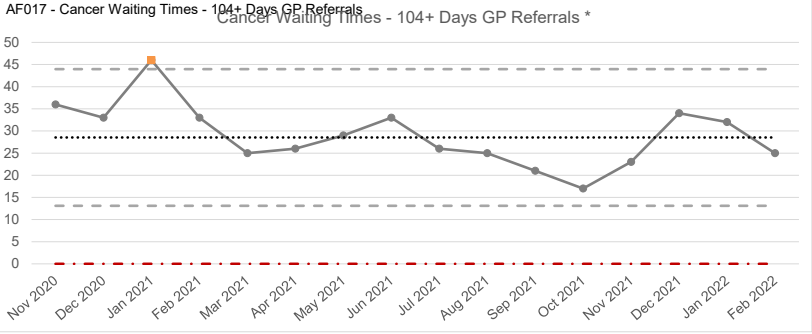
Mitigations:
• Weekly assurance that on the H2 planning numbers we continue to see a reduction in longer waiters and movement towards constitutional standards
• Risk Stratification of outpatient waiting lists
• Mutually agree the majority of out-patient appointments, to minimse DNA rates.

AF017 - Cancer Waiting Times - 62 Days GP Referrals



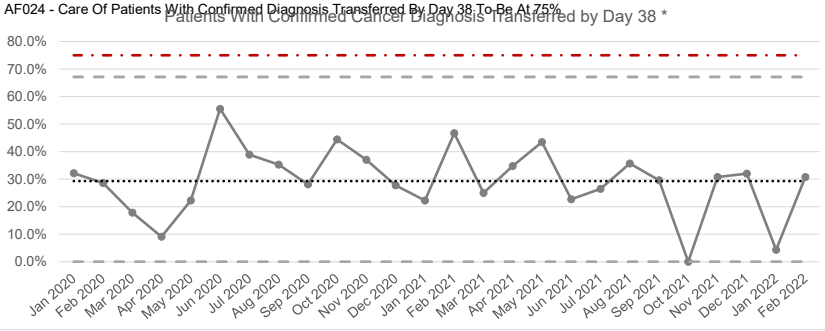
Feb 2022	Target	Variance	Assurance
65.1%	85.0%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates consistently falling short of the target

AF017 - Cancer Waiting Times - 104+ Days GP Referrals



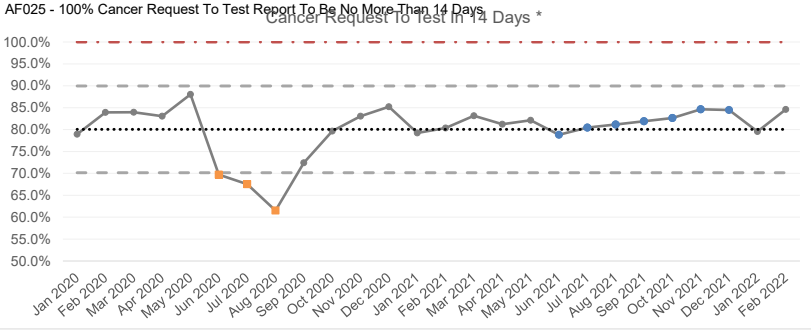
Feb 2022	Target	Variance	Assurance
25	0	Common cause - no significant change	Variation indicates consistently falling short of the target

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



Feb 2022	Target	Variance	Assurance
30.8%	75.0%	Common cause - no significant change	Variation indicates consistently falling short of the target

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



Feb 2022	Target	Variance	Assurance
84.6%	100.0%	Common cause - no significant change	Variation indicates consistently falling short of the target

Data Analysis:

62 days GP referral*: The rate has fallen below the mean line over the last 7 months and therefore has triggered a cause for concern in terms of data variation. This target has not been achieved over the last 2 years and the indicator will fail to meet the target without process re-design.

104+ days GP referrals*: This indicator has recorded no statistically significant change since November 2020. However, the target of zero has not been met for at least two years and the indicator will fail to meet the target without process re-design.

Transferred by day 38*: Performance has not changed significantly over the past 2 years, and the target has not been achieved during this time. It will continue to fail the target without process re-design.

Request to test 14 days*: Performance has stablised at a similar rate to pre-pandemic levels and is currently as expected. The target of 100% has not been achieved within the last 2 years and the indicator will fail to meet the target without process re-design.

Challenges:

- All tumour sites are affected by the increasing waiting times for oncology consultant appointments (62 day pathways) resulting in increased breaches of 62 days
- Most tumour sites are unable to achieve 62 day standard due to multiple factors, including diagnostic and pathoogy turnaround times
- Colorectal is a challenge but the teams are working to improve referrals in to ensure the right patients receive the diagnostics required.
- Medicine UGI and Lung tumour site pathways for 28 day performance are under further review.

Key Risks:

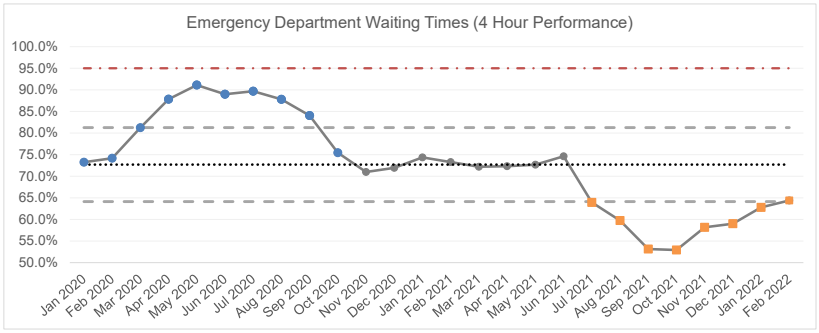
- There are a number of issues related to visiting consultant services (e.g urology, oncology), tertiary based staging scans (EUS, PET CT) which affect the ability to meet faster diagnostic standards, transfer (IPT) for treatment by Day 38 - as you are aware the oncology concerns when pts transfering to HUTH.
- Request to test (14 days) - in order to meet 28 day Faster Diagnosis Standard, this needs to be reduced to 7 calendar days.
- Meeting the 38 day IPT standard is impacted through delays occurring with tertiary diagnostics/staging TAT, and visitng consultant/oncology services (urology - prostate)
- HUTH have relocated Urology oncologist to Breast, which is causing a significant risk to waiting times
- Further reductions in oncology workforce are likely to see increases in 1st consultant oncology appointment which will impact on treatment times (currently waits of between 4-6+ weeks from referral to oncologist)

Actions:

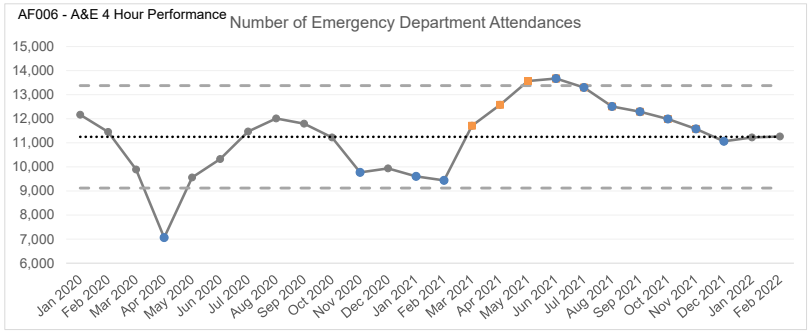
- 62 day performance is being reviewed and managed weekly - along with the 28 day performance. The GI RDC pathway is up and running and the intentionis to have CN's contact with all 2 WW referals within 48 hours.
- Colorectal - CNS straight to test commenced both sites in Jnauary and already making an impact on 28 day faster diagnosis
- UGI - consultant led straight to test commenced at SGH 1 Feb 2022.
- The Cancer Transformation team has completed a pathway analysis on 100 patient pathways for Lung. Outputs of this analysis have identified several areas for improvement and discussions are continuing with HUTH (joint pathway transformation and implementation of national optimal pathway). Gap analysis against all published national optimal pathways are in process (colorectal, UGI O-G, Prostate). H&N and Gynae (to be published April 22) - draft received, analysis in process with outputs to be presented at Divisional Boards.
- Improvement projects identified through analysis to be presented to MDTs and actions agreed.
- RDC (GI) pathway rolled out across all PCNs; non-site specific RDC pathway in development (anticipated to be in place from April 22).
- Divisional trajectories at tumour site level for 22/23 to deliver reduction in backlog, faster diagnosis, improved 38 days IPT and improvment in 62 day standard
- Single Lung MDT wiht HUTH & NLaG - expected date to commence 07.04.22.

Mitigations:

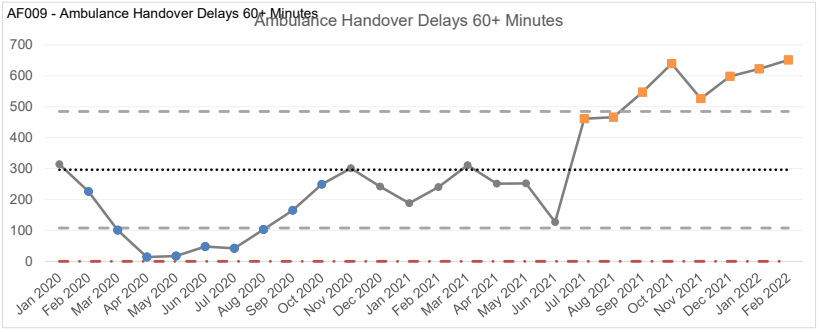
- The pathway analyser tool that has been developed within NLAG (using the IST tool) and the in depth analysis of pathways will enable teams to identify where improvements in NLAG can be achieved. Lung completed and fed back to clinical team - remedial actions being discussed.
- The joint transformation pathway work with HUTH will help with the transfer of patients between NLAG/ HUTH and to identify areas where the pathway can be accelerated
- Divisional ownership of transformation projects (particularly where change in clinical process is required)



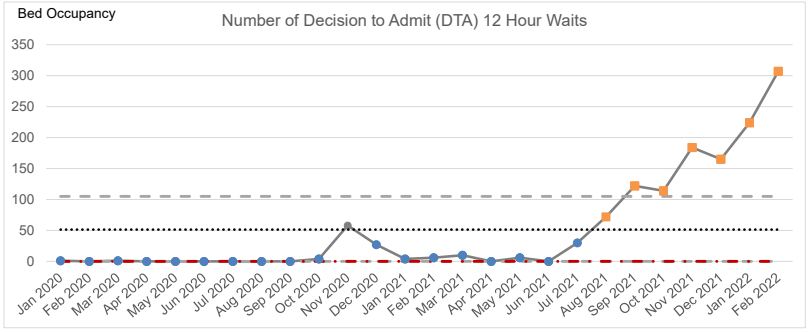
Feb 2022
64.4%
Target
95.0%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Variation indicates consistently falling short of the target



Feb 2022
11,265
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant



Feb 2022
651
Target
0
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates consistently falling short of the target



Feb 2022
307
Target
0
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

Emergency Dept 4 hour performance: There has been a significant deterioration in performance for the past eight months. The target has not been achieved within the past 2 years and the indicator will continue to fail the target without process re-design.
Emergency Dept Attendances: The number of attendances has fallen from a peak last June and as such the data is demonstrating an improving picture over the last nine months.
Ambulance handover 60+ minutes: The indicator is showing deteriorating performance over the last eight months. The target will not be met without process re-design.
DTA 12 hours: This indicator has recorded deteriorating performance for the past seven months. In February there were more than 300 patients waiting 12 hours or more for an admission bed after a decision to admit was made. The target will not be met without process re-design.

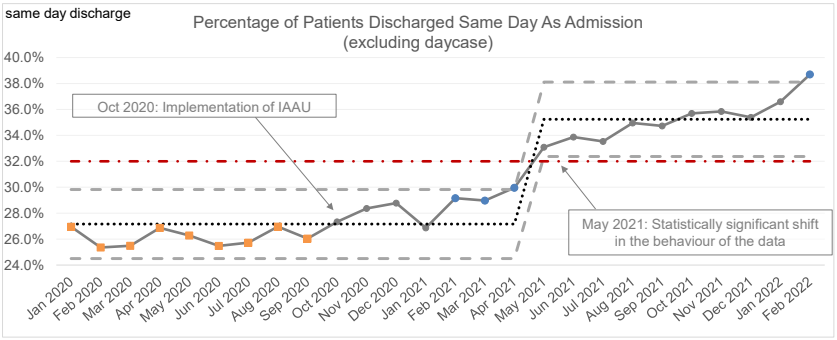
Challenges:
• Improvements in performance against the 4hr target continue month on month as the benefits of the Urgent Care Service continue
• Long patient waits in ED for admission continue to increase as available bed capacity across the system fails to meet demand with the bottleneck resulting in ED. This leads to no capacity to offload incoming ambulances and delays in wait to be seen times
• Workforce sickness, covid-19 isolation, low morale & impacts on staff wellbeing continue to challenge rota fill with a reduction of bank/agency pick up
• Northern Lincolnshire is experiencing the highest levels of acuity for EMAS conveyances and this is resulting in longer waits in resus
• Implications of COVID19 (zoning segregation, PPE, awaiting swab results, staff sickness and isolation) creating challenges and delays for patient pathway through the ED
• Patients remaining in resus after stablisation for too long due to lack of prompt access to HDU/CC

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

Actions:
• The Urgent Care Service (UCS) at SGH is providing improved patient experience and 99% performance during February 2022
• The UCS at DPOWH s providing improved patient experience and 100% performance during February 2022
• New patient pathways with streamlined access from arrival to seeing a clinician within the UCS
• Work progressing to access NEL Urgent GP appointment slots from DPOWH ED
• NHS111 First Initiative to reduce avoidable ED attendances
• New ED/AAU builds in development to increase ED phsyical capacity and bring ED and IAAU to a joint location
• Discharge to assess initiative to ensure patients are discharged in a timely manner to support adequate patient flow throughout the hospital
• Senior second reviews and long length of stay (LOS) reviews carried out
• Transfer of Category 5 EMAS calls to NL Single Point of Access has recommenced between 9am and 4pm, with pathway support from the CRT GP now secured
• Continued development of the role and offer of the CRT GP with January 2022 seeing the highest number of patients managed by the CRT GP since the service commenced at 732
• Actions to fully implement Urgent Community Response by deadline of 31 March 2022 continue
• Actions to expand Trust's Virtual Ward offer underway, including opening COVID Virtual Ward to admission avoidance pathway which will reduce admissions and also development of additional Acute Respiratory Infection, Frailty and Palliative Care Virtual Wards

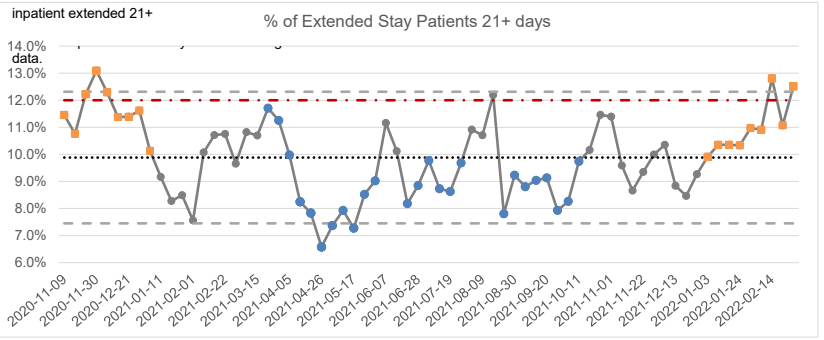
Mitigations:
• Tier system of Medicine senior management in place for prompt escalation, resolution and support for ED
• Fast track paediatric process in place
• Senior clinician reviews taking place in ambulances when delays to offloading occur
• Increased staffing in ED
• 2 hourly board rounds with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

same day discharge

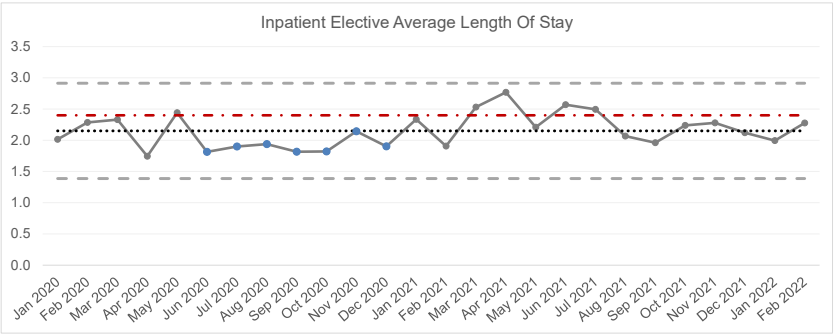


Feb 2022	Target	Variance	Assurance
38.7%	32.0%	Special cause of improving nature or lower pressure due to higher values	Variation indicates consistently passing the target

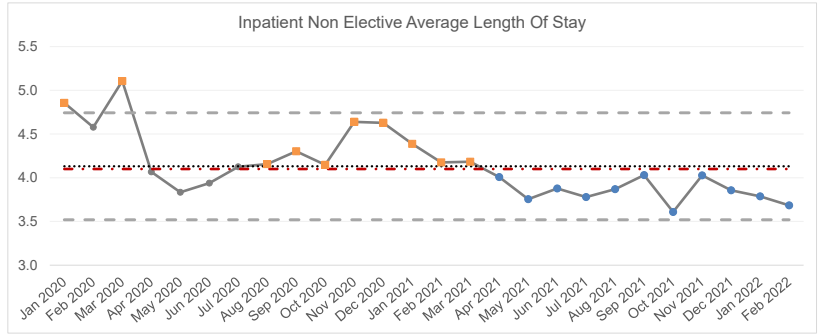
inpatient extended 21+



Feb 2022	Target	Variance	Assurance
12.51%	12.0%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Feb 2022	Target	Variance	Assurance
2.3	2.4	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Feb 2022	Target	Variance	Assurance
3.7	4.1	Special cause of improving nature or lower pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the target

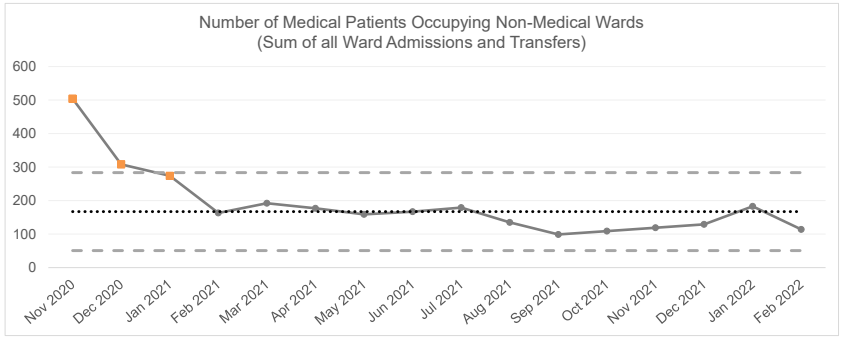
Data Analysis:
Discharged same day as admission: Following implementation of the IAAU in October 2020 this indicator has continued to show steady improvement. Since that time the trend has shown significant change. Performance is consistently exceeding the target.
% Extended stay 21+ days: The percentage of patients with an extended stay of 21 days or more has increased over recent weeks and has been showing concern since the beginning of 2022. The indicator will pass and fail the target at random.
Elective length of stay: The elective average length of stay has been stable for the past several months, however, the target can be expected to achieve and fail at random.
Non elective length of stay: This indicator has been showing an improvement for almost a year. This coincides with an increase in the percentage of patients discharged on the same day as admission. The target can, however, be expected to achieve and fail at random.

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

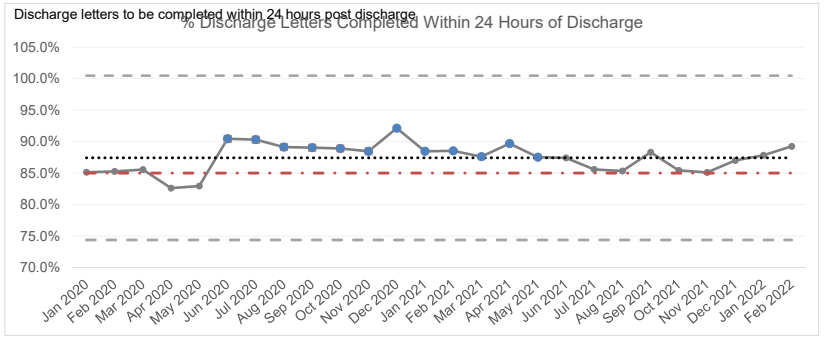
Key Risks:
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission and long patient waits in ED
- High acuity levels and patients means more patients require further support on discharge
- Multiple Care home closures to new patients/repatriations due to COVID oubreaks

Actions:
- Daily board rounds on wards
- Discharge rounds at weekends
- LLOS reviews in place for medicine twice per week led by the senior tri
- Regular meetings with system partners to understand current delays/issues
- Discharge imporvement plan currently being developed which pulls together all areasof discharge including checklist, discharge lounge, board rounds & transport
- Continuous engagement with ward staff around the discharge pathway
- Actions underway to implement 6 Day Provision for Acute Speech and Language Therapy which will support with improving patient flow
- Actions to expand Trust's Virtual Ward offer underway to develop additional Acute Respiratory Infection, Frailty and Palliative Care Virtual Wards.

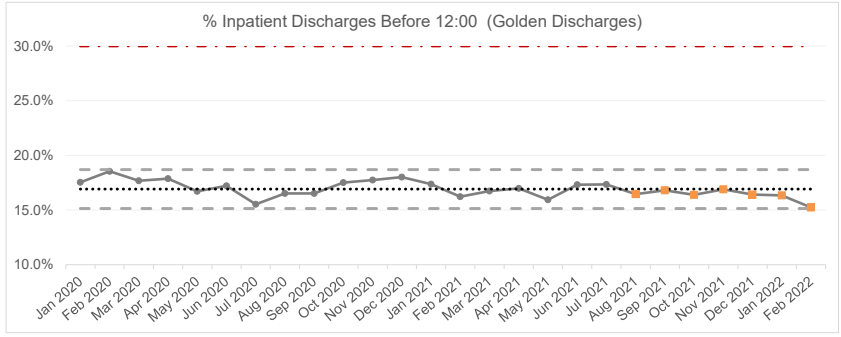
Mitigations:
- Daily board rounds on wards - work to further develop these to ensure they are effective and timley
- Discharge rounds at weekends
- LLOS reviews in place for medicine twice per week led by the senior tri, next step is to ensure this is in place for surgery as LOS for surgery have increased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



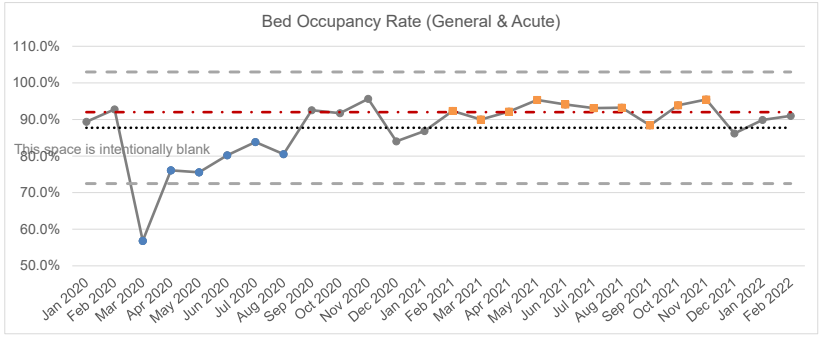
Feb 2022	Target	Variance	Assurance
114	No target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Feb 2022	Target	Variance	Assurance
89.3%	85.0%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Feb 2022	Target	Variance	Assurance
15.2%	30.0%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates consistently falling short of the target



Feb 2022	Target	Variance	Assurance
91.0%	92.0%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

Medical patients in non-medical wards: The analysis for this indicator has changed following a full review of the business rules with Operational colleagues. The data is now showing stable performance for the past 13 months.

Inpatient discharge letters: The target has been consistently achieved for more than 18 months and performance is currently stable. The indicator can be expected to achieve and fail the target at random.

Inpatient discharges before 12:00: Performance has fallen below the mean for the past seven months. Currently, the highest performance that can be expected without process re-design is 19% against a target of 30%. This indicator will not achieve the target without process re-design.

G&A Bed Occupancy: After a long period of poorer performance (since February 2021), performance has improved over the past three months. The target can be expected to achieve and fail at random .

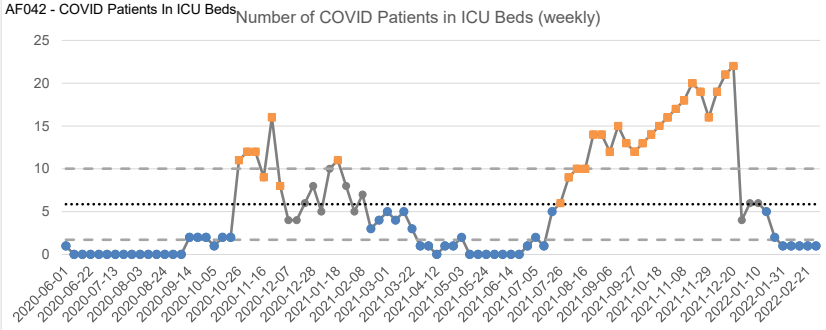
Challenges:
- Exit block due to social care constraints (staffing, interim bed availability, lack of packages of care availability)
- NLAG staffing constraints (staffing, sickness, vacancy, use of agency/bank staff)
- Covid and IPC requirements for social distancing
- Environment and ability to create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

Key Risks:
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission and long patient waits in ED
- High acuity levels and patients means more patients require further support on discharge
- Multiple Care home closures to new patients/repatriations due to COVID oubreaks

Actions:
- Daily board rounds on wards
- Discharge rounds at weekends
- LLOS reviews in place for medicine twice per week led by the senior tri
- Regular meetings with system partners to understand current delays/issues
- Discharge imporvement plan currently being developed which pulls together all areasof discharge including checklist, discharge lounge, board rounds & transport
- Continuous engagement with ward staff around the discharge pathway
- Actions underway to implement 6 Day Provision for Acute Speech and Language Therapy which will support with improving patient flow
- Actions to expand Trust's Virtual Ward offer underway to develop additional Acute Respiratory Infection, Frailty and Palliative Care Virtual Wards.

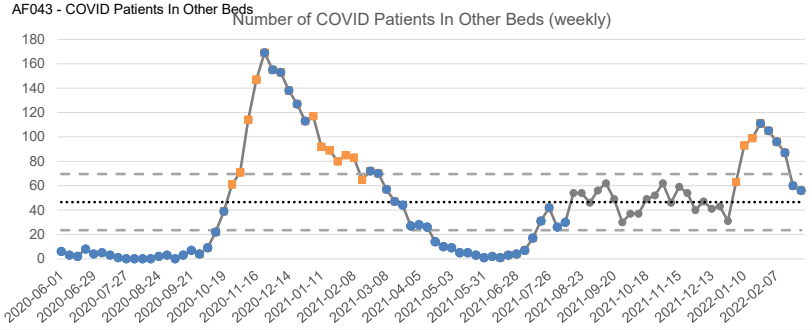
Mitigations:
- Daily board rounds on wards - work to further develop these to ensure they are effective and timley
- Discharge rounds at weekends
- LLOS reviews in place for medicine twice per week led by the senior tri, next step is to ensure this is in place for surgery as LOS for surgery have increased
- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clear action plan for delayed discharge and escalation plan. Any outstanding are escalated through their internal agencies with an outcome/plan for discharge to reported back by 2pm. if there is still no confirmation on a plan for the patient to leave the acute bed on that day this is then escalated to the system strategic leads for further action.
- Themes are collated during the week from these escalations and fed back to a fortnightly discharge improvement meeting and this feeds our improvement plan.
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire from 1 November 2021.
- Respiratory On Call Service revised to 7 Day Provision which will support with improving patient flow.

AF042 - COVID Patients In ICU Beds



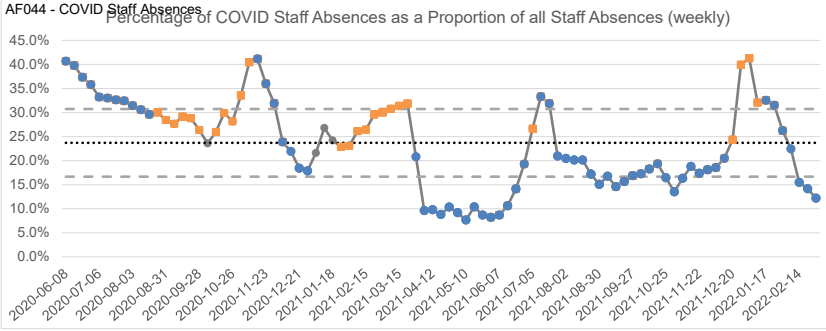
Feb 2022
1
Target
No target
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
There is no target, therefore target assurance is not relevant

AF043 - COVID Patients In Other Beds



Feb 2022
56
Target
No target
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
There is no target, therefore target assurance is not relevant

AF044 - COVID Staff Absences



Feb 2022
12.2%
Target
No target
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
There is no target, therefore target assurance is not relevant

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Data Analysis:

COVID Patients In ICU beds: The number of covid patients in ICU beds has decreased significantly in the past several weeks improving beyond the process limits.

COVID Patients In Other Beds: The number of covid patients in other beds has been decreasing since the beginning of 2022 and is now falling inside of the expected range. As such it is showing improvement.□

COVID Staff Absences: The proportion of staff absences due to covid has been decreasing over several weeks, and are now improving beyond the process limits.

Challenges:

• Omicron variant more transmissible with less symptoms more difficult to identify.
• Higher rate of sickness across the board impacting on all areas
• Limitation on cross cover for areas of higher specialised staff e.g critical care and theatres

Key Risks:

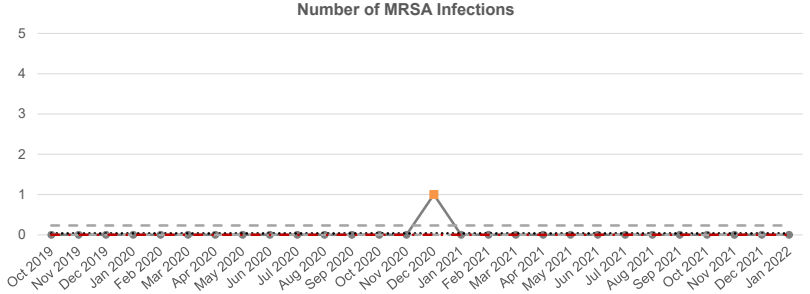
• Shortages in available workforce to meet service needs
• Covid-19 impacting physical capacity within the current footprint
• Quality of care when dependence of temporary staff to back fill sickness

Actions:

• Close monitoring of sickness and clear advise of guidance to all staff to ensure adherence to guidance is appropriate and minimal to meet safety and requirements of IPC
• Encouragement of staff to uptake the vaccine
• Requirement of staff to regualr lateral flow test, 2-3 times a week
• Adherence to continued IPC steps of PPE as per national guidelines

Mitigations:

• Daily review of staffing by HON to support suitable deployment of staff across all areas
• Review in operations meeting of staffing resource in relation to activity and capacity
• Consolidation of COVID cases to dedicated areas with oversite of IPC
• Weekly review of staffing sickness levels by senior tri



Jan 2022
0

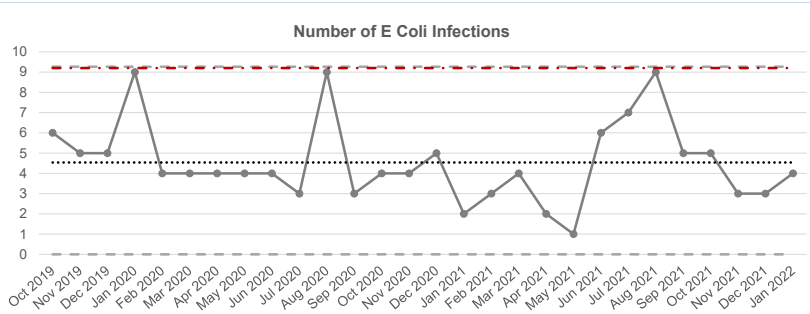
Target
0

Variance

Common cause - no significant change

Assurance

Variation indicates inconsistently hitting passing and failing the target



Jan 2022
4

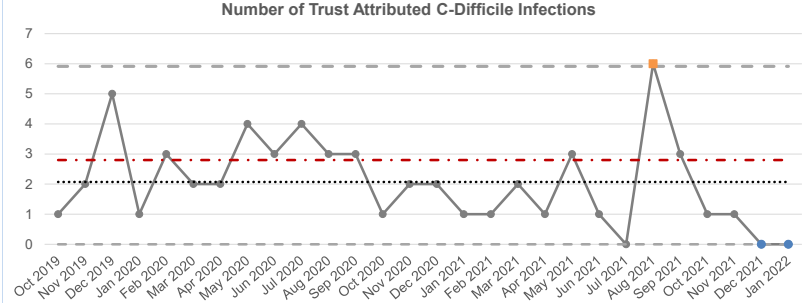
Target
9.2

Variance

Common cause - no significant change

Assurance

Variation indicates inconsistently hitting passing and failing the target



Jan 2022
0

Target
2.8

Variance

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

Assurance

Variation indicates inconsistently hitting passing and failing the target

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Data Analysis:
MRSA: No infections occurred in January 2022.
C Diff: No infections occurred in January 2022.
E Coli: Four infections occurred in January 2022.
Please Note: All the above indicators involve very small numbers and the nature of the data may lend itself to a different type of chart and this is being worked on.

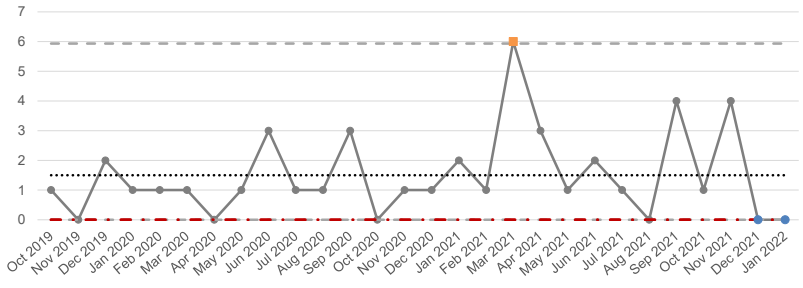
Commentary:

MRSA
> Cases of MRSA hospital onset bacteraemia remains within parameters.

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

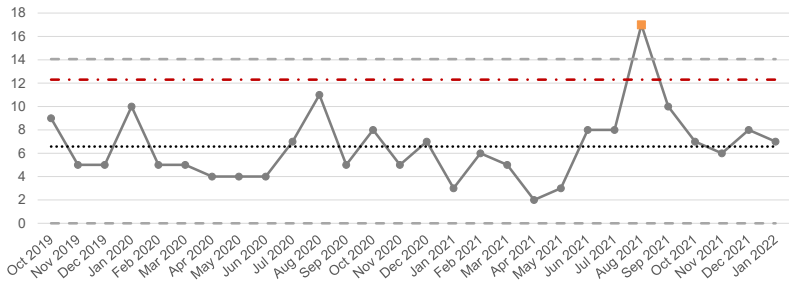
C Diff
>The Trust remains within acceptable parameters

Number of MSSA Infections



Jan 2022	0
Target	0
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Variation indicates inconsistently hitting passing and failing the target

Number of Gram Negative Infections



Jan 2022	7
Target	12
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and failing the target

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Data Analysis:

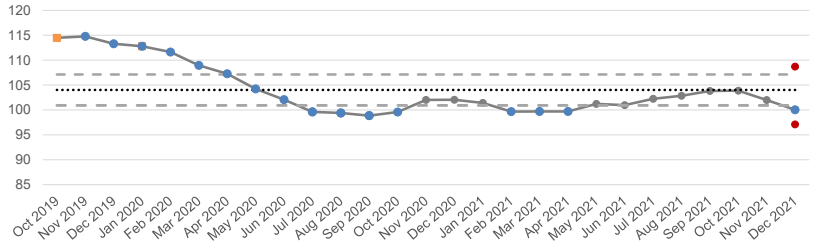
MSSA: No infections occurred in January 2022. This indicator involves very small numbers and the nature of the data may lend itself to a different type of chart and this will be looked at.

Gram Neg: Seven infections occurred in January 2022. This indicator involves very small numbers and the nature of the data may lend itself to a different type of chart and this will be looked at.

Please Note: The above indicators involve very small numbers and the nature of the data may lend itself to a different type of chart and this is being worked on.

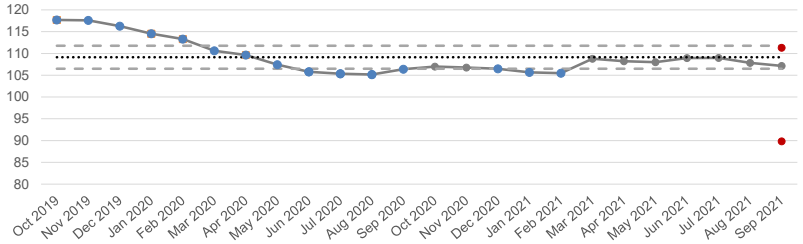
Commentary:

Hospital Standardised Mortality Ratio (HSMR)
Rolling 12 month position
Note: The red dots indicate the expected range



Dec 2021
100.0
Target
As expected
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Within 'Expected' range

Summary Hospital level Mortality Indicator (SHMI)
Rolling 12 month position
Note: The red dots indicate the expected range



Sep 2021
107.1
Target
As expected
Variance
Common cause - no significant change
Assurance
Within 'Expected' range

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Data Analysis:
HSMR: The data represents a rolling 12 month position. Performance remains within the expected range.
SHMI: The data represents a rolling 12 month position. Performance remains within the expected range.

Commentary:

HSMR

HSMR is a ratio between the number of actual deaths (in hospital) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.

December's HSMR continues to demonstrate a statistically significant improvement, remaining stable, within the expected range and in line with the national level.

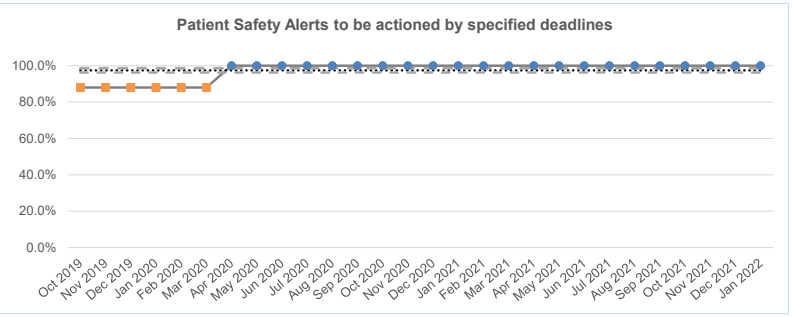
Mitigations: The HSMR along with other mortality indices are overseen by the Trust's Mortality Improvement Group (MIG).

SHMI
The official SHMI for the Trust remains within the 'as expected' range for the period of October 2020 – September 2021. Both SGH and DPOW SHMI scores remain within the 'as expected' bracket. The Trust has two official SHMI alerts: Cancer of Bronchus; Lung and Secondary Malignancies due to higher than expected mortality within the two diagnosis groups, although 'cancer of the bronchus' deaths this month are within the 'as expected' range for the first time since December 2019.

Issues/Risks:
There is a risk of breaching the Trusts 'expected range' if the out of hopsital SHMI rises.

Actions:
The Trust is working with NHSE/I and local commissioners to undertake a review of recent deaths and EOL care.
- Fortnightly meetings with the Trust's clinical leads for mortality continue to take place and oversee the data.
- Trust mortality clinical leads undertake screening on at least 85% of deaths per month to identify contributing factors, if any concerns are identified a full structured judgement review is undertaken to assess the care processes and to learn lessons.
- Review work underway to investigate and identify any themes for the official SHMI alerts relating to Cancer of Bronchus / Secondary Malignancy.

Mitigations:
- SHMI performance is overseen by the Trust's Mortality Improvement Group (MIG).
- Mortality and the reduction of SHMI is a Trust Quality Priority for 21/22 and will be included in the 22/23 Quality Priorities for further oversight.
- Monthly screening rates reported and monitored by the Trust's Mortality Improvement Group (MIG).



Jan 2022
100.0%

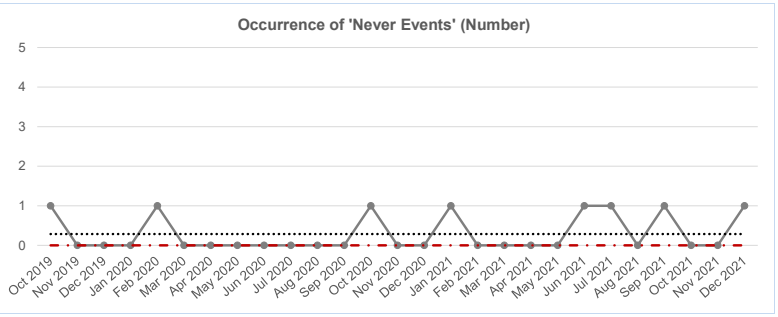
Target
No target

Variance

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

Assurance

There is no target, therefore target assurance is not relevant



Dec 2021
1

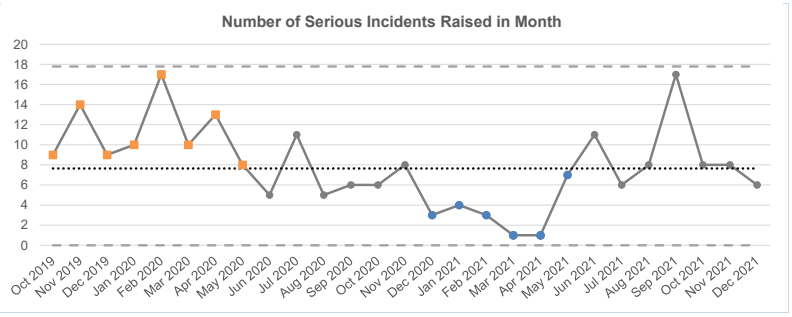
Target
0

Variance

Due to the infrequency of Never Events a line chart is considered more appropriate than an SPC chart therefore variance is not relevant.

Assurance

Due to the infrequency of Never Events a line chart is considered more appropriate than an SPC chart therefore target assurance is not relevant.



Dec 2021
6

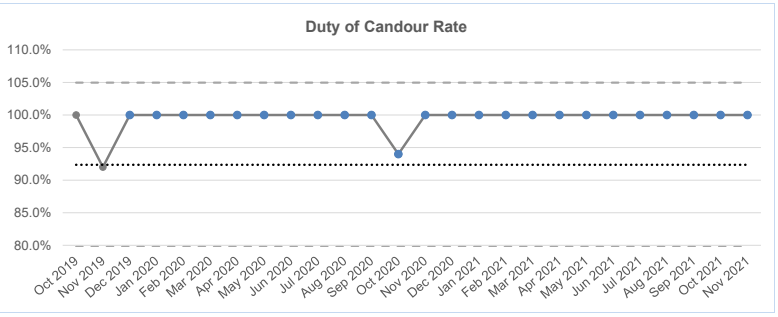
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant



Nov 2021
100.0%

Target
No target

Variance

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

Assurance

There is no target, therefore target assurance is not relevant

Data Analysis:
Patient Safety Alerts: Performance for January continued at 100%.
Never Events: Note the never events data is a subset of the serious incidents data. There was 1 never event recorded in December 2021 and this is the latest data provided.
Serious Incidents: Note this data is updated retrospectively to reflect any de-escalated incidents and also includes the patient safety alerts. There were 6 serious incidents recorded for December and this is the latest data provided. The data is within the expected range of variation.
Duty of Candour: Performance has remained stable for over a year and continues at 100%. The latest data provided is for November 21.

Commentary:
Never Events:
1 Never Event declared in January 2022, a retained object post procedure, catheter used as a sling was not accounted for.

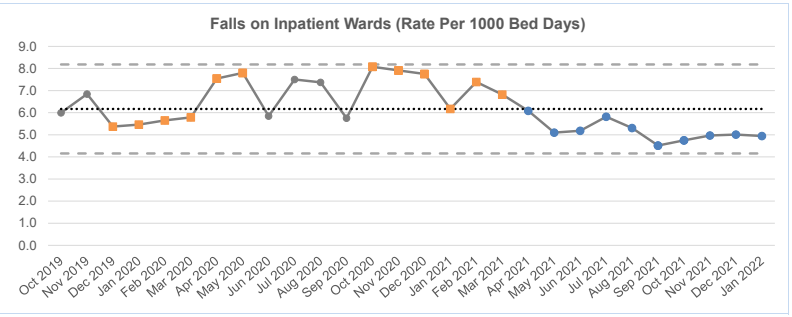
Mitigations:
Immediate meeting chaired by Medical Director to identify immediate actions: Carry out fact finding as to whether there is an alternative to using Foleys Catheter; When instruments are being set up the night before, if any consumables are missing to be escalated in the morning; All supplementary items must be written on the white board; Theatre Manager to determine improvements on how whiteboards can be set out/utilised to aid recording; Cease using theatre staff as surgical assistants; Theatres to share the learning from the last 2 years of relevant Never Events at the next audit day; Ergonomist expert is working with the Trust to look at the counting and reporting process in theatres.

Serious Incidents:
There were 7 Serious Incidents reported in January 2022

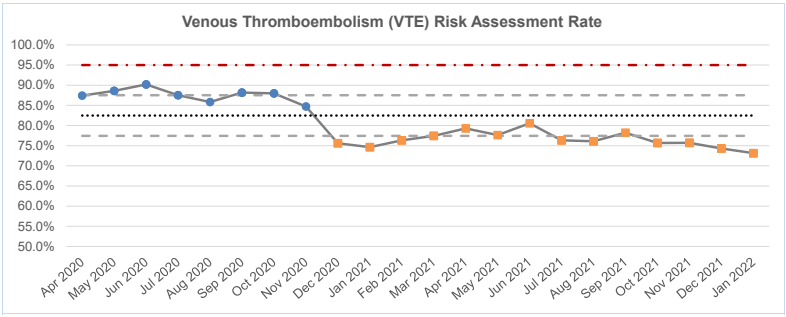
Duty of Candour: There was one breach for a Pressure Ulcer serious incident In December 2021 due to operational pressures and staff changes during the Christmas holiday period. For January 2022, compliance was 100%. Whilst in most months the Duty of Candour for serious incidents is 100%, there is a gap at present in relation to ensuring duty of candour is completed for all instances of moderate level harm. This presents the risk of non-compliance against regulations, which may result in a financial penalty.

Risk: Position in relation to Duty of candour for incidents other than serious incidents are reported to divisions on a weekly basis showing the number of which are still outstanding/overdue.

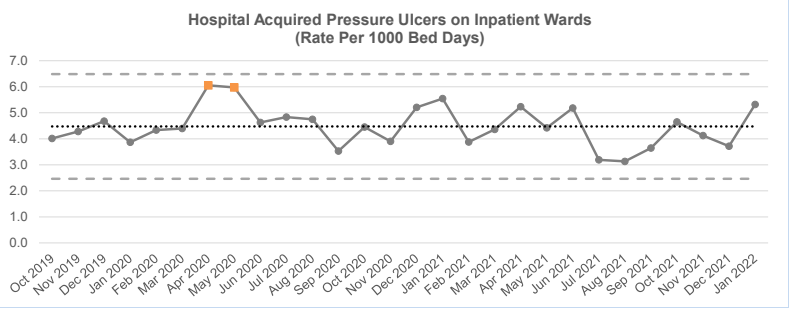
Actions: Working with Divisions to obtain assurance that all moderate (and above) harm instances have duty of candour completed (monitored through SI panel with significant improvement noted). Duty of Candour Reports are now availiable on Ulysses and are being monitored at divisional level as well as at SI Panel. Overdue duty of candour for relevant divisions will be discussed at the March PRIM meetings and assurances sought on the actions divisions are taking to improve their position.



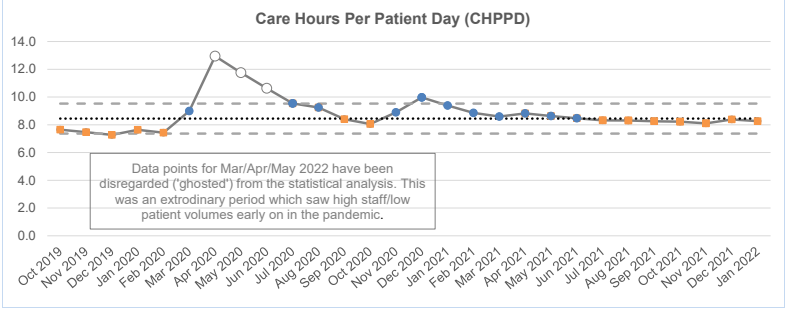
Jan 2022
4.9
Target
No target
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
There is no target, therefore target assurance is not relevant



Jan 2022
73.2%
Target
95.0%
Variance
Special cause of concerning nature or lower pressure due to lower values
Assurance
Variation indicates consistently failing the target



Jan 2022
5.3
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Jan 2022
8.3
Target
No target
Variance
Special cause of concerning nature or lower pressure due to lower values
Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:
Falls on Inpatient Wards: After a significant reduction last year, this indicator has been on a significant improvement trend since April 2021.
VTE Risk Assessment: Performance has been consistently in poorer performance since December 2020. The target will not be achieved without a process change.
Hospital Acquired Pressure Ulcers: The rate of hospital acquired pressure ulcers was 5.3 per 1000 bed days for January. This is within the expected range of variation.
Care Hours Per Patient Day: Performance has been consistently in poorer performance since April 2021 which is triggering concern on the chart.

Commentary:
VTE Risk Assessment
Data continues to demonstrate performance below the target, however it has been identified that the denominator to calculate compliance was incorrect. The reporting processes have since been reviewed and amended, and whilst reporting remains in line with national specification the change ensures that any admission that does not fall within the ePMA ward criteria automatically gets a 'VTE completed' flag and performance for said admissions will show as 100%. This intervention is not yet reflected in this month's compliance, however separate analysis provided demonstrates an improvement with a 90% completion rate.
The risk previously identified around completing risk assessment for stranded patients in ED has now been resolved. Medicine division are also exploring the feasibility of implementing EPMA within ED which may help with VTE Risk Assessments being completed on those patients post taken in ED by the specialty teams.
Issues/Risks:
- The Trust are still operationally very challenged in response to an increasing demand on acute care activity.
- The Trust's VTE policy is not in line with recently published NICE clinical guidance.
- Junior clinical staff report the desire for increased training and gain more confidence in undertaking VTE assessment / prescribing.
Actions:
- Trust policy and patient information leaflets are being updated to fall in line with the latest NICE guidance (deadline: April 2022)
- The Trust's approach to VTE risk assessments has been refreshed to make the process easier and more responsive for medical staff.
- Ongoing education work with clinical staff to understand and overcome identified barriers.
- Use of incorrect denominator escalated through Information and EPMA team for resolution
Mitigations:
- Performance and the improvement plan is monitored in the Trust's Performance Review meetings and in the Executive Governance report to Board.

Falls on Inpatient Wards: The total number of falls reported continues to decrease and remains within the expected range of variation.

Hospital Acquired Pressure Ulcers: The rate of hospital acquired pressure ulcers remains within the expected range of variation.

Care Hours Per Patient Days: The care hours per patient day has been falling for the last 9 months, with the latest (September) figure being

8.2

Mixed Sex Accommodation Breaches See Data Analysis Comments Below	Feb 2022 **4** Target **0** Variance There is currently insufficient data, therefore variance is not relevant Assurance There is currently insufficient data, therefore assurance is not relevant	This space is intentionally blank	
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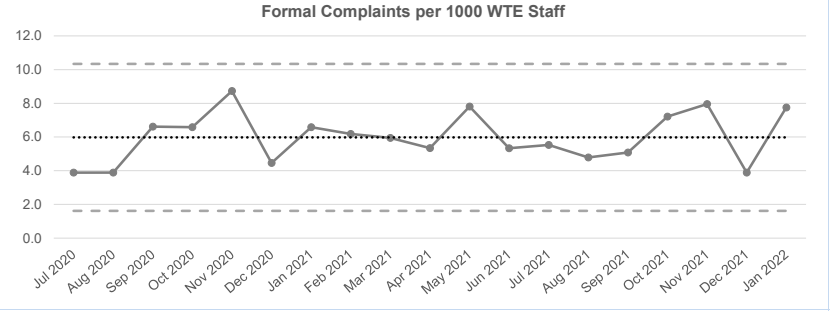
Data Analysis:
Mixed sex accommodation: The MSA return was suspended due to COVID and has now resumed. There was 4 reported for February 2022.

Commentary:
4 patients were identified within the mixed sex breaches within Critical care. This occurred due to lack of capacity out of the critical care areas. All patient involved were informed immediately and kept informed, prompt escalation was undertaken with Surgery and Critical Care and with the Operations centre. Escalation reporting was undertaken with guidance from the Mixed Sex accommodation Policy and reporting tools



Jan 2022
8

Target
No target

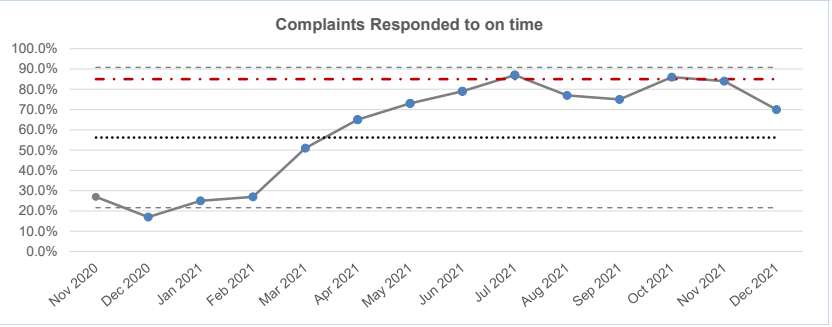
Variance

Common cause - no significant change

Assurance

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

Compliments (to be added if data available)



Dec 2021
70.0%

Target
85.00%

Variance

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

Assurance

Variation indicates inconsistently hitting passing and failing the target

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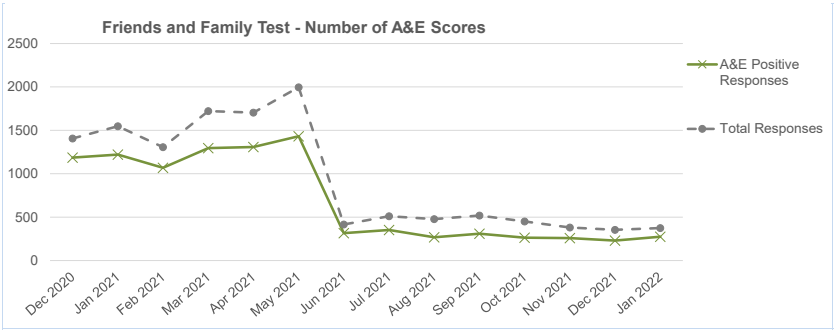
Data Analysis:
Formal Complaints: In January there were 8 formal complaints per 1000 WTE staff.
Complaints Responded to on time: This indicator has remained fairly stable and is showing improvement. The latest data provided is for Dec 2021.

Commentary:
Formal Complaints
Formal complaints are received by the Trust patients or someone on their behalf such as a relative, MP, solicitor or CCG. These are triaged by the Complaints Manager to ensure the correct route of management is undertaken. The current Trust policy aims to respond to formal complaint within sixty working days. This data is not a data set we currently report on and does not demonstrate the complaints performance and quality in a meaningful way. The data set shown represents new formal complaints measured against per thousand whole time equivalent (WTE) staff. The Trust currently sits towards the mid zone when benchmarked against other Trusts .
Issues/Risks:
Engagement with complaint process at divisional level continues to impact, further Covid surges have seen delays in process at times. Transition of incident reporting system is still inprogress and continues to evidence data errors which are addressed with the provider.
Learning log needs further development and learning from complaints needs embedding.

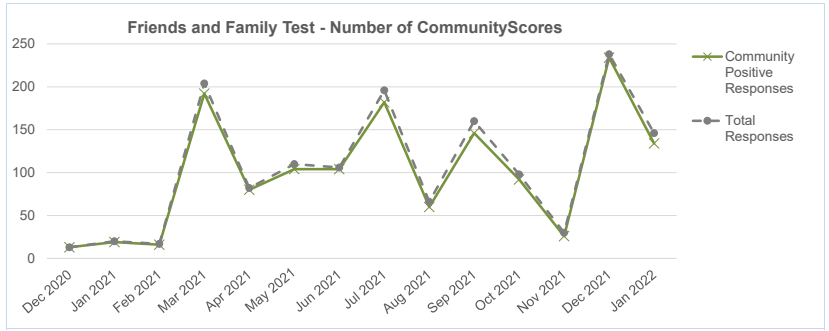
Actions:
> Continued support of lead investigator role
> Continued internal development of complaint module within new incident system - Ulysses
> Review of Management of Feedback from Complaints, Concerns and Compliments Policy - as one year into new process inprogress
> Monthly review of closed out of timescale complaints for learning

Formal Complaints Cont/d...

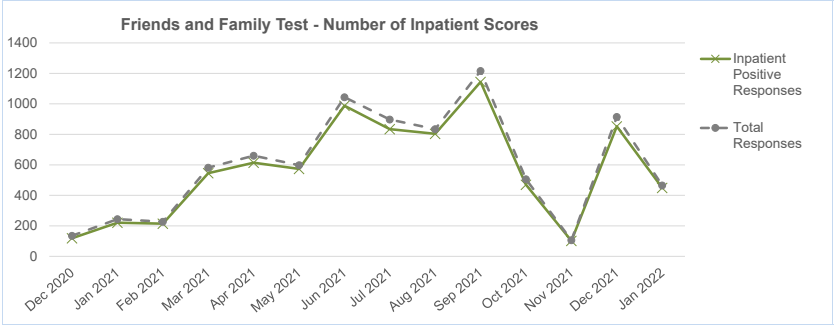
Mitigations:
> Monthly Reporting sent to divisions for good oversight
> Central Team support for all lead investigators and divisions
> Learning Log evident on current incident reporting module
> Support & Challenge Meetings weekly to monitor performance and quality
> Central Complaints team working with Ulysses to ensure accurate data mapping and reporting



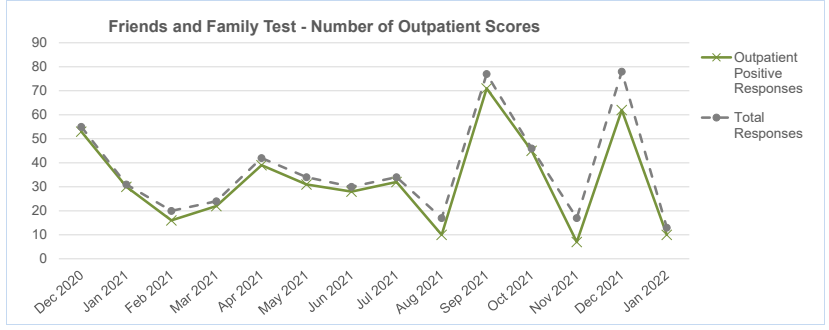
Jan 2022
274 out of 374
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jan 2022
134 out of 146
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jan 2022
449 out of 465
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jan 2022
10 out of 13
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

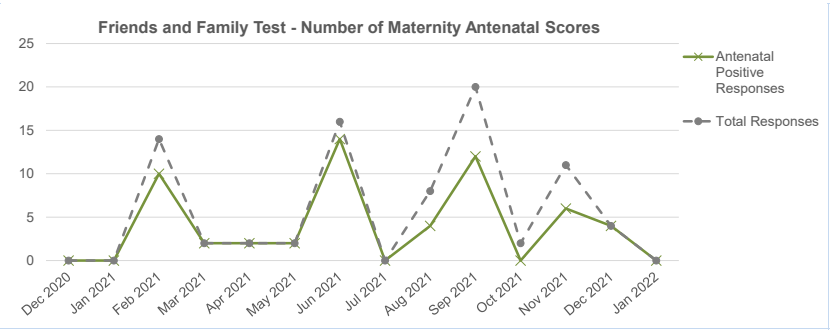
Data Analysis:
A&E FFT: There were 374 responses received in total for January, and 274 were positive.
Community FFT: There were 146 responses received in total for January, and 134 were positive.
Inpatient FFT: There were 465 responses received in total for January, and 449 were positive.
Outpatient FFT: There were 13 responses received in total for January, and 10 were positive.

Commentary:
The Friends and Family Test is a mandated patient experience measure which enables patient insights to gathered across all services within the Trust. During the Covid pandemic all mandated collection and reporting of data was paused until December 2020. The Trust adopted a soft relaunch at this point due to the second wave of Coronavirus. The Trust has procured an external company to deliver the systems to deliver FFT - the implementation process is still underway due to the impact of Covid 19. Inpatient FFT is delivered via paper/QR/ online. Response rates still require increasing to ensure the patient voice is representative in extracting information from the themes.
Issues and Risks:
> Staff engagement with process resulting in poor response rates
> Delays in stock ordering
> Difficulties using data due to low numbers
Actions:
> NHSEI funded band 7 role (until March 31st 2022) to support increased patient feedback
> Monthly meetings with IWANTGREATCARE and monthly performance meetings
> Monthly message and data sharing through Nursing & AHP leadership community
> Review of paper solution ordering to ensure good stock levels
> IWANTGREATCARE to support further with staff engagement
> Internal review of telephone number collection rates - re impact on SmS
> All Patient Experience tablets have app insitu to aid online collection
Mitigations:
> Monthly performance meeting with IWANTGREATCARE from July
> Review of paper processes commenced
> Consistent message to staff to utilise methods available

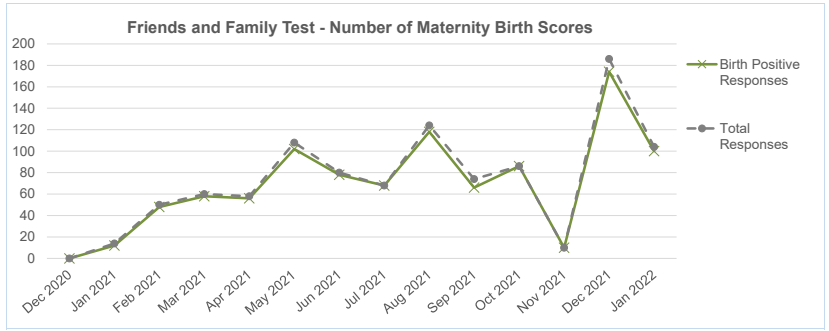
Inpatient FFT
Inpatient FFT is delivered via online/paper/QR.
Nationally the Trust is near the lower centile for inpatient response rates (82 out of 131), however consideration of patient numbers needs to be factored into this level of benchmarking.

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

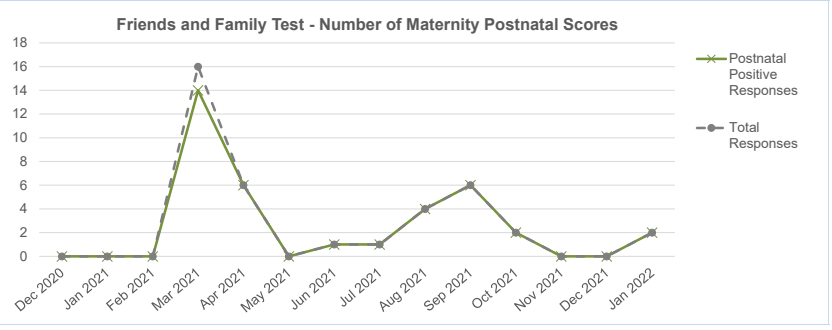
Community FFT
Community FFT is delivered via online/paper/QR.
Full internal review of community services to create improved collection systems



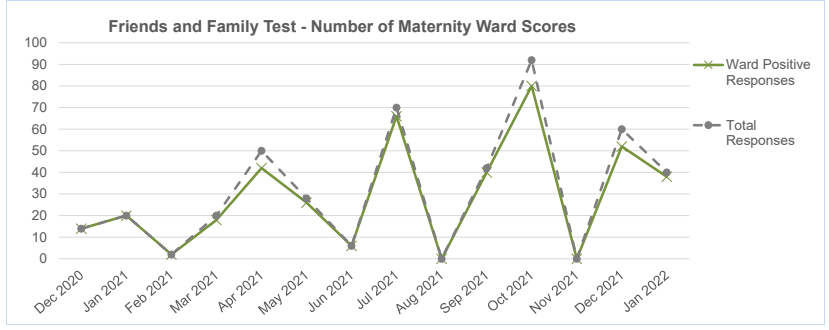
Jan 2022
0 out of 0
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jan 2022
100 out of 104
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jan 2022
2 out of 2
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jan 2022
38 out of 40
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

Data Analysis:
Maternity Antenatal FFT: There were 0 responses received in total for January.
Maternity Birth FFT: There were 104 responses received in total for January, and 100 were positive.
Maternity Postnatal FFT: There were 2 responses received for January, and 2 were positive.
Maternity Ward FFT: There were 40 responses received in total for January, and 38 were positive.

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

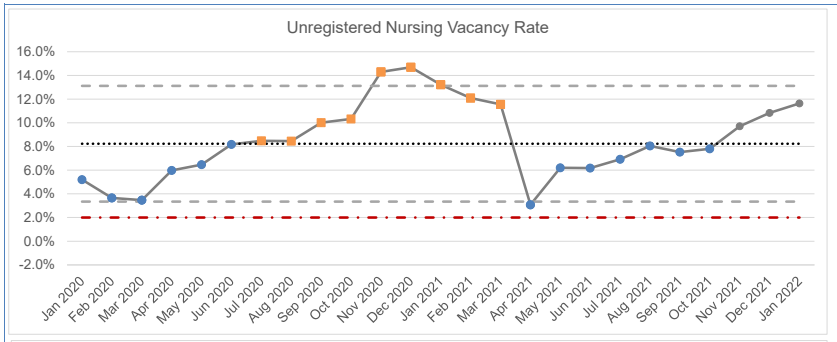
Issues and Risks:-
> Staff engagement with process resulting in poor response rates
> Delays in stock ordering
> Difficulties using data due to low numbers

Actions:-
> NHSEI funded band 7 role (until March 31st 2022) to support increased patient feedback
> Weekly meetings with IWANTGREATCARE and monthly performance meetings
> Monthly message and data sharing through Nursing & AHP leadership community
> Review of paper solution ordering to esnure good stock levels
> IWANTGREATCARE to support further with staff engagement
> Internal review of telephone number collection rates - re impact on SmS
> All Patient Experience tablets have app insitu to aid online collection

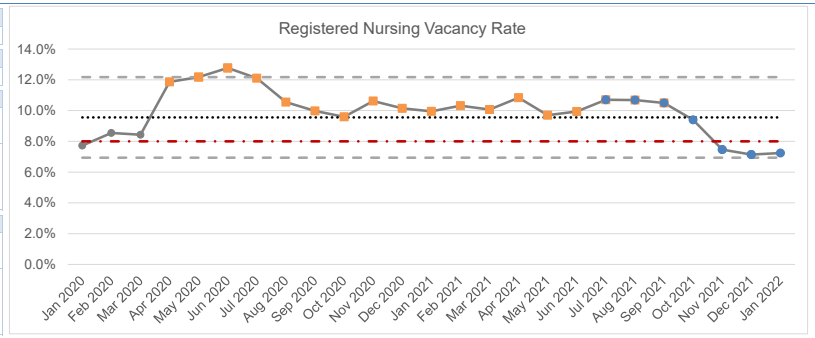
Mitigations:
> Monthly performance meeting with IWANTGREATCARE from July
> Review of paper processes commenced
> Consistent message to staff to utilise methods available

Workforce - Vacancies

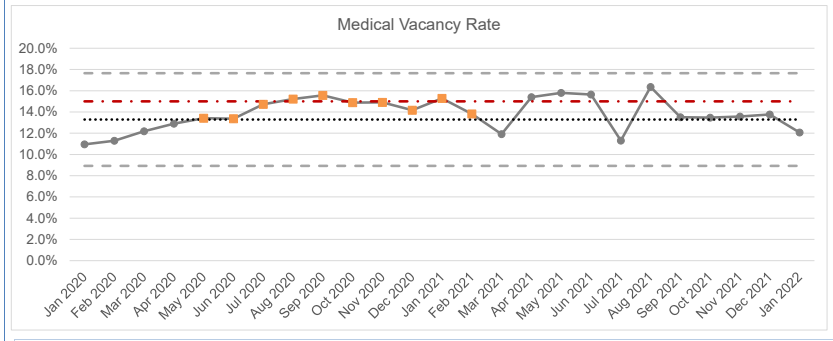
*Indicators marked with an asterix are unvalidated at the time of producing the IPR report.



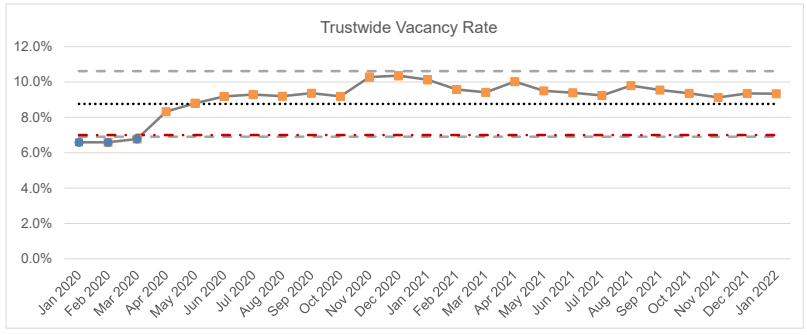
Jan 2022	Target	Variance	Assurance
11.6%	2.0%	Common cause - no significant change	Variation indicates consistently failing the target



Jan 2022	Target	Variance	Assurance
7.2%	8.0%	Special cause of improving nature or lower pressure due to lower values	Variation indicates inconsistently hitting passing and failing the target



Jan 2022	Target	Variance	Assurance
12.1%	15.0%	Common cause - no significant change	Variation indicates inconsistently hitting passing and failing the target



Jan 2022	Target	Variance	Assurance
9.3%	7.0%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and failing the target

Data Analysis:
Unregistered Nursing Vacancies: After a significant reduction last spring the figure has gradually been increasing. The target cannot be achieved without process redesign.
Registered Nursing Vacancies: After a period of relative stability the data has improved recently, however it is too soon to be confident that this indicator will continue to achieve the target.
Medical Vacancy Rate: Performance has been stable for almost a year. The target can be expected to achieve and fail the target at random.
Trustwide Vacancy Rate: The performance has been consistently showing poor performance since June 2020 and will continue to fail the target without process redesign.

Commentary:
Unregistered Nursing Vacancies:

Unregisterd nusting is made up of HCA's at band 3 and 3, Nusring assoicates, APIN'S and community based HCA'S
Issues/Risks: Retention of HCAs, particularly new starters. Unfamiliarity with the role and expectations of what the role entails influencing decisions to leave, and lack of quality data around leavers reasons.

Mitigations: A project group led by the Chief Nurse's office to oversee activity and consider mitigating actions. A bid has been succssful to secure additional funding to support recruitment, particarly focussing on materials and diversity, and to support a more robust induction process containing a supernumerary period. A pool of appointed HCAs has been appointed with 27 awaiting start. Further interviews are scheduled to take place, with a revised process in place including utilising a webinar for information regarding the Trust and the role to mitigage risks of individuals not fully appreciating the role and the impact on retention. Information on the HCA role is also provided to candidates at the interview stage, and also by CPD team as part of the induction process.

Actions: Continue advertising to maintain the pool of HCA appointments ready for allocation. The project will continuily monitor leavers across the trust identify hotspots and interventions

Registered Nursing Vacancies:

Issues/Risks: Travel restrictions/difficulties obtaining visas overseas are impacting start dates. Availability of accomodation can delay recruitment processes. CPD Team to capacity to support international nurses, and some difficulties with sourcing sufficient candidates from non-WHO ethical recruitment list countries.

Actions: Continue sourcing of nursing candidates via the Talent Acquisition Team - Domestic and international. Continued engagement with both Chief Nurse Directorate and Operations to review existing recruitment practices. Development of a nursing workforce plan as part of the Nursing Strategy inclusive of all pipelines including apprenticeship development and a strengthened domestic presence in the existing market place.

Mitigations: A project group led by the Chief Nurses office to oversee all activities. Newly qualified nurse (NQN) recruitment for 21/22 was successful with a further 8 scheduled to start in March, and attendence at university events to further strengthen NQN engagement. International nurses - ongoing recruitment of international nurses with cohorts planned for start.. A funding bid has been successful for further funding to support recruitment, with £360,000 awarded to support the arrival of 120 international nurses between January and December 2022. Under the terms of this bid candidates from countries on the WHO ethical recruitment list (regardless of whether directly sourced) are not permitted. Work is underway to diversify the pipeline of candidates to reduce this risk.

Commentary Vacancies Cont/d:
Medical Vacancies

Issues/Risks: Travel restrictions/difficulties obtaining visas overseas are impacting start dates. Availability of accomodation can delay recruitment processes.

Actions: Ongoing recruitment activity across specialties.

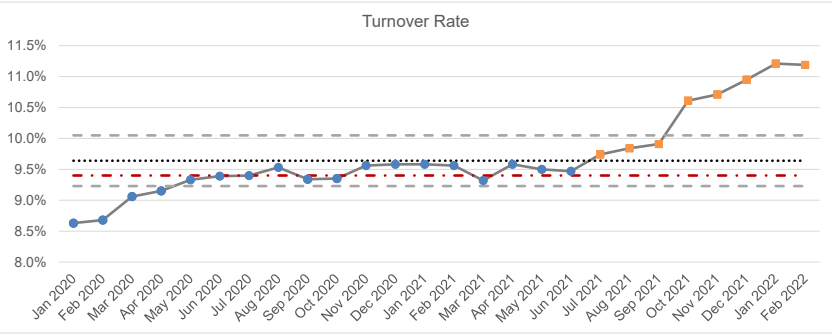
Mitigations: Recruitment team continuing to engage with candidates.. A pipeline of 66 medical staff has been established, with 14 scheduled to start in February and March and further starts in the longer term. A network of private landlords has been established to support accomodation needs where the Trust is unable to accomodate locally, and work undertaken by the onsite accommodation team to free up onsite accommodation. Accommodation team have given notice to long term tenants to free up on-site accommodation for new starters and a change of policy relating to length of stay. Recruitment team are meeting the accommodation team weekly to review priorities and identify accommodation needs. A review of the medical recruitment process is under way with engagement with operational groups to gather feedback and identify efficiencies.

Trustwide Vacancy Rate

Issues/Risks: Travel difficulties are delaying starts for some new employees..

Actions: Ongoing recruitment activity across various workstreams, engagement with candidates to reduce withdrawal rates.

Mitigations: Various projects for different staff groups, including international nursing and HCAs.



Feb 2022
11.2%

Target
9.4%

Variance

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

Assurance

Variation indicates inconsistently hitting passing and failing the target

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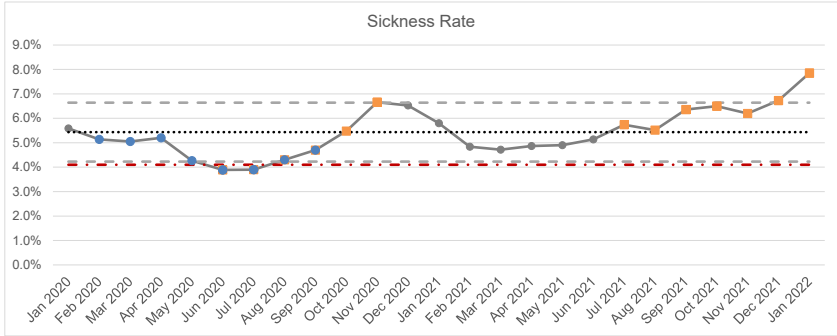

Jan 2022
7.9%

Target
4.1%

Variance

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

Assurance

Variation indicates consistently failing the target

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Data Analysis:
Turnover Rate: The turnover rate has recorded concerning performance for the past eight months. The past five months in particular are an outlier compared with performance since January 2020.
Sickness Rate: This indicator has recorded a general increase in sickness rates since last summer and is showing concern for the past seven months. It is unlikely that the target will be achieved without process redesign.

Commentary:
Turnover Rate

The latest turnover data point (11.2%) is over the Trust target of 9.4% which indicates that the turnover position is not improving or seeing signs of recovery in relation to pre-pandemic levels of turnover of 9%.

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

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

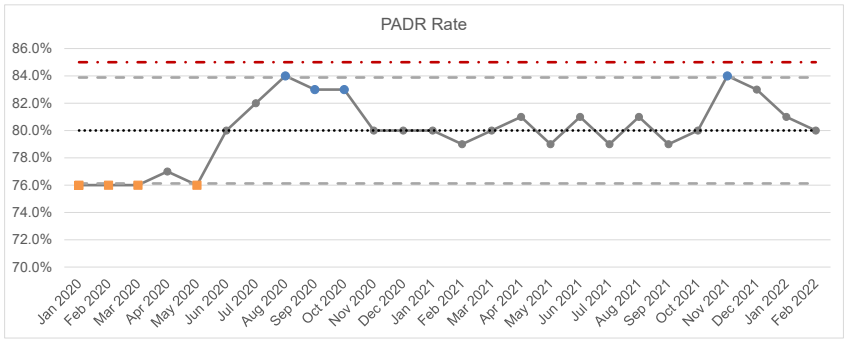
Mitigations: Planned earlier intervention in relation to known leavers. Creation of talent pools. Strengthen engagement levels; proactive health and wellbeing plan to address common themes affecting wellbeing-related retention. Deep dive of leavers data in March 2022 to identify hotspot areas with focused interventions. Re-launch Exit Questionnaire in ESR with comms and leaver checklist to form part of the new Manager Pathway. Comms to be released in March. Recruitment process review has started with a focus on improving the candidate experience.

Sickness Please note sickness will always be a month in arrears due to the extraction of information from the Health Roster System.

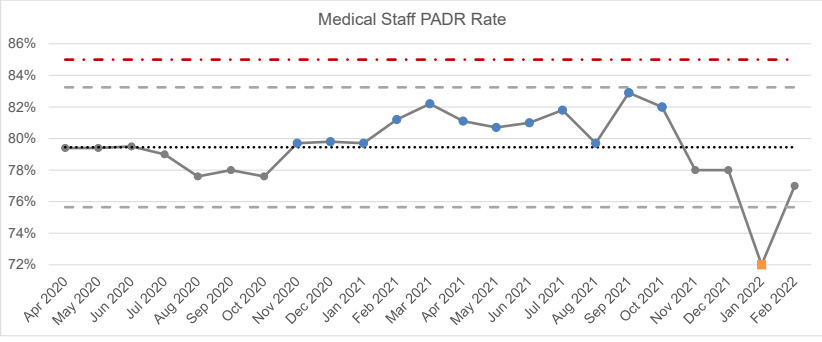
Issues/Risks: Sickness levels peaked in Jan 2022 as reported. More recent operational unverified data suggests that sickness levels are in decline in-line with a reduction in covid related illness and this should be reflective within the next period of reporting.

Actions: Following ratification of a revised sickness absence policy, a suite of training will rolled out to line managers that will include far greater levels of online content, in person training, and sectional guides that allow managers to refresh on parts of the sickness

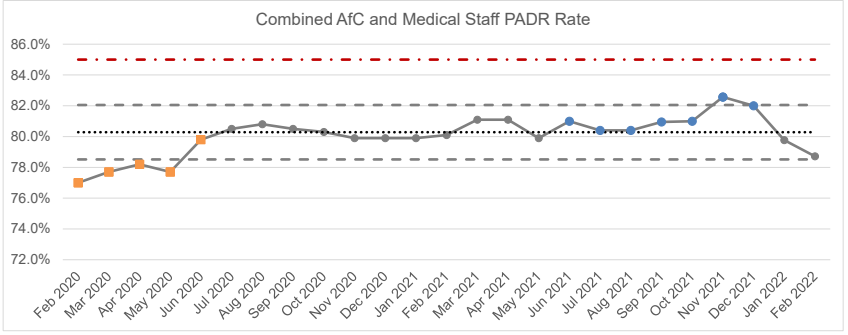
Mitigations: Continued close monitoring of sickness levels with increased operational reporting - volume, trends & themes. Greater levels of health and wellbeing resource awareness via the People Directorate. Greater levels of Occupational Health clinician time and on-site face to face counselling now in place. Operational areas responding to levels of sickness through rostering reviews to redeploy staff into areas of greatest need.



Feb 2022	80.0%
Target	85.0%
Variance	Common cause - no significant change
Assurance	Variation indicates consistently failing the target



Feb 2022	77.0%
Target	85.0%
Variance	Common cause - no significant change
Assurance	Variation indicates consistently failing the target



Feb 2022	78.7%
Target	85.0%
Variance	Common cause - no significant change
Assurance	Variation indicates consistently failing the target

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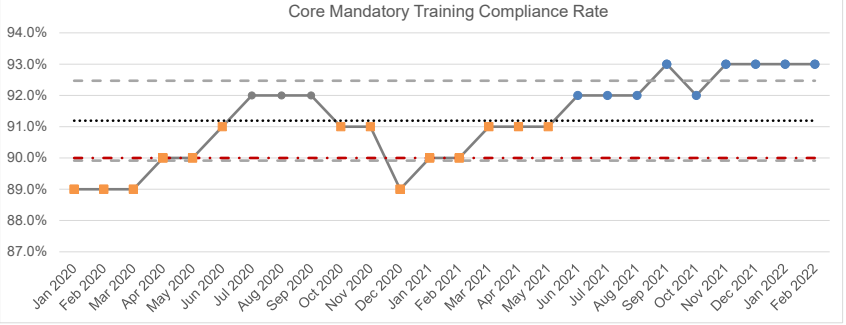
Data Analysis:
PADR Rate: This indicator continues to show common cause variation. The target cannot be met without process redesign.
Medical Staff PADR Rate: Performance has been predominantly as expected for the past two years. Without process re-design performance will continue to fail the target.
Combined AfC and Medical Staff PADR Rate: Performance has predominantly been as expected or improving for almost two years. However, without process re-design this indicator will continue to fail the target.

Commentary:
PADR Rate:
The non medical PADR compliance position currently stands at 80% this is below the Trust target of 85% .
Medical Staff PADR Compliance currently stands at 77% as of February 2022 below the Trust target of 85% .
The combined appraisal complaince currently stands at 79% as of February 2022.

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

Actions: Training and Development are currently undertaking regular risk assessment of PADR compliance and capacity for undertaking these in light of current operational pressures.

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



93.0%

90.0%

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

Variation indicates inconsistently hitting passing and failing the target

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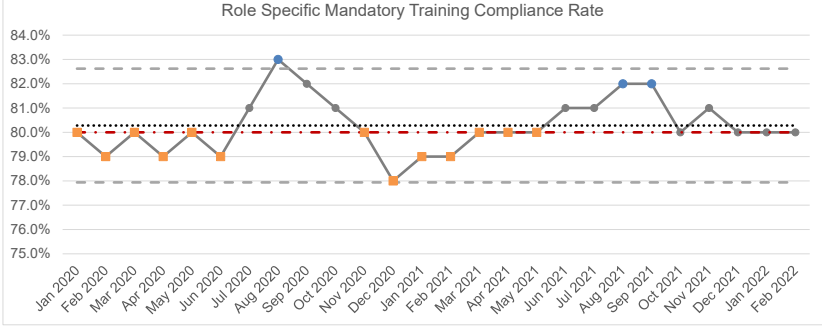

80.0%

80.0%

Common cause - no significant change

Variation indicates inconsistently hitting passing and failing the target

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Data Analysis:
Core Mandatory Training: Performance has recorded improvement for the past nine months and the target has been consistently achieved for twelve months. A few more months of improved performance are required to be confident of the data achieving the target.
Role Specific Mandatory Training: Over the past 2 years performance has been variable. The target will be achieved and not achieved at random.

Commentary:
Core Mandatory Training Compliance

The Core Mandatory Training position currently stands at 93%. This continues to be above the Trust target of 90%.

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

Actions: Training and Development are currently undertaking regular risk assessment of stat and mand compliance and capacity for training in light of current operational pressures

Present operational pressures may impact on specific core modules. If front line demand supercede capcity to attend e.g Resus and moving and handling training ETD will continue to monitor complaince leves proactivley risk assess in advance CQC inspections.

Role Specific Mandatory Training Compliance
The Role Specific Mandatory Training position currently stands at 80% (February 2022). This is continues to be in line with the Trust target of 80%.

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

Actions: Training and Development are currently undertaking regular risk assessment of stat and mand compliance and capacity for training in light of current operational pressures

Mitigations: Over the last 3 months the compliance position has been static. A new target has been made for Role specific which is 85% by end of March 2022 , this is a slight change from the previous target which was 80% by December 2021. ETD will continue to monitor complaince levels proactivley risk assess in advance CQC inspections.

Appendix A - National Benchmarked Centiles

Northern Lincolnshire and Goole NHS Foundation Trust

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

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

Source: https://publicview.health as at 11/03/2022

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

^ Indicates the benchmarked centiles use a variation on methodology to the IPR and should be taken as indicative for this reason

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Access & Flow	Planned	% Under 18 Weeks Incomplete RTT Pathways	Feb 2022	69.4%	92.0%	58	73/172	*Jan 2022
	Planned	Number of Incomplete RTT pathways 52 weeks	Feb 2022	296	0	62	66/171	*Jan 2022
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Feb 2022	18.4%	1.0%	44	89/159	*Jan 2022
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Feb 2022	65.1%	85.0%	31	95/137	*Jan 2022
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Feb 2022	64.4%	95.0%	20	107/133	Feb 2022
	Urgent Care	Number Of Emergency Department Attendances	Feb 2022	11,265	No Target	47	78/147	Feb 2022
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Feb 2022	307	0	14	135/156	Feb 2022
	Flow	Bed Occupancy Rate (General & Acute)	Feb 2022	91.0%	92.0%	38	99/159	^Q3 21/22
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Feb 2022	9.7%	No Target	24	128/168	*Jan 2022
	COVID	Number of COVID patients in ICU beds (Weekly)	Feb 2022	1	No Target	28	148/204	Feb 2022
	COVID	Number of COVID patients in other beds (Weekly)	Feb 2022	56	No Target			

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Quality & Safety	Infection Control	Number of MRSA Infections	Jan 2022	0	0	100	1/138	*Dec 2021
	Infection Control	Number of E Coli Infections	Jan 2022	4	9	78	31/138	*Dec 2021
	Infection Control	Number of Trust Attributed C-Difficile Infections	Jan 2022	0	3	96	7/138	*Dec 2021
	Infection Control	Number of MSSA Infections	Jan 2022	0	0	44	78/138	*Dec 2021
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Sep 2021	107.1	As expected	23	94/122	*Oct 2021
	Safe Care	Number of Serious Incidents Raised in Month	Dec 2021	6	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Jan 2022	8.3	No target	39	116/190	*Dec 2021
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Jan 2022	73.2%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Jan 2022	7.8	No target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Number of Positive Inpatient Scores	Jan 2022	449 out of 465	No target	61	53/135	Jan 2022

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Jan 2022	7.9%	4.1%	28	154/214	*Oct 2021

Appendix B - Access and Flow Committee Scorecard

Northern Lincolnshire and Goole NHS Foundation Trust

Note 'Action Required' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Planned	Percentage Under 18 Weeks Incomplete RTT Pathways*	Feb 2022	69.4%	92.0%	**Action Required**		F	Board
	Number of Incomplete RTT pathways 52 weeks*	Feb 2022	296	0	**Action Required**	L	F	Board
	Total Inpatient Waiting List Size	Feb 2022	10,340	11,563			P	Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Feb 2022	18.4%	1.0%	**Action Required**	L	F	Board
	Number of Incomplete RTT Pathways*	Feb 2022	30,340	No target			n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Feb 2022	15,326	No Target		L	n/a	FPC
	% of Inpatient Waiting List Risk Stratified (New and Review)	Feb 2022	100.0%	99.0%		H	P	FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Feb 2022	27,859	9,000	**Action Required**		F	Board
	Outpatient Did Not Attend (DNA) Rate	Feb 2022	9.7%	No target			n/a	Board
	% Outpatient Non Face To Face Attendances	Feb 2022	31.0%	No target			n/a	Board
	% Outpatient summary letters with GPs within 7 days	Feb 2022	30.4%	50.0%	**Action Required**		F	FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Feb 2022	88.5%	99.0%		n/a	n/a	FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Feb 2022	65.1%	85.0%	**Action Required**	L	F	Board
	Cancer Waiting Times - 104+ Days Backlog*	Feb 2022	25	0	**Action Required**		F	Board
	Patients With Confirmed Diagnosis Transferred By Day 38*	Feb 2022	30.8%	75.0%	**Action Required**		F	Board
	Cancer Request To Test In 14 Days*	Feb 2022	84.6%	100.0%	**Action Required**		F	Board
	Cancer Waiting Times - 2 Week Wait*	Feb 2022	95.2%	93.0%			?	FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Feb 2022	88.9%	93.0%	**Action Required**	L	?	FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Feb 2022	66.6%	75.0%			?	FPC
	Cancer Waiting Times - 31 Day First Treatment*	Feb 2022	98.0%	96.0%			?	FPC
	Cancer Waiting Times - 31 Day Surgery*	Feb 2022	100.0%	94.0%			?	FPC
	Cancer Waiting Times - 31 Day Drugs*	Feb 2022	100.0%	98.0%			?	FPC
	Cancer Waiting Times - 62 day Screening*	Feb 2022	70.0%	90.0%		H	?	FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Feb 2022	64.4%	95.0%	**Action Required**	L	F	Board
	Number Of Emergency Department Attendances	Feb 2022	11,265	No target			n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Feb 2022	651	0	**Action Required**	H	F	Board
	Decision to Admit - Number of 12 Hour Waits	Feb 2022	307	0	**Action Required**	H	?	Board
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Feb 2022	38.7%	92.0%		H	P	Board
	% of Extended Stay Patients 21+ days	Feb 2022	12.5%	12.0%	**Action Required**	H	?	Board
	Inpatient Elective Average Length Of Stay	Feb 2022	2.3	2.4			?	Board
	Inpatient Non Elective Average Length Of Stay	Feb 2022	3.7	4.1		L	?	Board
	Number of Medical Patients Occupying Non-Medical Wards	Feb 2022	114	No target			n/a	Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Feb 2022	89.3%	85.0%			?	Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Feb 2022	15.2%	30.0%	**Action Required**	L	F	Board
	Bed Occupancy Rate (G&A)	Feb 2022	91.0%	92.0%				Board
COVID	Number of COVID patients in ICU beds (Weekly)	Feb 2022	1	No target		L	n/a	Board
	Number of COVID patients in other beds (Weekly)	Feb 2022	56	No target		L	n/a	Board
	% COVID staff absences (Weekly)	Feb 2022	12.2%	No target		L	n/a	Board

Appendix B - Quality and Safety Committee Scorecard

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

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Infection Control	Number of MRSA Infections	Jan 2022	0	0				Board
	Number of E Coli Infections	Jan 2022	4	9				Board
	Number of Trust Attributed C-Difficile Infections	Jan 2022	0	3				Board
	Number of MSSA Infections	Jan 2022	0	0				Board
	Number of Gram Negative Infections	Jan 2022	7	12				Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dec 2021	100.0	As expected			As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Sep 2021	107.1	As expected			As expected	Board
	Number of patients dying within 24 hours of admission to hospital	Feb 2022	14	No target			n/a	Q&S
	Number of emergency admissions for people in the last 3 months of life	Feb 2022	172	No target			n/a	Q&S
	Out Of Hospital (OOH) SHMI	Oct 2021	132.6	110.0	**Action Required**			Q&S
	Structured Judgement Reviews - Rate Completed of those required	Jan 2022	33.0%	100.0%	**Action Required**			Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Jan 2022	100.0%	No target			n/a	Board
	Number of Serious Incidents raised in month	Dec 2021	6	No target			n/a	Board
	Occurrence of 'Never Events' (Number)	Dec 2021	1	0			n/a	Board
	Duty of Candour Rate	Nov 2021	100.0%	No target			n/a	Board
	Falls on Inpatient Wards (Rate per 1000 bed days)	Jan 2022	4.9	0%			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate per 1000 bed days)	Jan 2022	5.3	0%			n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Jan 2022	73.2%	95.0%	**Action Required**			Board
	Care Hours Per Patient Day (CHPPD)	Jan 2022	8.3	No target	**Action Required**		n/a	Board
	Mixed Sex Accommodation Breaches	Feb 2022	4.0	0			n/a	Board
Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Jan 2022	7.8	No target			n/a	Board
	Complaints Responded to on time	Dec 2021	70.0%	85.0%				Board
	Friends and Family Test (FFT)							
	Number of Positive Inpatient Scores	Jan 2022	449 out of 465	No target		n/a	n/a	Board
	Number of Positive A&E Scores	Jan 2022	274 out of 374	No target		n/a	n/a	Board
	Number of Positive Community Scores	Jan 2022	134 out of 146	No target		n/a	n/a	Board
	Number of Positive Outpatient Scores	Jan 2022	10 out of 13	No target		n/a	n/a	Board
	Number of Maternity Antenatal Scores	Jan 2022	0 out of 0	No target		n/a	n/a	Board
	Number of Maternity Birth Scores	Jan 2022	100 out of 104	No target		n/a	n/a	Board
	Number of Maternity Postnatal Scores	Jan 2022	2 out of 2	No target		n/a	n/a	Board
	Number of Maternity Ward Scores	Jan 2022	38 out of 40	No target		n/a	n/a	Board
Observations	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Feb 2022	90.4%	90.0%				Q&S
	Percentage of Child Observations Recorded On Time (with a 30 min grace)	Jan 2022	100.0%	90.0%				Q&S
	Escalation of NEWS in line with Policy	Jan 2022	0.0%	No target		n/a	n/a	Q&S
	Blood Glucose taken in the Emergency Department in Adult patients when NEWs score >1	Jan 2022	95.0%	100.0%				Q&S
	Blood Glucose taken in the Emergency Department in Paediatric patients when PEWs score >1	Jan 2022	82.5%	100.0%				Q&S
Sepsis	Rate of Patients Screened for Sepsis using the Adult Sepsis Screening and Action Tool (based on Manual Audit)	Jan 2022	80.0%	90.0%		n/a	n/a	Q&S
	Rate of those who had the Sepsis Six completed within 1 hour for patients who have a Red Flag (based on Manual Audit)	Jan 2022	0.0%	90.0%		n/a	n/a	Q&S
Prescribing	Percentage of patients admitted to IAAU with an actual, estimated or patient reported weight recorded on EPMA or WebV (based on Manual Audit)	Jan 2022	67.5%	No target		n/a	n/a	Q&S
	Percentage of patients admitted to IAAU with an ACTUAL weight recorded on EPMA or WebV (based on Manual Audit)	Jan 2022	26.3%	No target		n/a	n/a	Q&S
	Percentage of patients admitted to IAAU whose weight was 50kg (+/- 6kg) who complied with prescribing weight for dosing standard	Jan 2022	75.0%	No target		n/a	n/a	Q&S
	Rate of Insulin administered on time within wards using EPMA	Jan 2022	99.3%	0.0%		n/a	n/a	Q&S
	Percentage of Medication Omissions for Ward Areas Using EPMA	Jan 2022	2.0%	No target		n/a	n/a	Q&S
Diabetes	Diabetes Audit Findings (percentage)	Jan 2022	76.7%	80.0%				Q&S
	Percentage of relevant staff who have completed mandatory diabetes training	Feb 2022	87.7%	90.0%	**Action Required**			Q&S
Re-admissions	Percentage of patients re-admitted as an emergency within 30 days	Feb 2022	7.9%	9.0%				Q&S

Note 'Action Required' is stated when either Variation is showing special cause concern or Assurance indicates failing the target.
*Indicators marked with an asterix have unvalidated status at the time of producing the IPR.
^ Draft - The optimum method for analysing/presenting these figures is in development.
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Vacancies	Unregistered Nurse Vacancy Rate	Jan 2022	11.6%	2.0%	Action Required		F	Board
	Registered Nurse Vacancy Rate	Jan 2022	7.2%	8.0%		L	?	Board
	Medical Vacancy Rate	Jan 2022	12.1%	15.0%			?	Board
	Trustwide Vacancy Rate	Jan 2022	9.3%	7.0%	Action Required	H	?	Board
Staffing Levels	Turnover Rate	Feb 2022	11.2%	9.4%	Action Required	H	?	Board
	Sickness Rate	Jan 2022	7.9%	4.1%	Action Required	H	F	Board
Staff Development	PADR Rate	Feb 2022	80.0%	85.0%	Action Required		F	Board
	Medical Staff PADR Rate	Feb 2022	77.0%	85.0%	Action Required		F	Board
	Combined AfC and Medical Staff PADR Rate	Feb 2022	78.7%	85.0%	Action Required		F	Board
	Core Mandatory Training Compliance Rate	Feb 2022	93.0%	90.0%		H	?	Board
	Role Specific Mandatory Training Compliance Rate	Feb 2022	80.0%	80.0%			?	Board
Disciplinary	Number of Disciplinary Cases Commenced	Feb 2022	0	No target		L	n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Feb 2022	0	12		L	?	WFC
	Number of Suspensions Commenced	Feb 2022	1	No target		L	n/a	WFC
	Average Length of Suspension (Weeks)	Feb 2022	0	No target		L	n/a	WFC

BOARD COMMITTEES VALUATION ASSESSMENT TOOL

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Introduction

In accordance with the requirements of good corporate governance and in order to ensure their ongoing effectiveness, it is recommended that Trusts should undertake a formal and rigorous annual evaluation of the performance of its Board committees (*see footnote 1 below*) . The following assessment tool has been developed to evaluate the performance of the Quality & Safety Committee.

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
1. Terms of Reference					
1a. Does the Committee have clearly defined Terms of Reference which have been approved by the Trust Board?	5		Terms of Reference Committee Minutes Trust Board Minutes Document Control Database		
1b. Are the Terms of Reference regularly reviewed and updated?	5		Terms of Reference Committee Minutes Trust Board Minutes Document Control Database		
1c. Has the Committee discharged its duties and responsibilities as per the Terms of Reference and the work programme?	5		Committee Minutes Action Log Annual Review of Effectiveness Work Programme		
2. Reporting & Accountability					
2a. Does the Committee regularly work towards the strategic objectives of the Trust?	5		Terms of Reference Committee Minutes		
2b. Has the Committee reported regularly and in a way that has furthered the work of the Trust Board and / or provided the necessary assurance to the Trust Board whilst also escalating matters as required?	5		Trust Board Agenda & Minutes Statement of Internal Control (SIC) External Standards & Compliance Reports 'Highlight' Reports including review of the Board Assurance Framework (BAF)	The Quality & Safety Committee highlight report to the Trust Board also provides assurance to the Governor Assurance Group and helps governors to hold the chair account for the performance of his NED role	

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
2c. Are the roles of and relationship between this Committee and the other Board Assurance committees clear, include the review of risk and avoid duplication of effort?	4	1	Terms of Reference Committee Agenda & Minutes Board Assurance Framework (BAF) Risk Register (high level/Significant risks)	**No** - Arguably there is too much overlap between the roles of the Q&S and F&P Committees. Personally I feel that quality and operational performance should be considered in tandem by a single assurance committee report **Yes -** The committee regularly refers questions on Performance and Workforce to the appropriate Committees where Q&S queries lead to further queries in these	
2d. Has the Committee received regular reports and / or minutes from the sub-groups which report to it, which avoid unnecessary detail	5		Committee Agenda & Minutes Work Programme 'Highlight' Reports from sub-groups Committee Minutes		
2e. Has the Committee sought and received assurance that the Trust has reliable, real time, up-to-date information (e.g. patient	5		Committee Agenda & Minutes Integrated Performance Report Other associated reports as	the timings are appropriate to the topics	
2f. Are issues referred to other Board Committees or management decision making groups, as appropriate?	5		Committee Agenda, Minutes and Action Log Committee Highlight Report Referral Communication (written or verbal)		
3. Leadership					
3a. Are the Committee meetings chaired effectively?	5		Evaluation Results & Feedback	Including the occasion when Maneesh Singh deputised	
3b. Is the Committee Chair visible, demonstrates leadership and	5		Annual Review of the Committee NED Chair visit records		
4. Frequency of Meetings					
4a. Has the Committee met at the frequency defined in its Terms of	5		Meeting Schedule Committee Agenda & Minutes		
4b. Where necessary, have	4	1	Committee Agenda & Minutes	**No** - This has not been necessary	

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
additional meetings of the Committee been held?			Attendance Matrix	in my short tenure although I do not believe that any additional meetings if required would be refused.	

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
5. Duration of Meetings					
5a. Is there sufficient time during meetings to consider and debate agenda items, ensure sufficient challenge and appropriate member contribution?	4	1	Committee Agenda & Minutes	**No** - Despite expert chairing there is frequently insufficient time to do justice to all agenda items **Yes** - Timing can be challenging however I have not yet seen any agenda item closed before debate has completed.	Consider rotating agenda items in line with the practice adopted by the F&P Committee
6. Membership					
6a. Does the Committee consist of the right number of appropriately knowledgeable, experienced,	5		Terms of Reference Committee Minutes Attendance Matrix	I think it would benefit from a further full NED member	
6b. Is the membership of the Committee kept under review?	5		Terms of Reference Committee Minutes Trust Board Minutes		
6c. Does the Committee ensure that relevant patients, staff and other key stakeholders attend meetings to enable it to understand the information it receives and supports delivery of its	5		Terms of Reference Committee Minutes	Governor attending in an observer capacity act as proxy patients Information is presented by staff and other key stakeholders who can contribute and represent the issues discussed.	
7. Receipt of Information					
7a. Are committee papers distributed appropriately to give members sufficient time to consider them fully and prepare for meetings?	5		Committee Agenda & Minutes	There is still the odd late paper but by and large papers are distributed in a timely manner. The terms of reference were amended to require papers to be distributed at least 7 days prior to meetings during 2021. Once this was agreed by the Board there is sufficient time to review papers.	

The results of the evaluation exercise are to be reported to the Trust Board.

Please note that attendance levels and quoracy of the Committee are monitored at each meeting and captured in the minutes.

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			

[1] Integrated Governance Handbook, Good Governance Institute, 2016

NLG(22)034

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Mike Proctor, Non-Executive Director	
Contact Officer/Author	Mike Proctor	
Title of the Report	**Quality & Safety Committee highlight report**	
Purpose of the Report and Executive Summary (to include recommendations)	To appraise the Board of the discussions at Quality and Safety Committee	
Background Information and/or Supporting Document(s) (if applicable)	None	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	None	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

Highlight Report to Trust Board

Report for Trust Board Meeting on:	April 2022
Report From:	Quality & Safety Committee on 22 February 2022 and 22 March 2022

Highlight Report:

Community and Therapies gave assurance on divisional governance, noting that the shortfall in funding had been agreed with Commissioners and work was underway to develop further virtual wards. Further assurance was then received on the EOL work.
Surgery and Critical Care gave assurance on their work to improve quality, including the cultural and process work following the Never Events, including the use of a specialist Ergonomist to look at the accountable items process.

The Committee received a report on the progress against the Ockenden report, which was approved for submission. Two new maternity Serious Incidents were noted on behalf of the Board, and two maternity reports were noted as complete with the full action plans and learning received demonstrating that the concerns identified had been addressed.

A framework on Patient Safety Partners, a volunteer role to ensure the patient voice in strategic decisions on patient safety, was approved. It was agreed that this needed to be discussed with Governors for clarity on the differences in roles.

The Committee received a report on Risk Stratification and Clinical harm, noting that while no harm had yet been identified, there remained a concern in regards to the patients who had been stratified as able to wait 3 months plus as in reality this wait was far longer and harm would not be evident until the patient came to clinic or for the procedure.

The Nursing Assurance report demonstrated the impact of the Omicron variant of Covid-19 on the Trust, and while safety and quality had been maintained, it had been a difficult period for staff.

The Safeguarding report identified ongoing concerns in relation to looked after children in North East Lincolnshire. It was noted that the Trust was doing everything possible to help address the concerns.

An update was given on QIA. It was agreed that this report could be 6 monthly henceforth.

There were no deviations from National Guidance including NICE guidance.

An update was received on the CQC action plan noting progress on the action including one action going from red to green.

A discussion on cancer identified a difference in views on how to marry single strategic oversight and governance structures. Further discussions were to be held in this regard.

The annual review of Committee effectiveness was received and is attached.

Confirm or Challenge of the Board Assurance Framework:

Discussed

Action Required by the Trust Board:
The Trust Board is asked to note the key points made. **Mike Proctor** **Non-Executive Director**

NLG(22)035

Name of the Meeting	**Trust Board**
Date of the Meeting	Tuesday 5 April 2022
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jane Warner, Associate Chief Nurse – Maternity Services
Title of the Report	**Ockenden update – a year on**
Purpose of the Report and Executive Summary (to include recommendations)	To provide assurance for the actions undertaking by the Trust following Ockenden report including 7 Immediate & Emerging Actions, updated Kirkup Report action plan
Background Information and/or Supporting Document(s) (if applicable)	https://www.england.nhs.uk/publication/ockenden-review-of-maternity-services/
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Quality & Safety Committee, Maternity Transformation Board
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	n/a
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance ☐ Information ☐ Review ☐ Other: Click here to enter text.

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4.	**To work more collaboratively**
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Ockenden Report – review of maternity services – one year on

Jane Warner
Associate Chief Nurse
March 2022

NLaG + Ockenden

- Ockenden report – December 2020
- 2022 - 7 Immediate and Emerging Actions
- Workforce plans
- Kirkup 2015 report update (Morecambe Bay)
- What have we achieved
- Where are we now
- What do we need

Ockenden report, 2020

- Donna Ockenden report – Maternity services at Shrewsbury & Telford
- Key Issues –
  - *Risk assessment*
  - *Management of complex women*
  - *Failure to escalate*
  - *Culture of normal birth*
  - *Poor fetal monitoring practice*
  - *Lack of kindness and compassion*
  - *Lack of anaesthetic support*
  - *Poor governance*
  - *Failure to listen to women and families*

7 Immediate & Emerging Actions (incl 12 Clinical Priorities) Feb 2022

	Compliant	Partially Compliant
1. Enhanced Safety Implement Perinatal Clinical Quality Surveillance Model. All maternity SI's are shared with Trust boards and LMS	✓ ✓	
2. Listening to Women and their Families Gathering service user feedback Executive Director with specific responsibility for maternity services. NED who supports Maternity Safety Champion	✓ ✓	
3. Staff Training and working together Consultant led labour ward rounds twice daily MDT training with schedule Ringfenced funding for maternity staff training	✓ ✓ ✓	
4. Managing complex pregnancy Named consultant lead and audit compliance Support Maternal Medicine Specialist Centres	✓ ✓	
5. Risk Assessment throughout pregnancy Must be completed at every contact.		✓
6. Monitoring Fetal Wellbeing Implement Saving Babies Lives bundle. Lead fetal monitoring midwife and clinician	✓ ✓	
7. Informed Consent Pathways of care clearly described for women	✓	

Workforce plans

Workforce plans

- Continued recruitment to current establishment
  - International recruitment of midwives – 5 – 6 recruited
  - Weekly surgeries with Student Midwives to aid support and future recruitment
  - Retention bid monies to support midwives and reduce leavers
- Birthrate Plus – awaiting final report
- Continuity of Carer – addl 16 midwives required (pending BR+ outcome)
- Diabetes midwife – required
- Project manager – to support Ockenden work

Kirkup (2015) Morecambe Bay report* February 2022

44 recommendations, 18 actions locally

Lack of sustained improvement

Updated action plan

- 9 green, 7 amber, 2 red
- Amber includes MT, PROMPT, PADR compliance, Embedding of Safety Champion work, Audit RCOG workforce guidance, OT Recovery training
- Red includes Risk Assessment SOP, Audit Risk Assessment guidance
- *Included on Trust Risk Register

- Fetal monitoring lead clinicians and midwife
- Saving Babies Lives lead midwife
- New posts – Clinical education, training admin, consultants
- Increased MDT training, TNA aligned to Core Competency Framework
- PCSP electronically
- Service user involvement throughout
- Staff engagement sessions
- Achieved CNST 10 Safety Actions
- SI detail to Trust Board / LMS
- Collaborative working with LMS includes cross-trust support re SI investigations
- Investigation training course (5 days)
- Co-production with MVP
- Listening to complainants as part of constructive feedback
- Working with inception of Maternal Medicine Centres
- Saving Babies Lives v2 – 2021
- Continuity of Carer – 3 teams, implementation plan agreed at Board
- Safety mailbox, Shout Out Wednesday
- Maternity Chat monthly events
- Maternity Chat Band 7 monthly events
- Collaborative working with HSIB
- Represent Trust at regional / national groups

- Identified a need to undertake targeted work with culture, compassion, kindness
- Requirement to support leaders to be the best they can be
- Outsourced delivery of culture sessions with NHSE/I monies (Health & Well-being) for all midwifery staff
- Large amount of audits, SOP creation, monitoring to do – e.g. Complex women, Risk Assessments
- Embedded PMRT, Consultant ward rounds, external PMRT reviewer
- Finalising Birthrate Plus review
- Working with women and clinicians regarding participating equally in decision making processes
- Great strides forward with QI projects – Induction of Labour, Triage, Newborn Bloodspot
- Establishment reviews with Chief Nurse planned
- Informed consent -

What do we need

Focus on progress

- Monitoring of action plan progress*
- Timely escalation
- Engagement of entire clinical team
- Project Manager

Ability to sustain improvement

- Continued audit cycle
- Weekly meetings – commitment of attendance
- Embedding Safety Champion work

Celebrate the achievements

- Share across the Division / Trust / LMS
- Put NLaG maternity services on the map

- ** Not meeting Ockenden recommendations is included on the Trust Risk Register*

Action plans

- Kirkup action plan, 2022

- Ockenden action plan, v8

- IEA, updated 22/2/22

NLG(22)036

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Gill Ponder	
Title of the Report	**Finance & Performance Committee Highlight Report – Performance 18-2-22 and 23-3-22**	
Purpose of the Report and Executive Summary (to include recommendations)	To highlight to the Board the main Performance and Estates & Facilities areas where the Committee was assured and areas where there was a lack of assurance resulting in a risk to the delivery of the Trust's strategic objectives.	
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Executive Leads
Which Trust Priority does this link to	✓ Pandemic Response ☐ Quality and Safety ✓ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ✓ Review ☐ Other: Click here to enter text.

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Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5 April 2022
Report From:	Finance & Performance Committee – 18-2-22 and 23-3-22

Highlight Report:

The Trust's 4 hour performance had improved slightly, but ambulance waits continued to cause concern due to inability to discharge patients and continued high demand on the service. UCS hours had been extended at Scunthorpe and the UCS had also gone live at Grimsby. 99% of patients were seen within 4 hours by the UCS, but that only led to a small improvement against the overall 4 hour target. Further improvement activities were underway, including IAAU discharging 38% of patients the same day and growth of 111 First resulting in fewer ambulance attendances. A paper was received by the Committee on the additional actions being taken to improve performance against the 4 hour standard, but the Committee was not assured that all of the improvements underway would result in the standard being met, due to workforce challenges and lack of flow out of the hospital.

The Planned Care waiting list and 52 week waits had both deteriorated, with a forecast outturn for the year of circa 100 52 ww patients, due mainly to anaesthetic need, patient choice, tipover, levelling up and lost capacity due to absences and theatre availability.

The Committee was assured by the draft Operational Plan for 2022/23 and the subsequent discussion about assumptions, dependencies, risks and further improvement plans, but it should be noted that the plan did not meet all the targets in the guidance received. This was mainly due to IPC limitations, theatre capacity, current backlog and levelling up which will increase Trust waiting lists. Funding availability for investments was also a risk.

The level of Backlog Maintenance required on the Trust estate was the reason for the continued high rating of the strategic risk, which would not reduce without significant extra investment. However, much of the structure was outdated and that would not change even if the existing buildings were fully maintained, reinforcing the need for a new hospital.

The Committee received two deep dive reports on Water and Lifts. An improvement notice had been received from Anglian Water in relation to cold water tanks at Scunthorpe. Funding had been included in 22/23 plans. If capital funding was available, the work could be completed before the next inspection date of 25 October. The Committee requested a quarterly update on the status of all enforcement or improvement notices affecting the Trust. The Committee were assured by the report on lifts, as there were no high risks.

Confirm or Challenge of the Board Assurance Framework:

A deep dive on Cancer performance was carried out, which highlighted that failure to meet the 28, 38 and 62 day targets was due to delays with diagnosis mainly due to inefficient paper processes, shortage of oncologists and increase in out of area referrals. Earlier notification when cancer had been ruled out would improve performance, as would improvements to EUS and PET/CET pathways and timescales at HUTH. It was agreed that a temporary workaround for the paper processes in diagnostics would be investigated.

Action Required by the Trust Board:

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

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

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	5 April 2022
Director Lead	Michael Whitworth, Non-Executive Director and Chair of Workforce Committee
Contact Officer/Author	Michael Whitworth, Non-Executive Director and Chair of Workforce Committee
Title of the Report	Workforce Committee Highlight Report and Board Challenge
Purpose of the Report and Executive Summary (to include recommendations)	The Committee recommended highlighting the following matters of concern to the Board, namely: • The Committee approved the revised disciplinary policy • The Committee agreed the Gender Pay Gap report to be published by the deadline of 30th March • The Committee also approved the Modern Slavery statement for the next 12 months. • A deep dive into the proposed leadership model was undertaken ahead of the report being presented to the April 2022 Board. No changes to the Board Assurance Framework were recommended.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	

Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	05 April 2022
Report From:	Michael Whitworth, NED & Chair of Workforce Committee

Highlight Report: Workforce Committee – 29 March 2022

1 Introduction

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

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

2.1 The Committee agreed to change the Trust targets for staff turnover and unregistered nurse vacancy rates.

2.2 The changes were made to bring the Trust in line with Humber Coast & Vale and other NHS partner target rates.

2.3 All the workforce targets in the Committee integrated performance were reviewed, however, the above 2 were the only ones changed.

2.4 It should be noted that the changes do not impact on any external reporting requirements or the Board Assurance Framework.

3 Items for Committee Ratification and Assurance

3.1 The Committee approved the revised disciplinary policy.

3.1.1 The revised policy includes the Dido Harding recommendations from May 2019, and supports the move to a Just and Learning Culture for the organisation.

3.2 The Committee approved the Gender Pay Gap Report for 2021 so that it could be published by the deadline of 30th March 2022.

3.3 The Committee approved the Modern Slavery Statement for the next 12 months.

3.4 Assurance deep dives were undertaken for:

- Culture Transformation programme
- Leadership Development
- Retention

3.4.1 The critical importance and also long-term nature of the culture and leadership programmes was highlighted by the Committee

3.4.2 The Committee also review available retention data and agreed metrics for regular performance reporting going forward. This is part of a suite of recruitment metrics that will be reported to the Committee in line with agreed Audit recommendations. 3.5 A comprehensive report from the Workforce Resource Centre was welcomed by the Committee.
Confirm or Challenge of the Board Assurance Framework:
No changes to the Board Assurance Framework were recommended.
Action Required by the Trust Board:
The Board is asked to receive and note the content of this highlight report.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG/22/038

Name of the Meeting	Trust Board - Public
Date of the Meeting	5th April 2022
Director Lead	Christine Brereton Director of People
Contact Officer/Author	Karl Portz EDI Lead
Title of the Report	Gender Pay Gap Statutory Reporting
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of the report is to present the Trust's Gender Pay Gap against the six key components. All public sector bodies in England with 250 or more employees are required to publish their gender pay and bonus gap. The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 bring in the gender pay gap reporting duty as part of the existing public sector equality duty (PSED). The data needs to be submitted annually by 30th March. Board are asked to note the information as approved for submission by the Workforce Committee at its meeting held on 29th March 2022. This report provides data for three years: 2019, 2020 and 2021. The Trust's Electronic Staff Record system has a specific standard report for this purpose. .
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ✓ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A

Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Achieving an inclusive and representative workforce demographic	
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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Gender Pay Gap Reporting

1. PURPOSE/AIM

1.1 The purpose of this report is to provide an overview of the data that the Northern Lincolnshire & Goole NHS Hospital Trust (NLaG) statutorily needs to publish on its website and report to the Government on the gender pay gap. The report covers data for 2019, 2020 and 2021.

2. BACKGROUND/CONTEXT

2.1 The introduction of the Government regulations in April 2017 saw the requirement for public sector bodies in England with 250 or more employees to publish their gender pay and bonus gap. The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 bring in the gender pay gap reporting duty as part of the existing public sector equality duty (PSED).

2.2 The main requirements are for public sector employers to carry out six calculations based on annual data and to publish those figures on their organisation's website and upload on the Government website, annually, by 30 March, with a rationale for the pay gap. This report provides data for three years: 2019, 2020 and 2021. The Trust's Electronic Staff Record system has a specific standard report for this purpose.

2.3 There are two sets of nationally mandated regulations. The first is mainly for the private and voluntary sectors and the second is mainly for the public sector. Employers have up to 12 months to publish their gender pay gap, on their own website and on the government's online reporting service https://www.gov.uk/report-gender-pay-gap-data. This means that the gender pay gap will be publicly available, including to commissioners, patients, employees and potential future recruits.

2.4 The purpose of a gender pay gap audit is to focus on reducing any gaps in the pay of male and female employees by comparing and evidencing the difference in their average earnings.

2.5 The Gender Pay Gap Indicators

The legislation requires employers to publish the results of six calculations, as set out below. This report provides information on each of these six calculations, the formulas for which are explained below:

1. **Mean gender pay gap in hourly pay -** adding together the hourly pay rates of all male or female full pay and dividing this by the number of male or female employees. The gap is calculated by subtracting the results for females from results for males and dividing by the mean hourly rate for males. This number is multiplied by 100 to give a percentage.

2. **Median gender pay gap in hourly pay -** arranging the hourly pay rates of all male or female employees from highest to lowest and find the point that is in the middle of range.

3. **Mean bonus gender pay gap -** add together bonus payments for all male or female employees and dividing this by the number of male or female

employees. The gap is calculated by subtracting the results for females from results for men and dividing by the mean hourly rate for men. This number is multiplied by 100 to give a percentage.

4. **Median bonus gender pay gap -** arranging the bonus payments of all male or female employees from highest to lowest and find the point that is in the middle of the range.

5. **Proportion of males and females receiving a bonus payment -** total males and females receiving a bonus payment divided by the number of relevant employees.

6. **Proportion of males and females in each pay quartile -** ranking all of our employees from highest to lowest paid, dividing this into four equal parts ('quartiles') and working out the percentage of men and women in each of the four parts.

2.6 Gender pay reporting is different to equal pay. The gender pay gap is the average difference between the gross hourly earnings for all men and women which is expressed as a percentage of men's earnings (as set out at 2.5 calculation 1). Equal pay refers to men and women being paid the same for like work; work rated as equivalent or work of equal value as set out in the Equality Act 2010. It is unlawful to pay people unequally purely because they are a man or a woman.

2.7 It should be noted that whilst current pay structures support equal pay for men and women, factors such as length of service can affect the gender pay gap.

2.8 The majority of the Trust's staff are on national terms and conditions of employment. These are recognised as being an excellent example of equal pay for work of equal value. This will significantly assist in reducing our pay gap.

3. NLaG TRUST DATA TO BE PUBLISHED BY 30TH MARCH 2022

3.1 This section provides the breakdown of the statutory information the Trust is required to publish by 30th March 2022; all 2021 data provided in the tables below is a snapshot of a month's data as at 31st March 2021. The report also includes data from the same point in 2019 and 2020 to provide comparative information.

3.2 All data provided has been internally verified by NLaG HR Systems and Finance departments.

3.3 The data for reporting is as follows:

Average gender pay gap as a mean average for years 2019, 2020 and 2021
(Mean is calculated as the sum of all the values (hourly rates) divided by the number of staff). Table 1

Average Hourly rate	2019	2020	2021
Male:	**£19.21**	**£19.72**	£20.23
Female:	**£12.66**	**£13.04**	£13.68

Gap:	**34.11%**	**33.84%↓**	**32.36%↓**

3.4 The Average Hourly Rate (in table 1 above) is the figure that is used to calculate our gender pay gap nationally. The Average Hourly Rate calculation for all employees includes any unsocial payments made in the reporting period (01st April 2020 -31st March 2021) i.e. unsocial hours and weekend allowances.

3.5 The average pay gap decreased by 1.48%, from 33.84% in 2020 to 32.36% in 2021. (Men's Average Hourly Rate (pay) increased by £0.51 and women's by £0.64 over the two year reporting period 2019 -2021), therefore a small increase in male and female Average Hourly Rates respectively. The reduction in the pay gap is due to a slightly higher increase in women's Average Hourly Rate compared to the Average Hourly Rate for men. Further analysis of Average Hourly Rate shows the reduction in the pay gap is due to the higher proportion of women in the workforce working in areas that attracted unsocial payments (i.e. unsocial hours and weekend allowances) compared to male staff.

3.6 **Median average gender pay gap for years 2019, 2020 and 2021**

Table 2

Median Hourly rate	2019	2020	2021
Male:	**£14.34**	£14.89	£15.35
Female:	**£10.46**	£10.78	£11.55
Gap:	**27.09%**	**27.59%↑**	**24.74%↓**

3.7 The median average gender pay decreased by 2.85% (men's median average hourly pay increased by £0.46 and women's by £0.77 over the two years). The higher increase in the median hourly rate for women has led to a slight improvement in our gender pay gap.

3.8 The improvement of the average mean and median pay gap is explained by the composition of our workforce. NLaG employed 4,305 more women (5692.00), than men (1387.00), in 2021; see Table 6 below for further breakdown. The increase for women is as a result of less women being at the top of their pay scale, with a greater percentage of women compared to men with headroom to move up the pay scale. A greater percentage of men have already reached the top of their pay scale due to longer service.

3.9 **Average bonus gender pay gap as a mean average**

Table 3

Average Bonus	2019	2020	2021
Male:	£7,155.02	£6,757.46	£7,280.07
Female:	£2,043.35	£2,374.18	£3,677.42
Gap:	**71.44%**	**64.87%↓**	**49.49%↓**

3.10 The table above shows the average bonus payments for the last 3 years. Bonus payments include 'Refer a Friend' incentives paid to staff for helping to fill 'hard to fill' posts as well as Clinical Excellence Awards (CEAs). CEAs are awarded to consultants who perform their role 'over and above' the expected standard and can be in the form of both national and local CEAs. In 2021, the average bonus

payment made to females increased by £1,303.24*. In comparison, male bonus payments increased by £522.61. This resulted in the average bonus pay gap being reduced from 64.87% to 49.49%. This improvement is largely due to the increased number of female consultants in the workforce qualifying for CEA payments and back pay of CEAs to female consultants. A large proportion of bonus payments made in 2021 were attributable to CEAs.

*Please note during the reporting year (2020-21) bonus payments includes back pay for CEA payments from 2014-18 and 2018-21; therefore 2021 saw a higher number of CEAs awarded compared to previous reporting years.

3.11 **Average bonus gender pay gap as a median**

Table 4

Median Bonus Payment	2019	2020	2021
Male:	£3,015.96	£3,015.96	£5,037.00
Female:	£731.25	£351.43	£1,841.00
Gap:	**75.75%**	**88.35%** ↑	**63.45%** ↓

3.12 The median average bonus pay decreased in 2021 by 24.9%, from 88.35% in 2020 to 63.45% in 2021. In 2021, the median bonus payment to females increased by £1,489.57. In comparison, the median male bonus payments increased by £2,021.04. The median bonus pay has improved due to the large increase in female consultants qualifying for CEA payments compared to previous years.*

*Please note during the reporting year (2020-21) bonus payments includes back pay for CEA payments from 2014-18 and 2018-21; therefore 2021 saw a higher number of CEAs awarded compared to previous reporting years.

3.13 **Proportion of males and proportion of females receiving a bonus payment**

Table 5

Proportion of bonus Payment	2019	2020	2021
Male:	6.23%	6.45%	9.89%
Female:	1.73%	0.86%	0.79%
Gap:	**4.50%**	**5.59%** ↑	**9.1%** ↑

3.14 Table 5 shows the proportion of male and female staff who received bonus payments. In 2021, the gap between male and female increased by 3.51% to 9.1% with more male staff receiving bonus payments. It can be seen that the percentage of the workforce who receive bonus payments remains higher for males and has reduced for females. This is mainly due to a higher number of male consultants in the workforce than females who qualify for CEA payments. Only 33 females were awarded a CEA compared to 115 males. CEA's awards range from values of £498.00 up to £36,192. This is the main reason for the bonus pay gap.

3.15 The data below ranks our full pay employees from highest to lowest paid, divided into four equal parts (quartiles) and then calculates the percentage of men and

women in each of the four groups. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries.

Table 6

No. of Staff				
2019				
Quartile	**Female**	**Male**	**Female %**	**Male %**
Upper Quartile	1129.00	576.00	66.22%	33.78%
Upper Middle Quartile	1440.00	265.00	84.46%	15.54%
Lower Middle Quartile	1537.00	222.00	87.38%	12.62%
Lower Quartile	1417.00	230.00	86.04%	13.96%
Total	**5523.00**	**1293.00**	**81.03%**	**18.97%**
2020				
Quartile	**Female**	**Male**	**Female %**	**Male %**
Upper Quartile	1117.00	600.00	65.06%	34.94%
Upper Middle Quartile	1441.00	275.00	83.97%	16.03%
Lower Middle Quartile	1476.00	241.00	85.96%	14.04%
Lower Quartile	1484.00	230.00	86.58%	13.42%
Total	**5518.00**	**1346.00**	**80.39%**	**19.61%**
2021				
Quartile	**Female**	**Male**	**Female %**	**Male %**
Upper Quartile	1176.00	596.00	66.37%	33.63%
Upper Middle Quartile	1443.00	324.00	81.66%	18.34%
Lower Middle Quartile	1531.00	239.00	86.50%	13.50%
Lower Quartile	1542.00	228.00	87.12%	12.88%
Total	**5692.00**	**1387.00**	**80.41%**	**19.59%**

3.16 The data in the upper quartile, shows that NLaG have a higher proportion of men in the upper quartile compared to all other quartiles. In contrast, there are fewer women in the upper quartile compared to the remaining quartiles.

3.17 Looking at the data in the upper middle quartile, men saw a large increase from 275 to 324 (2.31%). The number of females in the upper middle quartile increased by 2.

3.18 The lower middle quartile for females increased by 55. The number of males in this quartile increased by 2.

3.19 The lower quartile for men decreased in 2021 and the percentage in this quartile decreased by 0.54%. The number of women in this quartile increased by 58.

3.20 Overall, men's representation increased by 41 but with a greater increase in women employed, the overall male percentage fell by (0.02 %). There remain more women in the middle and lower quartiles. This is due to a high number of female staff applying for and being appointed to HCA and administration and clerical roles.

3.21 The table below illustrates NLAG gender pay gap scores compared to peer median (other acute trusts) and national median (Model Hospital). In common with the Acute Healthcare Sector, there is a higher number of female to male

ratio. Males represent 19.59% of our workforce and females represent 80.41%. This disproportionality in the upper quartile is one of the main reasons for both the mean and median gender pay gap. As can be seen in the comparator table below, NLaG has a higher proportion of males in the upper quartile compared to our peer groups.

Metric	Trust value	Peer median	National median
Average gender hourly pay gap	33.80%	26.20%	22.60%
Median gender hourly pay gap	27.60%	12.90%	10.00%
Proportion of males in lower quartile of hourly pay	13.40%	16.30%	18.70%
Proportion of females in lower quartile of hourly pay	86.60%	83.70%	81.30%
Proportion of males in top quartile of hourly pay	34.90%	31.60%	31.70%
Proportion of females in top quartile of hourly pay	65.10%	68.40%	68.30%

*Model Hospital recommended peer groups have been used as a comparator. Data period 2020/21.

4. WHAT HAVE WE DONE TO DATE?

4.1 In recognition of the importance workforce data plays in understanding the performance of the Trust we have successfully appointed an Associate Director of Workforce Systems and Recruitment. This role ensures the accuracy and consistency of workforce data, and together with the Trust Equality, Diversity and Inclusion Lead further interrogates our gender pay gap data to identify areas for improvement.

4.2 We have fully implemented Agenda for Change with the national job evaluation scheme in place to ensure our roles are evaluated against criteria that has been rigorously tested. The pay system is well-recognised as being an excellent example of equal pay for work of equal value.

4.3 The Trust Board have received a development session which focussed on Equality, Diversity and Inclusion. This session explored the importance of equity across all equality groups including; age, disability, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Trust EDI lead delivered a participative workshop enabling the Trust Board to strengthen knowledge and understanding of their individual and collective responsibilities in relation to our Public Sector Equality Duties. A further session is planned for 2022 including the themes of unconscious bias, the importance of values based leadership and updates on the Trust EDI work plan and strategy refresh.

4.4 To celebrate International Women's Day during 2021 some of the Trust's senior female consultants developed a free on-line health awareness session in partnership with the Health Tree Foundation. Additionally, the Trust shared information with our staff to promote equality and the 'Choose to Challenge' International Women's Day 2021 theme.

4.5 We have an equality impact assessment process for our policies and service changes to ensure we do not discriminate; we advance equality of opportunity and we foster good relations between all equality groups. In particular we have a number of family friendly policies which support flexible working, maternity and paternity, parental and adoption leave. We also have a new Health and Wellbeing Strategy, implementation plan and participation in the second NHS EI trail blazer pilot centred on enabling equal access to health and well being interventions.

4.6 Early discussions are taking place to introduce a Women's Staff Equality Network and to celebrate International Women Day 2022 we are currently planning a half day women's development conference.

4.7 The Trust has a very successful virtual Menopause staff equality network which has more than 200 members of staff.

4.8 Whilst the actions at 4.6 and 4.7 do not directly influence our gender pay gap disparity they do indirectly positively enhance our employee proposition for our female workforce.

5. NEXT STEPS

5.1 Gender Pay Gap report will be published on the Trust's website and the government's online reporting service as legally required.

5.2 We will continue to implement the Trust's Equality, Diversity and Inclusion work plan to ensure we meet our legal and contractual responsibilities, and to meet our social and fairness responsibilities as a large employer and healthcare provider. This work plan will incorporate the actions identified within this report.

5.3 The EDI Lead will monitor the diversity workforce data in relation to recruitment, retention, employee relations, access to training and the overall make-up of the Trust's workforce in relation to diversity. This data will be reported into the forthcoming Culture Transformation Working Group (CTWG) which will meet monthly to facilitate the Trust-wide culture change agenda. The CTWG will report quarterly to the forthcoming Culture Transformation Board, accountable to the Trust Workforce Committee for the delivery of our Culture Transformation agenda. Proactive action will be taken where the data is disproportionate.

5.4 We will continue to work with other NHS Trusts via the Yorkshire and Humber regional equality, diversity and inclusion leads group to learn from best practice and explore opportunities to develop joint activities.

5.5 The gender equality action plan, as can be seen in Appendix 1, has been reviewed and refreshed in line with our 2021 gender pay gap data and will be

monitored by the forthcoming Equality, Diversity and Inclusion Steering Group. The EDI steering group will feed its reporting into the CTWG.

6 CONCLUSION

6.1 Whilst we can see slight improvements in both the Average and Median pay compared to the last two years this improvement is small and potentially very fragile due to the narrow margins. It can be seen that we have a large female workforce (80.41% female) but the upper pay quartile disproportionately favours male staff. The improvements shown links to females moving up pay spines within their pay bands whilst many male staff are already at the top of their pay bands. This suggests we need to do more work in the area of female staff progression and recruitment.

6.2 Due to a disproportionally high number of male consultants compared to female consultants, we made 115 Clinical Excellence Awards (CEAs) to males, compared to only 33 CEAs to female consultants. As stated at 3.10 above, a large proportion of bonus payments made in 2021 were in relation to CEAs. Bonus payments made during the reporting year 2020-21 also include back pay for CEA payments from 2014-18 and 2018-21; therefore 2021 saw a higher number of CEAs awarded compared to previous reporting years.

7 RECOMMENDATIONS

It is recommended that the Trust Board:

1. **Note** the contents of this report and its data;
2. **Note that** the results, as set out in Section 3, have been submitted on 30th March, as approved by the Workforce Committee, on the Trust's website and to the government portal as required;
3. **Support** the next steps and actions to reduce the Trust's gender pay gap as monitored through the Workforce Committee.

Gender Action Plan 2021/22

Introduction

Northern Lincolnshire and Goole NHS FT is committed to reducing our gender pay gap and this is our 5th publication against this standard. April 2017 saw the introduction of the Government regulation setting out the requirement for public sector bodies in England with 250 or more employees to publish their gender pay and bonus gap. Northern Lincolnshire and Goole NHS FT, as an organisation that employs more than 250 people, has met our legal requirement of submitting gender pay gap data to the Government for five consecutive years.

For the 2021 result's we have produced an action plan that builds on some progress but also recognises that more work is required to narrow the gender pay gap. It provides detail on work planned to advance gender equality more generally. The action plan below has been developed into three themes to reflect the Trust's People Strategy.

NLaG People Strategy

- Workforce
- Culture
- Leadership

Monitoring and Evaluation

The action plan will be monitored by the Equality, Diversity and Inclusion Work Plan and the Culture Transformation Working Group on a quarterly basis, and through the Trust Board for end of year assessment and evaluation.

Gender – Action Plan 2021/22

No	Objective	Specific action	Lead	Timeline	Relevant Workforce Gender Data 2021	Indicators of improvement	Progress
1.0	**Workforce**						
1.1	**Ensure that recruitment and selection practices are inclusive for all prospective applicants regardless of gender**	Analyse recruitment data to explore drop-out rates by roles and service areas Identify reasons and trends for drop outs (all equality groups) Review and analyse inclusivity of recruitment materials (including where adverts are placed).	ADWS &R /EDI Lead EDI Lead EDI Lead / H of E	July 22 July 22 July 22	Average gender pay gap (mean): 32.36% Men: £20.23 Women: £13.68	Following EDI and Unconscious Bias training, all selection panels will be inclusive and EDI compliant. We aim to have gender representation on all Recruitment and Selection panels. Workplace Disability Equality Scheme (WDES) Workplace Race Equality Scheme (WRES) Equality & Diversity System 2 (EDS2) Gender pay gap report.	The median and mean pay gaps have reduced compared to 2020. Recruitment data is being reviewed to ensure that meaningful analysis can be undertaken. Adverts have been updated to include an inclusive statement. All job descriptions and person specifications to be reviewed to ensure that criteria are inclusive. All recruitment literature has been reviewed to ensure it is inclusive.
1.2	**Ensure policies are in place to support a diverse and inclusive**	For all newly created jobs and for all individual requests we will commit to	EDI Lead	August 22	Average gender pay gap (mean): 32.36%	Flexible working policy usage monitoring. Equality Impact	Flexible working policy in place.

No	Objective	Specific action	Lead	Timeline	Relevant Workforce Gender Data 2021	Indicators of improvement	Progress
	culture – linked to gender equality	exploring opportunities for more flexible or alternative shift working across the organisation. For all newly created jobs and for all individual requests we will commit to exploring whether flexible working could be introduced into a wider range of roles, including at a senior level.	EDI Lead	August 22	<table><tr><th>Men</th><th>Women</th></tr><tr><td>£20.23</td><td>£13.68</td></tr></table>	Assessment	
1.3	To hold comprehensive workforce data on all protected characteristics for staff	The intention is for the recently reenergised Equality, Diversity and Inclusion Steering Group to monitor the workforce data in relation to: Applications/ Shortlisting/ Recruitment Pay and reward	ADWS &R /EDI Lead	April 22	Average gender pay gap (mean): 32.36% <table><tr><th>Men</th><th>Women</th></tr><tr><td>£20.23</td><td>£13.68</td></tr></table>	The following mandated and published work programmes benefit from equality monitoring data Workplace Disability Equality Scheme (WDES) Workplace Race Equality Scheme (WRES)	Standard reporting templates under development

<table>
<tr><th>No</th><th>Objective</th><th>Specific action</th><th>Lead</th><th>Timeline</th><th>Relevant Workforce Gender Data 2021</th><th>Indicators of improvement</th><th>Progress</th></tr>
<tr><td></td><td></td><td>Employee relations case work
Access to training & development
Staff satisfaction. In addition WRES and
WDES data will continue to be presented at Workforce Committee

Monitor the make-up of the Trust's workforce in relation to all protected characteristics via the annual Equality and Diversity Report and to complete mandated reports to NHS England

To explore equality of access to</td><td>

EDI Lead

EDI Lead</td><td>

August 22

August 22</td><td>

Average bonus gender pay gap (mean): 49.49%

<table><tr><th>Men</th><th>Women</th></tr><tr><td>£7,280.07</td><td>£3,677.42</td></tr></table></td><td>Equality & Diversity System 2 (EDS2)

Gender pay gap report

NHS staff survey

As above</td><td></td></tr>
</table>

No	Objective	Specific action	Lead	Timeline	Relevant Workforce Gender Data 2021	Indicators of improvement	Progress
		leadership programmes for clinical / medical staff (all equality groups)	EDI Lead				
2.0	**Culture**						
2.1	**Staff work in an environment free from bullying, harassment and discrimination**	Develop a culture of dignity and respect for all staff which includes any behaviour considered to be disrespectful as a result of gender Unconscious Bias Training Package Design and deliver a range of knowledge, skills and awareness programmes focussed on	EDI Lead EDI Lead EDI Lead	Monthly events March 23 April 22		Fewer cases of conflict/ harassment going through formal processes (WDES, WRES) Staff are aware of Health and Wellbeing support and feel comfortable accessing it Staff feel confident about reporting incidences of bullying and harassment regardless of gender (NHS staff survey)	Monthly staff engagement events to support equality, health and wellbeing, and FTSU.

No	Objective	Specific action	Lead	Timeline	Relevant Workforce Gender Data 2021	Indicators of improvement	Progress
		strengthening inclusion and reducing exclusion, equipping staff with the skills to explore and understand difference. These modules will be included in the culture transformation and leadership development work 2022/23.					
2.2	**Examine gender issues experienced by staff to improve staff experience and increase retention**	Launch a Women's Staff Equality Network Host a Women's Network Event to promote female leader on International Women's Day (8th March)	EDI Lead EDI Lead	April 22 March 22		NHS staff survey NHS staff survey	Menopause virtual network in place 200+ members

No	Objective	Specific action	Lead	Timeline	Relevant Workforce Gender Data 2021	Indicators of improvement	Progress
3.0	**Leadership**						
3.1		Create an Equality, Diversity and Inclusion Steering Group Develop the EDS2 framework in relation to workforce gender equality (assemble evidence)	EDI Lead EDI Lead	March 22 May 22		Group in place EDS2 Grades (workforce)	
3.2	**To ensure that the Health and Wellbeing Services reflects the gender specific needs of staff**	Refresh the current Equality Impact Assessment (EIA) Policy and Procedure Undertake an Equality Impact Assessment on the Health and Wellbeing Services and ensure that the gender specific needs of staff are met	EDI Lead EDI Lead	July 22 July 22		New EIA system in place	EIA Policy and Procedure in place. New EIA system under development due to be introduced July 22

No	Objective	Specific action	Lead	Timeline	Relevant Workforce Gender Data 2021	Indicators of improvement	Progress
3.3	**To have enabling strategies that support staff to succeed regardless of their gender**	Ensure equality, diversity and Human Rights embedded into all training Monitor take-up of Learning and Development opportunities by protected characteristic, including at events designed to improve learning e.g. conferences, seminars.	EDI Lead EDI Lead	On-going August 22		WRES and WDES, workforce data metrics	

NLG(22)039

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Gill Ponder	
Title of the Report	**Finance & Performance Committee Highlight Report – Finance 18-2-22 and 23-3-22**	
Purpose of the Report and Executive Summary (to include recommendations)	To highlight to the Board the main Finance and Digital areas where the Committee was assured and areas where there was a lack of assurance resulting in a risk to the delivery of the Trust's strategic objectives.	
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Executive Leads
Which Trust Priority does this link to	✓ Pandemic Response ☐ Quality and Safety ✓ Estates, Equipment and Capital Investment ✓ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ✓ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5 April 2022
Report From:	Finance & Performance Committee – 18-2-22 and 23-3-22

Highlight Report:

Month 11 and year to date finances were on track and the Committee was assured that the risk to the achievement of the financial plan for the year was low. However, the Trust continued to significantly overspend on nursing and medical temporary staffing, with a 21% increase on the previous year. Whilst elective activity recovery was strong, the wider ICS performance limited funding that could be earned. Additional TIF/ERF+ income covers Independent Sector contracted activity. Strong CIP delivery has exceeded the stretch target for the year, albeit with 1/3 of the savings being non-recurrent and therefore adding to the challenge next year. Capital was underspent but was expected to be spent by the year end. Late notice allocations of additional capital to be spent in year were more challenging and it might not be possible for all of it to be spent, as it was dependent on suppliers' capacity.

The Committee received a detailed presentation on the 2022/23 operational and financial plan. The TIF capital business case had been supported for improvements to 3 of the 5 theatres submitted, which would increase theatre capacity for recovery of backlogs.

It would not be possible to mitigate all risks to the current draft plan, as some difficult choices would have to be made on proposed investments. Workforce remained a significant risk. The Trust has a draft £32.0m deficit and the ICS has a £140.0m deficit against an expectation of a balanced position. Risks include potential CIP targets of 4%, further impact of pandemic and shortage of investment funding for service improvements. However, the current draft plans financial gap could be reduced if the Trust could deliver increased core capacity to clear backlogs across the ICS and part of levelling up.

Whilst the Trust had met the criteria to exit from financial special measures, obtaining agreement to the 2022/23 Trust and system plan could delay exit if the current Trust and ICS draft financial deficit cannot be mitigated.

It was agreed that the Committee would receive a report from the new Director of Procurement for NLAG, HUTH and York in May on planned improvements to the service, along with a 6 monthly update on progress made after that.

The Committee were assured by progress within the Digital area, but noted the risks to recruitment and retention of skilled staff.

Confirm or Challenge of the Board Assurance Framework:

The Committee discussed the risk ratings for the remainder of the BAF and questioned in February why the rating for SO 3.3.1 would increase from 5 to 20 in 22/23 and 23/24. This reflected the high level of confidence in delivery of this year's financial plan and the considerable risks to the delivery of the targets in 2022/23 and beyond within the funding envelope available. The planned deep dive into this risk was deferred in March to enable the Committee to focus on the 2022/23 operational and financial plan.

Action Required by the Trust Board:

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Name of the Meeting	Trust Board (Public)	
Date of the Meeting	Tuesday 5th April 2022	
Director Lead	Jug Johal – Director of Estates and Facilities	
Contact Officer/Author	Jug Johal – Director of Estates and Facilities	
Title of the Report	**Estates and Facilities Executive Report**	
Purpose of the Report and Executive Summary (to include recommendations)	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.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	✓ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ✓ Estates, Equipment and Capital Investment ✓ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	-	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-	
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

***Board Assurance Framework (BAF) Descriptions:**

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

Facilities Services

	Lowlights	Risks

Commercial Services

Highlights	Lowlights	Risks
• Accommodation configuration adjusted at SGH to support the increase in HYMS Students in the August 22 intake due to relocating tenants in 2-bedded rooms to single bedded. 17% increase in capacity. • Overall Trust activity value rose during the period Sept-Nov, achieving MSP or above. Despite monthly levels falling away from December, there has been an overall improvement of 3% to a current position 5% below the Minimum Services Level • Utilisation of DSA to facilitate instrument repair and purchases through Services Provider realised additional vat recoverable of £3k via invoicing process; • Significant increase in Private Patient demand. Opportunity to target waiting lists if theatre slots are available. • Receipt of £26k credits in quarter from decontamination Services provider; • Confirmation has been received from North Lincolnshire Council (NLC) that the Trust can re-occupy children's centre's for Maternity Services, specifically Barton. • Memorandums of Terms of Occupancy (MOTOs) engrossments have been issued to formalise the Trusts' occupation in NHS PS properties. The Trust has agreed an extension to the Letter of Intent with Breathe Energy for the design (to RIBA stage 4) of the PSDS funded (£40.3m) energy decarbonisation works as we progress towards entering into a works contract (NEC4).	• Still unable to secure a regular weekly/ monthly theatre session which would allow for better planning and performance of Private Patients function. • Demand for accommodation at both sites exceeds supply. • Unable to implement Hybrid working paper. • Minimum Services adjustment payments of £29.7k • Additional payments of £60.4k – inclusive of Instrument purchases via DSA of £23.2k • Late deliveries exceeded Tolerance Threshold at 0.58% monthly average however month on month improvements are sustained Progress on lease arrangements with NLC for the Community Equipment Store remains challenging with NLC seeking to apply additional cost pressures to the Trust.	• Ability to provide surgery slots to meet demand for Private Patients. • If the Trust is unable to provide accommodation this can impact workforce and patient care. • Severe 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 Trust highly unlikely to achieve Minimum Services Level and will result in total adjustment payment of approx. £96k;

Safety & Statutory Compliance

	Lowlights	Risks

ESTATES & ENGINEERING

	Lowlights	Risks

CAPITAL PROJECTS

Highlights	Lowlights	Risks
• Further to the previous update, a number of projects have now successfully completed or are due to complete in 21/22 including: At SGH: new MRI facility; High-Voltage Electrical ring-main installation. At DPoW: Endoscopy 'JAG Accreditation' works; Oxygen system upgrade Phase 1 (two new VIE plants and ring main pipework) & Phase 2 (Ward infrastructure works to C5, C6, HDU, ITU); Fire Alarm replacement works (Phase 2); Removal of the CCU Modular units and associated internal ramp and roof replacement over old ITU; removal of the old MRI equipment and refurbishment of the room for Lung Function use; reconfiguration of Ultrasound rooms; X-ray room 4 installation. • Successful commencement of a number of projects, including the refurbishment of Ward 25 at SGH and preconstruction works for the Gamma Camera project at DPoW. • Continuation of the ED/AAU P22 projects, including: At DPoW: Completion of new multi-storey car park; continuing construction of the new ED building & HV Substation. At SGH: Completion of new multi-storey car park; successful demolition of the former Admin (War Memorial) Building; commencement of the new ED building and HV substation. •	• Impact of Covid-19 on project works on site • Difficulties and delays in recruiting / maintaining sufficient staff to deliver projects effectively and sustainably • Project delays due to supply chain and material shortages, in particular MRI SGH & ED/AAU •	• Supply chain and material resource availability impacting on ability to deliver projects • Ongoing inflationary pressures within the supply chain impacting on ability to deliver projects within budget constraints. • Difficulty in recruiting staff to both permanent and fixed-term roles •

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(22) 041

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	5th April 2022
Director Lead	Ivan McConnell, Director of Strategic Development
Contact Officer/Author	Kerry Carroll, Deputy Director of Strategic Development Claire Hansen, HAS Programme Director
Title of the Report	**Executive Report - Strategic & Transformation**
Purpose of the Report and Executive Summary (to include recommendations)	The attached report provides the Board with an update and overview of our progress against the delivery of: **Strategic Objective 1 - 1.3: To give great care** **Strategic Objective 4: To work more collaboratively** The Board is asked to note: • The progress that is being made on the delivery of the Humber Acute Services critical milestones of both Programme 1 Interim Clinical Plan and Programme 2 Core Service Change • The progress that is being made on the development of a Capital SOC to support major capital investment within NLAG and HUTH • Our continued participation in and leadership of collaborative ventures through partnership working The Board is asked to note that whilst significant progress has been made in the delivery of the agreed milestones for Humber Acute Services there are potentially significant risks to future implementation and delivery: • The handover of Programme 1 (Interim Clinical Plan) to the Operational Teams at the end of March 2022 – to be governed through the Joint Development Board and the Committee(s) in Common • The timing for the approval of the Core Service Change PCBC, and the impact on consultation and implementation, given the changes to legislation for the implementation of the ICS • The risk of not being one of the 30 Trusts selected to submit additional information as part of the New Hospitals Programme
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ✓ Partnership and System Working ☐ Workforce and Leadership ✓ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable

Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ✓ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ✓ Review ☐ Other: Click here to enter text.

Strategic Service Development and Improvement – March 2022
Strategic Objective 1 (1.3) - To give great care
Strategic Objective 4 – To work more collaboratively

- 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 of a Pre- Consultation Business Case (PCBC) for the delivery of new models of care for ***(programme 2) linked to submission of a Capital EOI and Pre SOC (Programme 3) for:***

    - Urgent & Emergency Care
    - Maternity, Neonates & Paediatrics
    - Planned Care and diagnostics

- 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.

	Lowlights	Risks

- Aligning potential models of care to capital to support potential identification of a Preferred Way Forward
- Continued engagement with Doncaster and Lincoln health systems re potential displacement activity and EMAS/YAS in terms of potential pathway changes
- ORH ambulance transport modelling commissioned
- NHSE/I monthly assurance review continue with positive challenge and support
- Evaluation Criteria and Framework approved at Executive Oversight Group and methodology for evaluation supported by NHSEI
- Evaluation workshops x 5 held in March with c126 attendees forming part of balanced room approach to evaluate the potential models of care against the criteria
- Briefing held with Primary Care Humber Collaborative
- Initial draft of enablers section and evaluation outputs of PCBC developed and will be tested by end of March 2022
- Assumptions for P2 and P3 being used as part of acute collaborative modelling of planned care recovery planning

Programme 3 (P3)

- Following submission of Expression Of Interest (EOI), workshops progressed the development of the Capital Strategic Outline Case (SOC) aligned to the PCBC
- 5-10 year modelling progressing with agreed assumptions linking to PCBC
- Finalising potential capital development options to be included in a Strategic Outline Case for capital investment to include:
  - Do minimum options
  - Do intermediate options
  - Do maximum – aligned to Capital EOI submitted on 9th September 2021

- Potential impact on staff who have been engaged in process due to legislation delay – may loose interest and enthusiasm

Partnership and System working

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

Highlights	Lowlights	Risks
Humber Coast and Vale (HCV) Health & Care Partnership: NLaG is an active member of a number of Boards/Groups across the Humber Coast and Vale ICS: • Trust is member of HCV Partnership Board • The Trust is an active member of the Collaboration of Acute Providers Board and other members of the Trust leadership community participate in sub groups • The Trust is an active member of the Community Provider Collaborative • The Trust is actively involved various community collaborative (i.e. Outpatients Transformation, Planned Care Programme, Diagnostics, Urgent & Emergency Care Network, Community Paediatrics) • The Trust COO and Head of Cancer are members of the HCV Cancer Alliance Board • Senior leaders from across the Trust are active participants in HCV Clinical Networks • Linkages and alignment to the ICS Out of Hospital Programme Board and U&EC Network as part of the HAS Programmes. • The Trust is an active participant in the emerging Place Based Partnerships **National and regional networks:** • Members of the Trust Board and Senior Leadership Community are active members of national and regional networks. The Trust is an active participant in Getting It Right First Time (GIRFT) reviews and recently participated in the HCV review of ENT, Urology and Orthopaedics • As part of the HAS Programme the Trust is actively engaged with National and Regional Network and GIRFT leads on Urgent Emergency Care, Maternity and paediatrics and a number of planned care specialties	• Pace of design and development of Place Base Partnerships – at different stages of development • Place Based Boards – lack of clarity of role • Potential delay to the timing of the Health and Care Act by four months	• Aligning the /strategies/ objectives/ priorities of the PCNs to HASR

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee	
Contact Officer/Author	Ellie Monkhouse, Chief Nurse Dr Kate Wood, Medical Director	
Title of the Report	**HTF Trustees' Committee Highlight Report –** 3 March 2022	
Purpose of the Report and Executive Summary (to include recommendations)	The attached highlight report summarises key issues presented to and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 3 March 2022 and worthy of highlighting to the Public Trust Board.	
Background Information and/or Supporting Document(s) (if applicable)	HTF Trustees' Committee Terms of Reference	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5 April 2022
Report From:	Health Tree Foundation Trustees' Committee held on 3 March 2022

Highlight Report:

Annual Report

- The Trustees received and approved the 2020/21 HTF Annual Report, a copy of which has been placed on the HTF website, the NLAG Hub and also a hard copy has been sent to the HTF Patron Sir Reginald Sheffield.

Terms of Reference

- The Trustees approved the annual review of the HTF Trustees' Committee Terms of Reference, a copy of which has been sent to the Trust Board for ratification.

HM The Queen Platinum Jubilee

- The Trustees supported a suggestion from the HTF Charity Manager that HTF could work with NLAG colleagues and create appropriate events to mark the Platinum Jubilee.

Financial Plan 2022/23

- The HTF Charity Manager produced a draft financial plan for the next financial year. Trustees were content but asked for the plan to be developed in further detail for the next Trustees' Meeting.

Confirm or Challenge of the Board Assurance Framework:

Not Applicable

Action Required by the Trust Board:

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

Neil Gammon
Independent Chair of Health Tree Foundation Trustees' Committee

NLG(22)043

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Kate Wood, Medical Director Ellie Monkhouse, Chief Nurse	
Contact Officer/Author	Clare Woodard, Charity Manager	
Title of the Report	**Health Tree Foundation Terms of Reference**	
Purpose of the Report and Executive Summary (to include recommendations)	Minor changes to TOR	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Finance

HEALTH TREE FOUNDATION TRUSTEES COMMITTEE

Membership and Terms of Reference

Reference:	DCT041
Version:	3.2
This version issued:	04/06/21
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	01/06/21
Approving body:	Charitable Funds Trustees Committee
Date for review:	March 2022
Owner:	Lee Bond, Chief Financial Officer
Document type:	Terms of Reference
Number of pages:	7 (including front sheet)
Author / Contact:	Lee Bond, Chief Financial Officer

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
  - Chief Financial Officer
- ~~2 Independent Trustees~~

5.2 In attendance:

- Health Tree Foundation Charity Manager
- ~~Chief Executive~~ Head of Smile Health - HEY 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 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 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.

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).

Appendix A

CHARITABLE FUNDS – DELEGATION LIMITS

1.	Up to £250	Authorisation from Health Tree Foundation Charity Manager
2.	Between £251 - £5,000	As above plus ~~A~~further authorisation from the Fund Guardian
3.	Between £5,001 - £25,000	As above plus ~~A~~further authorisation from Fund Guardian and from either of the Charitable Funds Executive 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.

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Sean Lyons, Chair	
Contact Officer/Author	As above	
Title of the Report	**Humber Acute Services Development Committee Highlight Report & Board Challenge**	
Purpose of the Report and Executive Summary (to include recommendations)	The report presents the highlights from the meeting held on 15 February 2022	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ✓ Partnership and System Working	☐ Workforce and Leadership ✓ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☒ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

***Board Assurance Framework (BAF) Descriptions:**

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

Report to the Board in Public
Humber Acute Services Development Committee held on 15 February 2022

Item: Director Overview Report P2 and P3	Level of assurance gained: Substantial
P2 and P3 engagement plans had been agreed with NHS E/I. 5 Overview and Scrutiny Committees had approved the engagement approach and given positive feedback. Future milestones were discussed along with risks to the delivery of the programme and capital funding. Any delays in the programme could be impacted by the dis-establishment of the CCGs. Communications support to be sought.	
Item: P1 Handover Plan	Level of assurance gained: Substantial
The plan would conclude 31 March 2022. An interim clinical plan has been established for the vulnerable services reviewing workforce and delivery of service. Each specialty had carried out a waiting list stock take, impact assessments, risk assessments and had process mapped their service. Clinical strategies and Lorenzo interface to be aligned with the programme.	
Item: Joint Development Board	Level of assurance gained: Substantial
Work was ongoing with nuclear medicine and the vascular pathways and there were discussions around the Breast Imaging Team joining forces due to the challenging workforce position. MC added that a number of non-clinical areas such as digital, finance, information governance and clinical coding were also working together on strategy development. Linda Jackson and Stuart Hall would oversee the establishment of the 10 key areas.	
Summary by the Chair • A high level risk register to be developed – MC to review with RT • Internal Communications to be increased. Both Boards to be briefed routinely but specifically before the 7th March MP meeting. • Important not to link P1 and P2 programmes for consultation purposes. • PCBC comments to be submitted to IMc by mid March 2022	

NLG(22)045

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Linda Jackson, Vice Chair	
Contact Officer/Author	As above	
Title of the Report	**Strategic Development Committee Highlight Report & Board Challenge**	
Purpose of the Report and Executive Summary (to include recommendations)	Highlights of the Strategic Development Committees held on 10 March and 30 March 2022	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ✓ Partnership and System Working	☐ Workforce and Leadership ✓ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5th April 2022
Report From:	Strategic Development Committee – 24th February and 30th March 2022

Highlight Report:

HASR Programme 1 – A comprehensive update was given in the February meeting on progress to date. It was noted in the March meeting that the handover to the Joint Development Board will be delayed until end of April to support the PMO arrangements being set up by Michelle Cady. It was agreed a further deep dive "post implementation review" into this area of work would be undertaken in the May meeting of the committee to gain assurance on the delivery of the plan and the actual impacts being seen by our patients.

HASR Programme 2 – A comprehensive update was given on this area of work on what is going to be a busy 6-month period. During February and March, the programme has undertaken several key stakeholder briefings and assurance reviews these have included Local Authority Private cabinet briefings for NEL NL ERY and HC Councils. There has also been a further NHSEI Regional Director Review in late February. Feedback from all meetings has been very positive and constructive and key areas flagged are: local service provision, equality of access, travel and transport, digital exclusion and potential displacement of services where services may be more centralized. The next step is the Clinical Senate which is planned for 8th April although work has already started to be shared in advance of this session. Attached is a copy of the current timetable being worked to for information.

HASR Programme 3 – The Trust are not expected to know about the success of the 720m Strategic Capital bid until July 2022. The committee received a detailed update on the various scenarios and potential funding options being considered as part of the SOC development process:

- Do minimum option – upgrade and replace facilities as and when funding becomes available,
- Do intermediate option – adjust the balance of the program to include a higher proportion of retained and refurbished estate and a lower proportion of new builds
- Do maximum option -. Maintain the programme of capital developments set out in the EOI subject to funding
- The committee noted there was also a bid submitted as part of targeted investment monies to support elective recovery of 6.8m for refurbishment of two theatres at DPOW and one at SGH

Strategic Digital Programme – The committee received an update on both the System and Trust digital priorities for 2022/23,along with an update on the digital transformation workstream .It was acknowledged that with NLAG and HUTH already joining up the PAS this year it would seem sensible the next focus area would be looking at the feasibility for one EPR system with HUTH.

Confirm or Challenge of the Board Assurance Framework:

BAF risks will be spit out and reported to the committee from April 2022.

Action Required by the Trust Board:

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

Linda Jackson
Vice Chair / Chair of Strategic Development Committee

APPENDIX A

Milestone	Forecast Date	Issues/ Risks
Evaluation Workshops Finalised	March 2022	Inability to draw conclusions from multiple "Balanced Room" reviews Multiple Options remain for consultation
Capital Evaluation Workshops	March 2022	Provides overview of Do Minimum, Do Medium, Do Maximum – may not get on NHP Programme Need to consider options if not allocated NHP Funding
Finalise PCBC	April 2022	
Clinical Senate Review **Clinical Senate draft report** **Senate Council ratification** **Publication of report**	April 2022 May 2022 July 2022 August 2022	Outcome may challenge clinical models of care – pre briefing and engagement undertaken to mitigate If challenged then need to amend timeline to reflect
NHSE/I Approval of Capital	June/July 2022	If we are in the Top 25 for Capital then we will be required to produce additional documentation and presentations – work to date should support this. If Capital decisions are delayed then we will need to revise PCBC/Consultation and Gateway 2 timelines If we are not in the Top 25 then we need to quickly define alternative funding options and implications on clinical models and options for evaluation
ICS/(B) Board Approval of PCBC	July 2022	Need to ensure early Chair and CEO Designate and Exec Team briefings – commenced
NHSE/I Gateway 2 Review	June/July 2022	Review will cover both PCBC and capital expenditure Need to consider if capital can be decoupled into multiple schemes if funding not approved

		Review will be contingent on Clinical Senate Approval Review Report will require National Approval through NHSE/I
Establishment of JHOSC	June 2022	Cannot be established pre Local Government Elections as membership may change and needs to align to formal approval of ICS/(B) Will have statutory role in review of Consultation Process, Reporting and Decision
Statutory Consultation	September 2022	The Consultation is likely to be a 12 week process Planned for September to avoid Summer Vacation

NLG(22)046

Name of the Meeting	Trust Board - Public
Date of the Meeting	5th April 2022
Director Lead	Christine Brereton, Director of People
Contact Officer/Author (s)	Alison Dubbins, Associate Director of Leadership, Culture and OD Christine Brereton, Director of People
Title of the Report	Development of a Leadership Strategy
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this report and supporting presentation is to share with the wider Trust Board progress made on developing a Leadership Strategy to support the overall culture transformation programme at NLaG. The strategy outlines a Leadership Development model which has been developed over the last 6-12 months, with a range of internal and external stakeholders. The aim of our overarching Leadership Strategy is to focus on 3 strands as follows: 1. ***Foundations in Leadership*** – aimed at new and existing leaders to provide them with core people leadership skills to effectively lead and manage our staff 2. ***Professional Development*** – aimed at supporting and developing leaders through their own professional journey, including talent development/spotting of our future leaders 3. ***Values Based Leadership*** – *Be the Change: Leading with Kindness, Courage and Respect* – aimed at all people leaders and those that influence and improve culture change to lead in line with our values of Kindness, Courage and Respect with a key focus on equality, diversity and inclusion. This will be a continued journey of Pride and Respect. Implementation of the 3 strands of the Leadership Strategy will commence from April 2022 onwards in line with the Trust priorities for 21/22 and 22/23. Implementation of the strategy will be a continual process and each strand will continue to be developed and rolled out as we embed further programmes. This will include further development later in 22/23 of a supporting talent development model. This will also be dependent upon available resources to support. The Trust Board are asked to: • Note the development of the Leadership Strategy and the 3-strand model (outlined in section 5) next steps and priority areas (as outlined in section 8) • Support the overall approach and provide overall sponsorship for its implementation through the Workforce Committee and Trust Board • Monitor its effectiveness through developing People metrics through the Workforce Committee and Trust Board.

Background Information and/or Supporting Document(s) (if applicable)	The Trust priorities for 21/22 outline under priority 2 – Workforce and Leadership as follows: …we will "scope out our ***Leadership Development Framework*** to enhance the capabilities of clinical and non-clinical leaders at all levels". The Trust priorities for 22/23 will also focus on continued culture change and leadership development.	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Workforce Committee
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	The financial implications for this. have been factored into the business planning round for 22/23.	
Implications for equality, diversity, and inclusion, including health inequalities (if applicable)	The value-based Leadership Programme (strand 3) will focus on bringing our values of Kindness, Courage and Respect to life and follow on from the work started from the Pride and Respect Campaign. The programme will be designed with EDI at its core and will outline the expected behaviours, responsibilities and ownership of equality and diversity of our leaders.	
Recommended action(s) Required	☐ Approval ✓ Discussion ✓ Assurance	✓ Information ✓ Review ☐ Other: Click here to enter text.

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1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

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EXECUTIVE SUMMARY

Effective Leadership within the NHS and locally within NLaG has never been more important than it is right now, the effects of the ongoing pandemic and emerging recovery plans alongside the ever increasing people challenges including nursing and medical workforce shortages, health and wellbeing and staff morale are evident across the NHS.

The National NHS People Plan, our own Trust priorities and People Strategy highlight the important of developing effective and sustainable Leadership to lead us through these ongoing turbulent times.

The Trust priorities for 21/22 outline under priority 2 – Workforce and Leadership as follows:

…we will "scope out our Leadership Development Framework to enhance the capabilities of clinical and non-clinical leaders at all levels".

This priority will continue in the Trust priorities for 22/23 will also focus on continued culture change and leadership development and references as follows:

…...designing and implementing a 3-strand Leadership Development Strategy focused on developing our emerging and existing leaders which includes: Leadership Core Skills, Career Development, and a Values Based Leadership programme centred on Kindness, Courage and Respect.

During 2021 and early 2022, the People Directorate have been focussed on gathering information on what the Trust currently has in place for its Leadership offer, whether this be for first time leaders or leaders on a professional career pathway. There is evidence that there are some excellent programmes for leadership development in our nursing, medical and corporate divisions. These include external provider programmes such as NHS Leadership Academy offers, apprenticeships and bespoke provider offers. These offers sit across a few divisions.

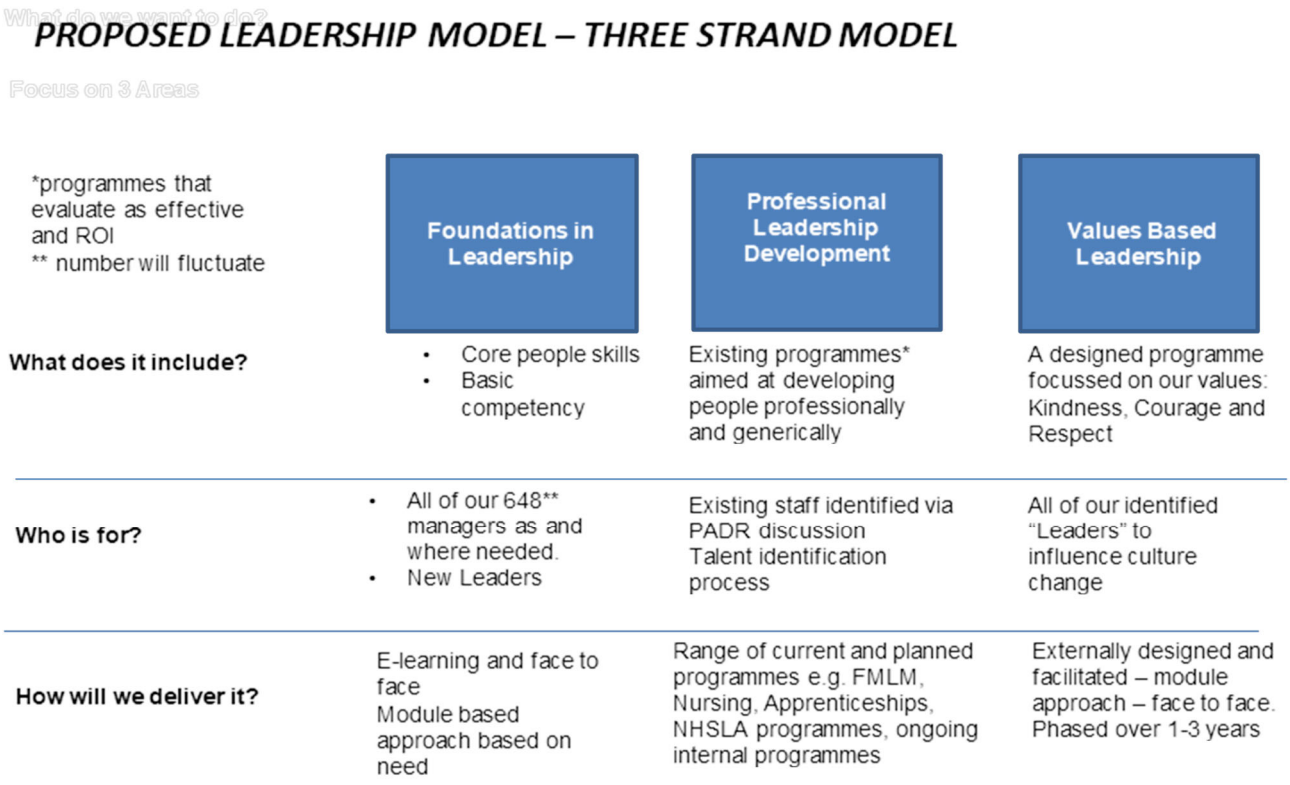
This has also previously been underpinned by the wide-spread delivery of our Pride and Respect Campaign for our leadership community and staff. However, the review has also identified that we need to do more to effectively govern, assess, and evaluate our leadership offer, including how we measure our return on investment and impact.

It is acknowledged that effective Leadership will help the Trust with its ambitions to improve culture and create the right environment for our people to grow and flourish which will assist us in delivering safe and quality services to our patients. Furthermore, we know the impact and effects when poor leadership is not at a play, increased HR cases, increase in negative FTSU cases, poor behaviours and poor Trust reputation resulting in our ability to recruit and retain good staff.

Developing effective leadership which is truly felt by our staff will take time to fully embed but it is important that the Trust begins this journey. Work has therefore commenced to develop a Leadership Strategy which incorporates three main areas.

The aim of our overarching Leadership Strategy is to focus on 3 strands as follows:

1. ***Foundations in Leadership*** – aimed at new and existing leaders to provide them with core people leadership skills to effectively lead and manage our staff
2. ***Professional Development*** – aimed at supporting and developing leaders through their own professional journey, including talent development/spotting of our future leaders
3. ***Values Based Leadership*** – *Be the Change: Leading with Kindness, Courage and Respect* – aimed at all people leaders and those that influence and improve culture change to lead in line with our values of Kindness, Courage and Respect with a key focus on equality, diversity and inclusion. This will be a continued journey of Pride and Respect.



Implementation of the 3 strands of the Leadership Strategy will commence from April 2022 onwards in line with the Trust priorities for 21/22 and 22/23 and will be a continual process and each strand will continue to be developed and rolled out as we embed further programmes. This will include further development later in 22/23 of a supporting talent development model. This will also be dependent upon available resources to support.

The Trust Board are asked to:

- Note the development of the Leadership Strategy and the 3-strand model (outlined in section 5) next steps and priority areas (as outlined in section 8)
- Support the overall approach and provide overall sponsorship for its implementation through the Workforce Committee and Trust Board
- Monitor its effectiveness through developing People metrics through the Workforce Committee and Trust Board.

1.0 BACKGROUND

1.1 The Northern Lincolnshire and Goole (NLaG) People Strategy references:

"In the NHS culture forms the foundation where we can all thrive, feel part of something, and feel professionally and personally fulfilled. Equally a culture which allows this to happen also recognises that as well as being healthcare professionals, we have a diverse range of needs and interests. Creating this culture will make us the 'employer of choice' aiding recruitment of future staff and the retention and job satisfaction of current staff".

1.2 Further, it defines the importance of our leadership development goals for the next year and onwards, within the following context:

"Effective leadership is key in supporting the Trust to achieve its aims and strategic objectives given the challenges faced within the NHS nationally, regionally and locally at NLaG

The people challenges have never been more acute than they are right now, we firmly believe that these challenges will be made easier with "good", effective, and compassionate leadership from our managers and leaders at all levels. We will begin our journey this year to map out our overall approach to Leadership and Management Development with the development of an overall framework setting out clear expectations, whether our leaders occupy a medical or non-medical role.

This will include Board development to lead the way, setting out and demonstrating Leadership from the top. We will combine all our existing leadership programmes under one umbrella framework so that we have clear links and consistency. The results of this will be felt in a positive way by our staff, will impact positively on their health and wellbeing and will help to improve our culture……..".

1.3 As well as the national NHS People Plan and our own NLAG People Strategy, our overall Trust Priority 2 for Workforce and Leadership is clear and states that we will "scope out our Leadership Development Framework to enhance the capabilities of clinical and non-clinical leaders at all levels".

1.4 The Care Quality Commission measure how healthcare provider leadership teams lead their staff under the Well-Led Key Line of Enquiry (KLOE), specifically:

"Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture".

1.5 To support the ambitions outlined in 1.1 - 1.4, the Leadership and OD team within the People Directorate have been focussed in 2021/2022 on:

- Identifying Leadership Development Programmes already in place: identifying what works
- Reviewing and analysing current data on Leadership temperature, i.e. staff survey
- Seeking feedback from Leadership Community on Leadership needs at different levels
- Engaging with external facilitators to draw up proposals for a framework
- Costing out and seeking approval on next stages

1.6 The role inclusion plays in this strategy must not be overlooked and will be central to our Value Based Leadership Programme. Recognising and addressing poor behaviours at all levels including our leaders, ensuring that our staff feel valued and included is what will help us to shape a culture that NLaG can be proud of.

2.0 PURPOSE

2.1 The purpose of this report is to outline and define a leadership and career development strategy for the Trust, reflecting the current, emerging and anticipated future needs of the Trust's leadership community in the next 3 years whilst building towards a longer term vision for culture and leadership development.

2.2 The content of the approach set out in the paper reflects the priorities articulated in the NHS People Plan centred on the development of leaders able to influence, shape and drive forward a culture of patient-centred compassionate leadership both clinically and non-clinically, thus assuring we are leading optimally engaged teams in the delivery of safe effective patient experience. Additionally, the curation of a compelling, innovative leadership development proposition and its attendant influence on the growth of a healthy, inclusive, career enriching culture staff want to commit to upholding and nourishing, will strengthen another of our Trust People Strategy aims for the Trust to become a preferred employer in the region.

2.3 This paper will mainly focus on two sections:

1. To set out an ***overview of current leadership & talent development offer*** at the Trust, and establish how if, we get a return on investment.

2. To set out plans for the ***introduction of a 3 strand Leadership Model*** which includes focus on foundations of leadership, professional development as leaders and value-based leadership to support our culture transformation and EDI agenda.

3.0 THE IMPORTANCE OF EFFECTIVE LEADERSHIP AT NLaG

3.1 Before we commence design work on building 'advanced' leadership capability in any of these management and leadership communities, it's prudent at this juncture to reflect on any and all contributing factors influencing and shaping current leadership style, practice, competence and behaviours across the Trust. It will be important for us to first take stock of our baseline, foundational, people management skills at all levels.

3.2 The division between 'what' we do and 'how' we go about doing it is largely overlooked in leadership development strategy and attendant development programmes. We focus on the academic models of leadership technique, but we don't transfer this into leaders learning how to apply this new knowledge.

3.3 We know that leadership style ('how' leaders apply their knowledge and skill), is an influential factor in shaping organisational culture.

3.4 If we want to improve our culture at NLaG to improve our staff experience, we will need to continue to build highly skilled, consistent, fair, just and transparent application of people management practice including working knowledge of people management policies and procedures across our people leader staff groups, (the 'what') *and* develop the skills in the application of this knowledge (the 'how'). Put simply, a manager who understands the steps for managing sickness absence will execute them efficiently. A manager who understands how to translate the policy into compassionate conversations,

coaching, proactive wellbeing management, and inclusive relationship management, will lead their staff member through a period of sickness absence effectively.

3.5 We know from the casework that manifests within the HR Employee Relations function that line managers currently have patchy, inconsistent understanding of, and skill in applying, our people policies and procedures. When a line manager attempts to have a difficult conversation about a complex performance issue, from the position of good intention with a member of staff, broadly, one of two outcomes tend to emerge, or both:

- The member of staff 'feels' bullied or harassed
- The line manager 'feels' vulnerable, anxious, misunderstood and/or out of their depth

What tends to unfold is:
- The member of staff raises a bullying and harassment claim, and
- The line manager is held to account for their clumsy style, being erroneously assessed as intentionally aggressive or harmful

3.6 This has resulted over time in a culture of fear and blame, with little to no latitude for 'learning or making mistakes as we learn'. This prevailing lack of permission to get things wrong and time to set things right has driven staff towards our Freedom to Speak up channel, unhelpfully and unintentionally creating a culture of helplessness, low levels of resiliency and at worst, "You have hurt me, I will hurt you back".

3.7 Unfortunately this then creates the perfect conditions for line managers to be reluctant to apply policy and procedure when they should, for fear of falling foul of the investigative process and an absence of time and support to put things right and learn from mistakes, in the spirit and principle of a just and learning culture.

3.8 This doesn't negate the fact that every organisation has a small percentage of line managers who may use the application of policy and procedure as a blunt instrument, and a small percentage of staff who will use the complexities of the investigative process to achieve an outcome beneficial to themselves, often at cost to those they make allegations against.

3.9 No one comes out of these processes emotionally or psychologically unharmed. In fact, residual sensitivity to being further deprived of compassionate and collective commitment to helping each other be better, whether leaders or not, results in heightened anxiety and a hair trigger tendency to misinterpret future behaviours.

3.10 The baseline foundation knowledge (the 'what') and skills (the 'how') we should focus on strengthening to address these influences are:

- equip all line managers with understanding and skill in applying people policies and procedures, specifically:
  - recruitment technique
  - grievance and disciplinary
  - sickness absence management
  - welfare and wellbeing conversations
  - performance appraisal and development conversations
  - behaviour based performance coaching conversations
  - coaching skill
  - difficult conversations & de-escalating tensions
- equip all staff with the knowledge and skills to be able to navigate their way optimally through their NLaG careers, specifically:

- an understanding of what constitutes personal resiliency and why it's unique to individuals
- increased empowerment to hold themselves accountable for their behaviour's vis a vis the Values framework and a clear delineation of 'what good looks like'
- a healthy understanding of the role that coaching and feedback play in developing a capable, competent workforce, and making these characteristics of being led and managed commonplace and enabling instead of rare and punitive
- the ability to have performance/behaviour based/difficult conversations, apply personal resilience, and achieve enabling outcomes to improve

3.11 The key organisational mind-set shifts required to support this work are:

- The senior leadership teams being prepared to commit to supporting line managers when they address people issues, and creating the capacity within operational structures for line managers to undertake these aspects of their roles qualitatively
- Acknowledging that before things start to improve, they can get worse for a short period of time, and holding this tension with courage
- The HR processes, whilst fair, transparent, and equitable, ensuring that the originating problem does not remain unaddressed through complex casework processes, robust union challenge and a tendency to fix fast but not sustainably.
- The development of a Just and Learning culture orientation and practices
- Both the unions and leadership teams establishing collaborative trust and preparedness to work together to support line managers in addressing people issues together (a learning culture with a supporting framework to ensure individual processes are quality checked for consistency)

3.12 Whilst we continue to prioritise cost over investment, and 'fast fix over slow gain' we will continue to apply our HR and OD resources and energies on reactive, task focused transactional solutions to symptoms to demonstrate that we've addressed issues, when in fact we are not addressing the underlying causes which are often more complex, centred essentially around people leader absence of skill and clumsy management of process, and take longer to address (e.g. behaviour change, performance coaching, skills uplift etc.).

3.13 If we would like to see real differences in the margins we currently report through the national staff survey and people pulse check around culture, leadership, engagement and wellbeing, we need a shift towards being prepared to move slowly, collaboratively, and with a proactive longer term focus on enabling our managers and teams to embrace, practice, and sustainably change/improve behaviours to live our values of Kindness Courage and Respect. This is slow work. If focused on being prepared to change 'how' we do what we do. No amount of fast, task-based action will enable sustained long-term behaviour change and culture shift.

3.14 The two key themes nationally *broadly* arising from the last National Staff Survey 2020-21 were Leadership and Wellbeing.

3.15 The recent publication of the NHS England NHS England » The future of human resources and organisational development cited Leadership and Culture as being pivotal to ensuring we continue to invest in and develop system and local leadership equipped with the expertise to nurture and curate cultures of compassion, inclusion, engagement and value in a changing healthcare climate where competing for and keeping clinical and non-clinical talent will be increasingly challenging.

3.16 At a recent NSHEI-led staff engagement event, John Drew, NSHEI Director for Staff Engagement and Health and Wellbeing stated that “Staff experience is a better measure of how we’re performing, more so than meeting our financial controls”.

3.17 The research the Hay Group did in 2011 for the development of the Healthcare Leadership Framework (HLF 360) articulated the connection between the underpinning competencies required in effective leadership and their direct influence on organisational performance, patient experience and health outcomes. The Model Employer (https://model.nhs.uk/home) framework sets out these underpinning leadership competencies with associated performance metrics).

3.18 It is the intention of the forthcoming Trust Culture Transformation Board and Working Group (subject to Trust Management Board-TMB sign off) to use these metrics as our baseline Power BI model for measuring staff engagement, alongside the National Staff Survey, the Quarterly People Pulse Check, and a range of local engagement activities including Staff Network, Patient Safety Advocate, Volunteer and other colleague groups inputs.

4.0 OUR CURRENT LEADERSHIP OFFER

4.1 The Trust has a number and variety of leadership / clinical leadership themed development programmes in various stages of development, implementation, and revision, set out in table 1 below. These include external provider programmes such as NHS Leadership Academy offers, apprenticeships and bespoke provider offers. These offers sit across a few divisions.

4.2 Whilst several of the schemes and programmes have benefited individuals, they currently lack overarching governance, oversight, curatorship, financial management and consistent return on investment analysis.

4.3 Below is a table setting out the range of current programmes both internally commissioned and accessed through external provision. Work has already commenced to understand the quality, value, and full return on investment of these programmes. It will be essential to bring all of these programmes of work collectively together and to ensure that the Trust has a collective understanding and “grip” on what is offered, where, and to whom and what the Trust can seek to gain in return.

Table 1:

Leadership Category	Programmes
Pathway to Management **(Newly Recruited/existing/moving to new managerial role)**	Corporate Induction
	Manager Development Modules: • HR • Finance • Governance & Risk
	Healthcare Leadership Framework – Self Assessment
	Mentor
Aspiring Leader/Team Leader (Band 4/5)	People Leader Induction
	Access to OLM E-Learning packages and short courses
	Manager Development Modules: • HR • Finance • Governance & Risk
	Self-Assessment – Healthcare Leadership Model
	Leadership & Management Apprenticeship – Level 3
	Edward Jenner – NHS Leadership Academy Leadership Foundation Award
First Line Manager (Bands 5/7)	People Leader Induction
	Mentor
	Manager Development Modules: • HR • Finance • Governance & Risk
	Access to OLM E-Learning packages and short courses
	Self-Assessment – Healthcare Leadership Model
	360 LQF
	RCN – Clinical Leadership Programme (Introduction)

	Leadership & Management Apprenticeship – Level 5
	NHS Leadership Academy Mary Seacole Programme (First Leadership Role)
Middle Manager (Band 7/8b)	Management Induction
	Coaching
	Access to OLM E-Learning packages and short courses
	Self-Assessment – Healthcare Leadership Model
	Healthcare Leadership Model – 360-degree Feedback
	Leadership & Management Apprenticeship – Level 7
	NHS Leadership Academy Elizabeth Garrett Anderson Programme
	RCN Clinical Leadership
	RCN – Developing Leadership
	Medical Leadership
	Action Learning Sets
Senior Manager (Band 8b and above)	Management Induction
	Access to OLM E-Learning packages and short courses
	Healthcare Leadership Model – 360-degree Feedback
	Board Programmes
	System Leadership Programmes
	NHS Leadership Academy – Nye Bevan Programme
	RCN System Leadership
	Medical Leadership
Executive & Non-Executive Director	Management Induction
	Aspiring CEO Programme

	Board Development Programme
Access to support Diversity and Inclusion	All above relevant to role
	Stepping Up, BAME, Helping Develop Leaders
	Ready Now, BAME, Senior Leaders
	Coaching / Mentoring

4.4 In summary, whilst there is lots of choice, the overall offer is patchy and benefits the few and not the many. Further, the current offering will benefit and support those that wish to engage and develop (the competent). Our approach needs to be wider and more inclusive. Our offer needs to support our leaders in recognising that they have a responsibility to develop their own leadership skills every bit as much as their professional skills. The Trust needs to support that by providing the right development opportunities and environment to grow.

4.5 Finally, the current offering concentrates in a large part on developing professionally individually. We need an offering that helps to collectively grow our leaders to support a culture shift and inclusive organisation.

5.0 OUR DEVELOPING LEADERSHIP MODEL

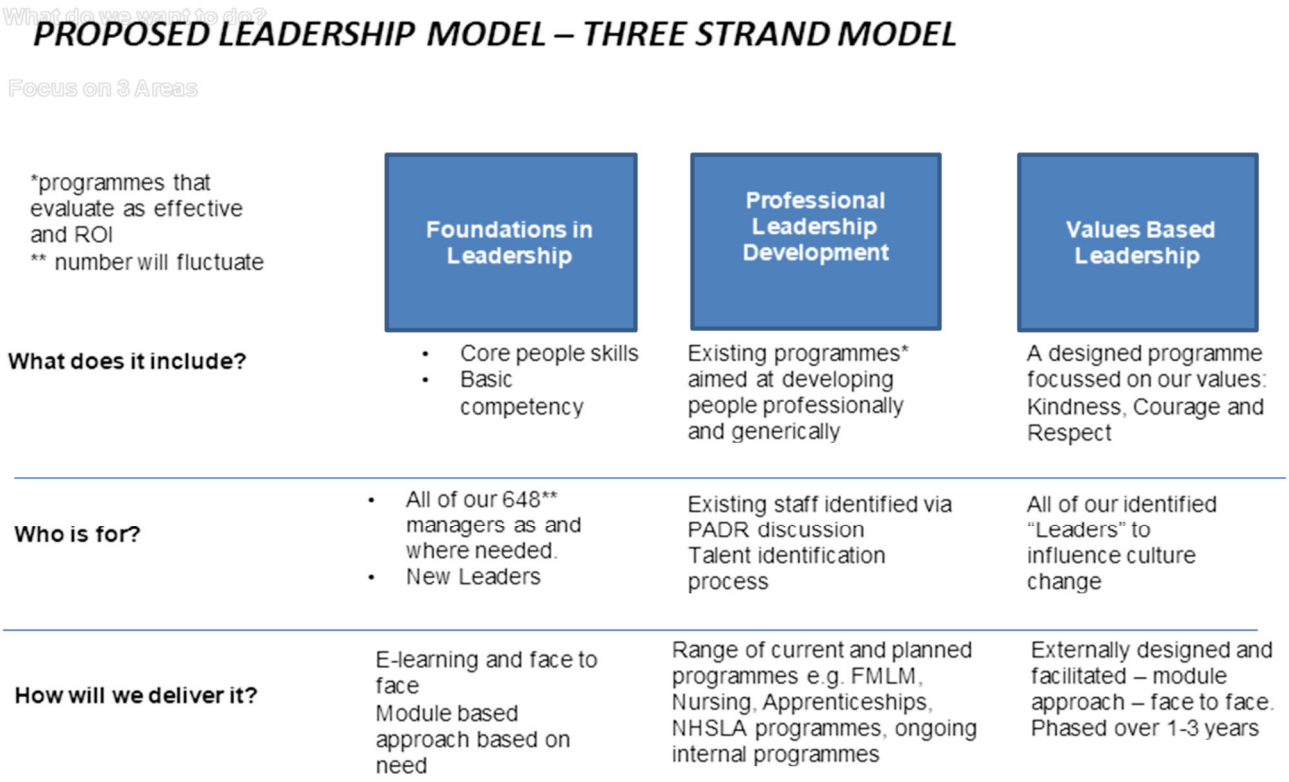
5.1 Firstly, we recognise that in developing an overall strategy for Leadership there are different key component parts that will be needed. Firstly, we mustn't underestimate or assume that our existing leaders have the skills, competence, or confidence to carry out this aspect of their role (as defined in section 3 of this report). We acknowledge that leaders are often recruited due to their technical competency rather than their leadership skills. We therefore need to address this potential shortfall with a programme for new and existing leaders on the ***Foundations of Leadership***, whether this is how do something, or developing and learning the skills to do it. This will be about providing them with core people skills. Our staff deserve this.

5.2 Secondly, we do not want to suddenly remove all of the current ***Professional Leadership*** courses/programmes that are currently in place, there are excellent examples across the medical and nursing directorates where programmes have been successful. We want to endorse and enhance them ensuring that the right people continue to access them and that the Trust benefit from them.

5.3 Finally, as a Trust embarking on improving our culture, including diversity and inclusion, we must make our values come alive and this must be driven by our leaders at all levels, starting with, and endorsed by, our Board and senior leaders. Therefore, ***Value-Based Leadership*** is a must.

5.4 To support these needs, we have developed a 3-strand leadership model simultaneously implementing the different component parts, whilst continuing the development the infrastructure that will support it, including coaching and mentoring, talent development and succession planning. Table 2 below: Our 3-strand Leadership Strategy in summary.

5.5 **Leadership Model**



Strand 1 – Foundations in Leadership

This strand will be aimed at developing Core People Leader Skills for new and existing leaders. We will develop a Leadership Core Skills Programme which will outline all the required skills and understanding that we require of our managers and leaders, whether this be around people policies and processes or skills to do them. (e.g. Effective PADR conversations, Managing Sickness Absence, Managing Conflict Resolution, Having Effective Behaviour-focused Conversations.

We will then provide a safe 'amnesty-style' period for existing people leaders to undertake an NLaG Leadership Core Skills Needs Analysis (the Leadership Individual Development Analysis (LIDA)), regardless of seniority/length of service and ask them to self-rate themselves against the required standards. Once they have completed it, we will then ask them to work with our OD Business Partners and Education, Training and Development team to develop a confidential, individual core people leader skills development plan to complete within 2022. This will identify any gaps/areas for improvement for them on a personal level.

Much of filling the gaps can and would be done via E-Learning/online sessions, with possibly some discrete 1:1 coaching where needed. This will require investment in skills in the Education, Training and Development team for the design of immersive blended learning enabling agile access to effective blended and online core skills learning. We will allow our leaders a period to complete their plan so that this can work around their roles and responsibilities.

For some leaders this will be wholescale development, for others, a light touch. It will however, set standards for our leaders at all levels. All new people leaders will complete the LIDA as part of their People Leader Induction period.

Strand 2 – Professional Leadership Development

Section 4 of this report outlined some of the programmes that are already in place for our leaders on a professional basis. There is a wealth of training opportunities from external providers attracting funding and benefiting individuals to grow and develop in their professional fields and as leaders. We would wish to retain this as a strand of work whether this be for medical, corporate, or nursing staff. However, at present we are unable to demonstrate the true return on investment (this is supported by feedback from some of our external providers also). For some programmes there is no definitive understanding on whether they are beneficial for the Trust or how individuals are selected to attend. We need to tighten up our oversight and governance of this for all key programmes and bring them together in one place so we can assess their overall effectiveness. To this end we aim to introduce a set of Portfolio Governance Boards (PGBs). Details are provided further at 5.7.

Stand 3 - Values Based Leadership Development Programme

We want to design, develop and implement a values-based leadership programme **Be The Change – Leading with Kindness Courage and Respect**, for the whole leadership community, whether this be people leaders or those leaders who can influence culture change at the Trust. This will further develop the embedded work and success of the previous Pride and Respect Campaign.

The programme will centre on how, as leaders we turn up, authentically at work as leaders and live our values. This will demonstrate our commitment to improving diversity and inclusion. The programme will be delivered by several modules (potentially four) by external expert facilitators on different subject themes falling from the recently completed and continuing diagnostic 1:1s and focus groups. It would be an expectation that all leaders will attend these programmes.

Work is already underway and during February and March we have engaged with external providers to facilitate an exercise to gather information from a wider range of leaders across the Trust from Board to Ward. This has been done through 121 interviews and focus groups. The purpose is to co-design the VBL programme directly with our leaders. From this we will design and then begin to roll out this programme. We will also aim to develop and introduce a behavioural framework around our values, to further support living our values, for all our staff.

The recommended approach with our current cultural pulse is to populate cohorts by level in the leadership hierarchy, starting with the senior team and working downwards. Additionally, we would also start at the bottom of the hierarchy and run cohorts in parallel, encouraging senior leaders who have attended modules 1-2 of their programme, to co-facilitate the introductory module with the external provider for cohorts of the lower levels of the leadership hierarchy. This is a well-used constructive approach to achieving:

- Psychologically safe spaces for leaders to exercise courage and the vulnerability to stretch outside their own comfort zone with a group of peers
- Reinforced learning for senior leaders as they coach out their own learning to junior leaders
- Deepening their own capacity to and opportunities to practice change by role modelling for others
- Clear support and endorsement of a commitment to culture change from the senior team to junior leadership teams
- Stronger, more effective peer groups post-learning; evidence shows that when groups of people working towards common goals don’t work as well as they could organically, putting them through a shared experience where they have to support each other to achieve the goal strengthens collaborative team-working,

improves the quality of decision making and capacity for resolving conflict sustainably and independently of third party intervention

5.6 **Measuring Impact**

It is important that we effectively manage and monitor all the programmes of work in the three strands, so that we can ensure effectiveness and value of the programmes and more importantly our return on investment. We will through the ongoing development of our people metrics (being developed as a pilot in partnership with NHSEI) develop metrics that illustrate how demonstrable leadership impacts on overall culture change. Section 3.18 of this report also refers to this. This work is already in progress and will support achievement of the Model Employer performance standards.

5.7 **Overall Governance**

To oversee the programme delivery and design of all training (core skills, leadership etc), we intend on introducing **x3 Portfolio Governance Boards (PGB).** Their aim will be to have oversight and governance ensuring we are streamlined and that there is a place (with the right stakeholders across the Trust) to agree, monitor and manage training delivery). The proposed introduction of 3 new multi-discipline stakeholder led governance and decision-making fora will be as follows:

- Talent & Leadership Development PGB (including a Course Approvals Panel)
- Core Skills Development PGB
- Clinical Workforce Development PGB

Further, it is proposed that the Talent and Leadership Development Portfolio Governance Board would provide this governance for our Leadership Strategy, bringing all programmes into a structured NLaG leadership development framework. The Terms of Reference for the 3 Boards are in draft, the next step being to secure executive and senior leader commitment to supporting the Boards through active involvement.

The Talent and Leadership Development PGB will include a sub-committee for the approval of applications for career development, accountable to the Talent and Leadership PGB. This sub committee's remit will be to design, introduce, manage, and report to the PGB on our leadership and career development course applications process. The aim of this function is to provide a transparent, equitable process for all staff to apply for funding and/or non-cost sponsorship to attend development programmes identified through their PADR and discussions with line managers as relevant to either strengthening competence in current role or developing competence as part of our talent development process (yet to be mapped). This sub-committee will be led by the Head of Education, Training and Development, with representatives from all divisions, union colleagues, and our Quality Improvement team. Staff will be able to apply for places on programmes using pre-determined criteria against which all applications will be assessed. Decisions will be evidence based, and closely adhere to the principles of:

- Is this development central to the applicant's ability to perform well in their current role
- Is this development required as part of the Trust's talent development process (through which the applicant has been identified)
- Can the applicant demonstrate clear qualitative or quantitative or both, return on investment for the individual, their team, their department/division, and/or the Trust.

In order for this process to operate effectively, the sub-committee would need to hold responsibility for the allocation of the Support Staff Learning and Development Fund (SSLDF), the Apprenticeship Levy, any additional access to health sector funding, and a ringfenced budget allocation of funds for talent development.

6.0 SUPPORTING INFRASTRUCTURE

6.1 It is recognised that if our Leadership Strategy is to be successful, we will need to embed a supporting infrastructure. This will be as follows:

1. The reinvigoration of a collaborative approach to our ***Attraction and Recruitment Strategy***, strengthening and enriching the employment offer at Northern Lincolnshire and Goole (NLaG), reaching wider clinical and leadership talent pools to consider NLaG as a positive career progression opportunity.
2. The redesign of our ***Performance and Development Review*** (PADR) policy and process to include best practice talent identification (feeding our succession planning approach), the NHSEI compulsory Wellbeing conversation (strengthening our employee engagement agenda), improved objective setting (strengthening clarity of purpose and measurement of performance, a key engagement factor), and a formalised section on development needs contributing to:
3. The refresh and expansion in scope of an annual ***Training Needs Analysis and Planning*** process to include statutory and mandatory demand, core people leader skills demand, and more widely, for all staff, generic core skills demand to ensure we are proactively planning, budgeting, resourcing, and formally committing to an annual plan of annual core skills training activity to maintain required levels of statutory compliance and core skills competence.
4. The refresh of our Trust coaching offer moving to a ***Coaching and Mentoring Community of Practice*** populated with qualified coaches and mentors whose responsibility it will be to maintain their coaching / mentoring knowledge, skills and where required, certifications, within a supervisory model providing assurance to participating staff that they are being coached/mentored within an ethical, professional code of conduct and supervision.
5. The introduction of a ***Culture Transformation Programme, Board and Working Group*** centred on enabling a longer-term shift in staff engagement and employee experience. It's scope of work focuses on addressing current poor levels of morale, inclusion, dignity and respect through a range of staff engagement initiatives and behavioural development programmes of work including response to our national staff survey and quarterly pulse check results, staff networks' partnership working, developing a Just and Learning culture, and strengthening a speak up culture through appreciative enquiry and the avoidance of fear and blame.

7.0 RESOURCE REQUIREMENTS

7.1 The Leadership Development programme will need to be resourced and this has been factored into the Business Planning round for 22/23. Further support on the wider Culture Transformation work will be provided by NHSEI.

7.2 The OD and Education, Training and Development teams will need to be resourced sufficiently to:

- Maintain the same pace of delivery of the above programme alongside implementing the OD components set out at Section 6

- Refresh, develop and deliver (both face to face delivery and the design of immersive, innovative eLearning) core people leader skills modules
- Mobilise the Culture Transformation Board and Programme of work including the refresh of the Equality, Diversity and Inclusion Strategy, delivery of the EDI action plan to achieve compliance with the EDS2 Framework
- Redesign and implementation of the PADR policy, process, and skills to support improved goal setting, performance management, wellbeing management, talent identification and success planning
- Maximise the Apprenticeship Levy in collaboration with the Nursing Division, building accredited career pathways
- Ensure the Trust is compliant in all statutory and mandatory training requiring face to face training, specifically moving and handling, resuscitation, Induction, and the proposed People Leader Induction

7.3 The longer-term development proposals included in this paper will require resource investment to enable implementation and long-term rigorous sustainability, specifically:
- the refresh of core leadership skill solutions
- the values-based leadership development programme
- implementation of our Equality, Diversity and Inclusion strategy and work plan, and attendant shifts in culture towards one of inclusion and wider representation
- maximising use of the Apprenticeship Levy and potentially exploring the viability of moving our Education and Training function to Academy status (longer term)
- a move to immersive blended learning (building our capability and resources to design and implement E-learning solutions as learning moves increasingly towards agile, self-paced, hybrid pedagogical models combining face to face interactions with online content)

8.0 NEXT STEPS

8.1 Below are the proposed milestones to commence implementation of the 3 strands set out above, subject to operational capacity and financial support:

Feb-March 2022	Design Leadership Core Skills Needs Analysis Inventory – LIDA (online checklist model) and purchase the Smart Survey online tool (commenced)
	Conduct Values based leadership programme diagnostics 1:1s and focus groups to draw out collective, generic needs and compile diagnosis of findings to inform design phase of programme content for **Be the Change – Leading with Kindness Courage and Respect**
April + 2022	Compile collective needs analysis from LIDA Inventory; identify economies of scale and group needs by subject and degree of need; update, refresh and where applicable, design new eLearning and face to face core skills modules to address needs on a scale/priority/risk basis (will require immersive and blended learning expertise / resource Publish 12-month calendar of People Leader core skills training modules (E-Learning and face to face)
	Run 1-2 pilot multi-disciplinary cohorts (from top and bottom 5% of senior and junior leaders; 8-10 leaders per cohort) **Be The Change – Leading with Kindness Courage and Respect** leadership programme, evaluate feedback, make relevant modifications and sign off for Year 1 roll out subject to available investment

April 2022+*	Start phased multi-disciplinary roll out of Year 1 **Be the Change – Leading with Kindness Courage and Respect** leadership programme
*	With 648 leaders, we anticipate that it will take approximately 2 years to ensure all leaders complete the 4-module programme at ca 10 participants per cohort on a phased rolling programme (e.g. multiple cohorts running at the same time.

8.2 We will prioritise the following development activities in 2022:

- The Leadership Core Skills Needs Analysis (LIDA) to identify current levels of self-assessed the core people leader skills training needs, informing…
    - The core leadership skills modular programme of blended learning to strengthen people leader competence, reduce ER casework, support organisational culture change, and start to address engagement issues.
    - The strengthening of immersive and blended learning design skill in the ETD function to support these aims
- The refresh of the PADR process in readiness to support the implementation of a structured approach to talent identification and inform investment in advanced leadership development and succession planning through the Leadership and Talent PGB Course Approvals Process
- The Coaching and Mentoring Community of Practice, ensuring we have a fit for purpose, supervisory model for all leadership coaching, including a defined outsourcing process providing assurance that coaches procured outside of the NHS system are qualified, maintain their accreditations and operate within our coaching and mentoring contracting model
- The values-based leadership programme “Be the Change: Leading with Kindness Courage and Respect” is launched, starting with the diagnostics and pilot cohorts early in 2022

9.0 RECOMMENDATIONS

9.1 The Trust Board are asked to:

- Note the development of the Leadership Strategy and the 3-strand model (outlined in section 5) next steps and priority areas (as outlined in section 8)
- Support the overall approach and provide overall sponsorship for its implementation through the Workforce Committee and Trust Board
- Monitor its effectiveness through developing People metrics through the Workforce Committee and Trust Board.

NLG(22)047

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	5 April 2022
Director Lead	Simon Parkes, NED / Chair of Audit, Risk and Governance Committee
Contact Officer/Author	Simon Parkes
Title of the Report	**Audit, Risk & Governance Committee Highlight Report – February 2022**
Purpose of the Report and Executive Summary (to include recommendations)	The attached highlight report summarises the key issues present to, and discussed by the Audit, Risk and Governance Committee at its meeting on 24 February 2022: **1.** **Medical Staff Job Planning Internal Audit Report** – Concern expressed regarding low level of completed and signed off job plans for 2021/22 and potential associated consequences. Referred to Workforce Committee. **For Board to Note.** **2.** **Board Assurance Framework (BAF)** – Trust Board invited to look again at the organisations Risk Appetite and conflicts with existing risk scores. **For Board to note / consider.** **3.** **Losses and Compensations Report** – Generally improving picture (setting aside overseas visitors), however concern expressed at loss of patients possessions and impact on patient dignity. Internal audit review to be considered as part of 2022/23 IA plan. **For Board to note.** **4.** **Mortuary Services** – Positive assurance on progress made since December 2021 Trust Board discussion, except in relation to reviews of CCTV and swipe card access for Goole body store. **For Board to note.** **5.** **Document Control Report** – continuing lack of movement with Trust documents overdue for review. Timely action needed to address. **For Board to note.** **6.** **Salary Overpayments** – Significant increase in Q3. Unacceptable online abuse directed at Trust's Payroll team via NLAG staff Facebook group. **For Board to note.**
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk & Governance Committee Agenda Papers – 24 February 2022
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ☐ Other: Click here to enter text.

Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ✓ Finance ☐ Partnership and System Working	✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ **Oversight of entire BAF process, completion and achievement**
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5 April 2022
Report From:	Audit, Risk & Governance Committee – 24 February 2022

Highlight Report:

1. **Medical Staff Job Planning Internal Audit Report** – The Committee received details of this review and the resulting 'Limited Assurance' opinion. Although the Trust has systems and processes in place for the consistent development of job plans throughout the organisation, concern was expressed regarding the low level of completed and signed off job plans for 2021/22. The Committee discussed the potential risks associated with this issue (incorrect pay, not performing work expected, inappropriate establishment numbers; wrong activity for costing data, etc.). This matter has therefore been referred to the Workforce Committee for further consideration, scrutiny and oversight.

2. **Board Assurance Framework (BAF)** – see BAF section below.

3. **Losses and Compensations Report** – The Committee was pleased to see a generally improving picture over the three reported financial years (when overseas visitors charges are removed from the equation). However, members were concerned that the loss of patient's possessions during their stay in our hospitals could have a significant personal impact on the patient involved e.g. loss of dentures could impact a patients dignity. It was suggested that an internal audit review be considered for the 2022/23 internal audit plan with a view to forming an opinion as to the robustness of controls in place to prevent such losses and the consequences for patients as far as possible.

4. **Mortuary Services** – Further to a report to the December 2021 Trust Board meeting on the Trust's compliance with national guidance on mortuaries and body stores, the Committee received an update in this regard. The Committee was pleased to receive positive assurance on progress made since December with the exception of reviews of CCTV and swipe card access for the Goole body store. It is also now anticipated that the Human Tissue Authority inspection will take place in May as opposed to April 2022.

5. **Document Control Report** – the Committee noted the lack of movement with Trust documents which are overdue for review. The areas concerned need to take timely action to move these documents forward.

6. **Salary Overpayments** – The Committee received the latest report on salary overpayments, and noted a considerable increase in the last quarter with almost 80% of the increase attributed to non-payroll errors (e.g. late notification of reduction in PA's, late submission of termination and pay change forms, incorrect data supplied, etc.). The Committee also heard of instances of the Trust's Payroll team receiving general online abuse through the NLAG staff Facebook group, and the Committee stated that this was unacceptable.

Confirm or Challenge of the Board Assurance Framework:
The Committee considered the Q3 BAF report and, after discussion, agreed to invite the Trust Board to look again at the organisations Risk Appetite and where it is in conflict with existing risk scores, and also consider timelines for how risks will be brought to their target risk score.
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 **Simon Parkes** **Non-Executive Director / Chair of Audit, Risk & Governance Committee**

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	5 April 2022
Director Lead	Simon Parkes – Chair of Audit, Risk and Governance Committee
Contact Officer/Author	Lee Bond – Chief Financial Officer
Title of the Report	**Annual Review of ARG Committee Terms of Reference**
Purpose of the Report and Executive Summary (to include recommendations)	In line with its agreed annual work plan, the Audit, Risk and Governance Committee performed its annual review of its formal Membership and Terms of Reference at its meeting on 24th February 2022. Helen Harris, Director of Corporate Governance was also tasked with reviewing all Trust Board sub-committee ToR to ensure they were standardised, as far as possible, in terms of format and content. The ARG Committee ToR document is also produced in line with the HFMA NHS Audit Committee Handbook (2018). Helen Harris supplied the proposed changes to Sally Stevenson, Assistant Director of Finance – Compliance and counter Fraud who, following discussion with Helen, then incorporated them into the existing ToR document as necessary. Tracked changes are shown on the attached for new narrative or deletions, but are not shown where existing sections have simply been moved around in the document. The key additions to the ToR are at sections 7.4 (Attendance at Meetings) and 7.7.(Decision Making). **The Trust Board is asked to approve the revisions to the Audit, Risk and Governance Committee's Membership and Terms of Reference.**
Background Information and/or Supporting Document(s) (if applicable)	ARG Committee agenda papers from 24th February 2022.
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: ARG Committee
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:**

	☐ 1 - 1.6 **To be a good employer:** ☐ 2	☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Finance

AUDIT, RISK AND GOVERNANCE COMMITTEE

Membership and Terms of Reference

Reference:	DCT122
Version:	1.7
This version issued:	~~10/02/21~~
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	~~02/02/21 / 21/01/21~~
Approving body:	Trust Board / Audit, Risk & Governance Committee
Date for review:	January, 202~~2~~3
Owner:	Lee Bond, Chief Financial Officer
Document type:	Terms of Reference
Number of pages:	21 (including front sheet)
Author / Contact:	~~Lee Bond, Chief Financial Officer /~~ Sally Stevenson, Assistant Director of Finance – Compliance & Counter Fraud / 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 Constitution

1.1 ~~The Audit, Risk and Governance Committee (the Committee) is a standing committee formally established by the Trust Board (the Board).~~

1.2 The Trust has established the Audit, Risk and Governance Committee as a formal sub-committee of the Trust Board. The Committee is responsible for oversight, challenge and assurance, on behalf of the Trust Board.

2.0 Purpose

2.1 The Committee ~~is a non-executive assurance committee of the Board and~~ has no executive powers, other than those specifically delegated in these terms of reference.

2.2 These terms of reference have been produced in line with the guidance contained within the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2018).

3.0 Authority

3.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

3.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3.3 The Provisions in the attached Annex to these Terms of Reference will only come into force at the explicit discretion of the Trust Board; and then only for those periods of time such as it determines to be appropriate in order for the Trust to discharge its functions under its business continuity plans during periods of potentially significant disruption to service delivery.

4.0 Accountability and Reporting Arrangements

4.1 Minutes of each meeting shall be submitted to the next meeting for formal approval and signature by the Chair as a true record of that meeting. The approved minutes will be submitted to the next meeting of the Board for information.

4.2 The Chair shall draw to the attention of the Board (via a highlight report) any issues that require disclosure to the Board, or require executive action.

4.3 The Committee shall report to the Board annually on its work in support of the Annual Governance Statement specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence that shows the organisations

is fulfilling regulatory requirements relating to its existence as a functioning business and the robustness of the processes behind the quality accounts.

4.4 The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The report will also outline its workplan for the coming year.

4.5 The Committee's annual report and workplan will also be submitted to the Council of Governors for information.

5.0 Responsibilities

5.1 General Duties

5.1.1 The Committee supports the Board by:

- Assessing the Trust's overarching framework of governance, risk and control
- Obtaining assurances about the design and operation of internal controls
- Seeking assurances about the underlying data (upon which assurances are based) to assess their reliability, security and accuracy
- Challenging poor and/or unreliable sources of assurance
- Challenging relevant managers when controls are not working or data are unreliable

The duties / responsibilities of the Committee are categorised as the follows:

5.2 Integrated Governance, Risk Management and Internal Control

5.2.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

5.2.2 In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications

- The policies and procedures for all work related to counter fraud and corruption as required by the NHS Counter Fraud Authority

5.2.3 In carrying out this work the Committee use the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers.

5.2.4 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

5.2.5 As part of its integrated approach, the Committee will have effective relationships with other Trust Board Sub Committees (which may include reciprocal membership) to provide an understanding of processes and linkages and particularly to enable review and oversight of the other Sub Committee's governance of risk. This will include the exchange of their chair's action logs and highlight reports to the Trust Board.

5.3 Internal Audit

5.3.1 The Committee shall assure itself that there is an effective internal audit function that meets Public Sector Internal Audit Standards (PSIAS) and provides independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved

- Reviewing and approving the internal audit strategy, the annual internal audit plan and more detailed programme of work, that is consistent with the audit needs of the Trust as identified in the Assurance Framework

- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources

- Monitoring the implementation of agreed internal audit recommendations in line with agreed timescales, and where concerns exist in relation to the lack of implementation in a particular area the Committee can request the relevant operational manager to attend a meeting and give explanation

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation

- Reviewing the Internal Auditor's annual report before its submission to the Board

- Monitoring the effectiveness of internal audit and carrying out an annual review and obtaining independent assurance that Internal Audit complies with PSIAS

5.4 External Audit

5.4.1 The Committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Assisting and advising the Council of Governors in their appointment of the External Auditors (and make recommendations to the Board when appropriate)
- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Establishing a clear policy for the engagement of external auditors to supply non-audit services; and for scrutinising and where appropriate approving uses of, or exceptions to, this policy.

5.5 Financial Reporting

5.5.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

5.5.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

5.5.3 The Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements

- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances

5.6 Risk Management

5.6.1 The Committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks the Committee considers it is appropriate to do so. This will include:

- Reviewing the Trust's information governance and cyber security arrangements, in order to provide assurance to the Board that the organisation is properly managing its information and cyber risks and has appropriate risk mitigation strategies
- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks
- Overseeing actions plans relating to regulatory requirements in terms of the Single Oversight Framework and Use of Resources
- Providing the Board with assurance over developing partnership arrangements (e.g. accountable care organisations) and mitigation of risks which may arise at the borders between such organisations

5.6.2 The Board will however retain the responsibility for routinely reviewing specific risks.

5.7 Counter Fraud and Security

5.7.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud that meet the NHS CFA's standards and shall review the outcomes of work in these areas. The Committee shall receive the annual report and annual work plan from the Local Counter Fraud Specialist, and shall also receive regular progress reports on counter fraud activities.

5.7.2 The Committee shall also receive and review the annual report and the annual work plan from the Local Security Management Specialist. It shall receive other security activity reports as appropriate.

5.8 Management

5.8.1 The Committee shall request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

5.8.2 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit).

5.9 Other Assurance Functions

5.9.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

5.9.2 These will include, but not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g. the Care Quality Commission, NHSE/I, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

5.9.3 In addition, the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular this will include any clinical governance, risk management or quality committees that are established. The Committee shall receive the action logs and highlight reports to the Trust Board of the following Board sub-committees for information:

- Finance and Performance Committee
- Quality and Safety Committee
- Remuneration & Terms of Service Committee
- Workforce Committee
- HealthTree Foundation Committee
- Ethics Committee
- Strategic Development Committee

5.9.4 In reviewing the work of the Quality & Safety Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

5.9.5 The Committee will review Standing Financial Instructions, Scheme of Delegation and those elements of the Trust Constitution (Standing Orders) that provide assurances on the internal management of procurement and financial matters. It will also review the Trust's Standards of Business Conduct Policy.

5.9.6 The Committee will receive and review the Board Assurance Framework (BAF) on a quarterly basis prior to its submission to the Board.

6.0 Membership ~~and Quorum~~

6.1 Core Membership

6.1.1 The Committee shall be appointed by the Board from among the Non-Executive Directors of the Trust and shall consist of not less than three members. One of the members shall have recent relevant financial experience.

6.1.2 The Chair of the Trust shall not be a member of the Committee.

6.1.3 The Trust Board may appoint such Associate Non-Executive Directors as it deems beneficial to add expertise to the Committee and these will be non-voting positions not forming part of the quorum.

6.2 Regular Attendees

6.2.1 The following shall normally attend meetings: ~~Chief Financial Officer and internal and external audit representatives shall normally attend meetings.~~

- Chief Financial Officer
- Director of Corporate Governance
- Internal Audit representative(s)
- External Audit representative(s)

6.2.2 ~~The Trust Secretary Director of Corporate Governance shall normally attend meetings.~~

6.2.3 The Local Counter Fraud Specialist will attend to report upon and discuss counter fraud matters.

6.2.4 An invitation to join the Committee as an attendee in an observer capacity will be extended to a Governor to be identified by the Lead Governor.

~~6.2.4~~**6.2.5** The Chair of the Trust and the Chief Executive should be invited to attend and should discuss at least annually with the Audit, Risk and Governance Committee the process for assurance that supports the Annual Governance Statement. The Chief Executive should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

~~6.2.5~~**6.2.6** Other Executive Directors/managers ~~should~~ may be invited to attend, normally for their items(s) only, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director/manager.

~~6.2.6~~6.2.7 Representatives from other organisations (e.g. NHS Counter Fraud Authority (NHS CFA)) and other individuals (e.g. Local Security Management Specialist) may be invited to attend on occasion.

~~6.2.7~~6.2.8 At least once a year, usually at its ~~May~~ Audited Accounts meeting, members of the Committee shall meet privately with the External and Internal Auditors. Other meetings will take place at the request of members or auditors.

7.0 Procedural Issues

7.1 Frequency of Meetings

7.1.1 The Committee should normally meet at least five times per year at appropriate times in the audit cycle to allow it to discharge all of its responsibilities in line with its annual workplan. Additional meetings, including any focus working group, may be called as required. The Committee will review this annually.

~~7.1.1~~7.1.2 The Committee will maintain a twelve month rolling workplan capturing its main items of business at each scheduled meeting. This will be updated throughout the year as the Committee sees fit.

~~7.1.2~~7.1.3 The Accountable Officer, External Auditors and/or Head of Internal Audit may request a meeting if they consider that one is necessary.

7.2 Chairperson

7.3 One of the members will be appointed Chair of the Committee by the Board.

7.4 Attendance ~~at Meetings~~

7.4.1 Attendance is a minimum of 75% of all Committee meetings for members and regular attendees (as listed at 6.2).

7.4.2 Other regular attendees (as listed at 6.2 must ensure that in his/her absence, a nominated deputy is briefed to present required information and to respond to scrutiny on his/her behalf.

7.4.3 Executive Directors who are unable to attend will arrange for the attendance of an appointed deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend. Formal deputies can attend up to 25% of all meetings.

7.4.4 For joint Trust roles however, such as the Chief Financial Officer or any such role, attendance is required to be 50% of Committee meetings with appointed deputies covering the remainder of meetings.

7.5 Quorum

7.5.1 A quorum shall be two of the three members.

7.5.2 A quorum must be maintained at all meetings.

7.6 Administration and Minutes of Meetings

7.6.1 Agenda items for consideration to be submitted at least twelve calendar days before the Committee meeting.

7.6.2 The agenda for the Committee shall be approved by the Chair of the Committee (or his or her nominated deputy).

7.6.3 Secretarial support (including distribution of agenda and papers to the Committee and noting of apologies) will be arranged by the Chief Financial Officer (or his or her nominated deputy).

7.6.4 The Secretary to the Committee shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

7.6.5 Agenda papers will be circulated to all members of the Committee no less than ~~five working~~seven calendar days prior to each meeting. Late papers may only be circulated, or tabled at the meeting, with the prior approval of the Chair.

7.7 Decision Making

7.7.1 Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.

7.7.2 Where this is not possible then the Chair of the meeting will ask for members to vote using a show of hands, all such votes will be compliant with the current Standing Financial Instructions and Scheme of Delegation of the Northern Lincolnshire & Goole NHS Foundation Trust.

7.7.3 In the event of a formal vote the Chair will clarify what members are being asked to vote on – the 'motion'. Subject to the meeting being quorate a simple majority of members present will prevail. In the event of a tied vote, the Chair of the meeting may have a second and deciding vote.

7.7.4 Only members of the Committee present at the meeting will be eligible to vote. Members not present and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

7.7.5 The Trust's Standing Orders and Standing Financial Instructions apply to the operation of this Committee.

7.7.6 Decisions which are outside of the Scheme of Delegation will be escalated to the Trust Board with the findings and recommendations of the Sub Committee for action at Board level.

8.0 Monitoring, Compliance and Effectiveness

8.1 In accordance with the requirements of good governance and in order to ensure its ongoing effectiveness, the Audit, Risk and Governance Committee will undertake an annual evaluation of its performance and attendance levels.

8.2 The Committee will carry out an annual self-assessment (Appendix A) that is based on the good practice guide found in the HFMA's NHS Audit Committee Handbook.

8.3 As part of the annual evaluation process, the Committee will formally review performance against core duties, completion of the actions outlined in the action log and effectiveness of the work programme.

8.4 Where gaps in compliance are identified arising from this evaluation, an action plan will be developed, and implementation will be monitored by the Committee.

8.5 The results from the annual evaluation exercise, including any agreed actions, will be reported to the Trust Board.

9.0 Review

9.1 The Committee will review its Terms of Reference annually, or as necessary in the intervening period, to ensure that they remain fit for purpose and best facilitate the discharge of its duties.

9.2 It shall recommend any changes to the Trust Board for approval.

10.0 Access to the Committee Chair

The Head of Internal Audit, representatives of External Audit and the Local Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

11.0 Whistleblowing / Freedom to Speak Up Guardian

11.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensures that any such concerns are investigated proportionately and independently.

11.2 The Trust's Freedom to Speak Up Guardian, or his or her nominated deputy, shall attend the Committee at least annually to provide assurance on the design and operation of the function.

12.0 Equality Act (2010)

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

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

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

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

ANNEX

Additional Provisions under Terms of Reference Paragraph 6.3

Under the provisions of paragraph 6.3 of the Committee's Terms of Reference:

(a) The application of the provisions in this Annex is subject to the explicit written prior approval and review of the Trust Board;

(b) References to *"The Period"* in this Annex mean to such period(s) of time as the Trust Board may specify, and;

(c) The provisions in this Annex are additions to the Committee's Terms of Reference and therefore should in no way be interpreted as diminishing the overall remit of the Committee.

"3.0 Attendance at Meetings":

Additional paragraph **3.9** added:

(a) "*During The Period meetings of the Committee may be held on such basis – physical; teleconference and/or videoconference – as may be decided by the Chair of the Committee in consultation with the Chief Financial Officer.*

(b) *Subject to adhering to the requirements for quorum (section 2.0) then it will be a matter for the Chair of the Committee in consultation with the Chief Financial Officer to determine who should be a participant in any Committee meeting during The Period.*

(c) *Notes are to be made of both the attendance at the meeting and of the decisions taken on the items discussed at the meeting for subsequent formal written presentation to the Trust Board monthly.*

(d) *The Chair in consultation with the Chief Financial Officer will maintain a log of those agenda items tabled but not discussed at the meetings during The Period; this will be presented to the Trust Board monthly in writing for information with a statement on the intended action."*

"5.0 Frequency of Meetings":

Additional paragraph **5.3** added:

"During The Period the Committee shall meet with such frequency as may be determined by the Chair in consultation with the Chief Financial Officer and also in order to comply with any revised year-end or other reporting procedures required of it by NHSE/I."

"7.0 Responsibilities":

Additional bullet point added to paragraph **7.1**:

- *"Reviewing the adequacy of the Trust Board's revised arrangements for governance and assurance during The Period; including any proposal to suspend Standing Orders; and making recommendations to the Trust Board in these matters."*

"7.2 Integrated Governance, Risk Management and Internal Control":

The following text added to the final bullet point to paragraph **7.2.2**:

- *"…with a particular focus on the heightened risk for fraud and criminal activity during The Period."*

The following text added to paragraph **7.2.5**:

- *In the absence of the operation of any of the other Trust Board Sub-Committees during The Period it will fall to the Chair of the Committee to maintain regular liaison with those Sub-Committee Chairs in order to remain briefed on any issues that may be of interest to the Committee."*

"7.3 Internal Audit":

The following text added to the end of this section:

"During The Period to agree such revised arrangements with the Internal Auditors (such as the conduct of the work programme for internal audits and follow-ups; and the obtaining of audit opinions, etc.) as may be deemed necessary in the circumstances."

"7.4 External Audit":

The following text added to the end of this section:

"During The Period to agree such revised arrangements with the External Auditors (such as the conduct of annual audit plan; and the annual audit opinion, etc.) as may be deemed necessary in the circumstances."

"7.6 Risk Management":

The following text added as an additional bullet point to **paragraph 7.6.1**:

- *"During The Period any such other matters as the Committee may consider to be relevant in the prevailing circumstances, but in particular in the absence of the operation of any of the other Trust Board Sub-Committees the Committee will assume general oversight of the Sub-Committee-level of the Trust's Board Assurance Framework and report any issues or concerns to the Trust Board*

"7.7 Counter Fraud & Security":

The following text added to paragraph **7.7.2**

"…with a focus on the particular nature of the heightened risk for fraud and criminal activity during The Period."

"7.9 Other Assurance Functions":

The following text added as a new paragraph **7.9.6**:

- *"During The Period and in the absence of the operation of any of the other Trust Board Sub-Committees the Committee may, if considered relevant in the prevailing circumstances, consider such assurance reports as the other Sub-Committees may otherwise have considered and propose a course of action on each."*

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

Appendix A

HFMA NHS Audit Committee Handbook, 2018 – Extract

This checklist is designed to elicit a simple yes or no answer to each question. Where 'no' answers have been given, the issues should be debated to determine if any further action is needed.

Area/Question	Yes	No	Comments/Action
Composition, establishment and duties			
Does the audit committee have written terms of reference and have they been approved by the governing body?			
Are the terms of reference reviewed annually?			
Has the committee formally considered how it integrates with other committees that are reviewing risk?			
Are committee members independent of the management team?			
Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?			
Does the committee prepare an annual report on its work and performance for the governing body?			
Has the committee established a plan of matters to be dealt with across the year?			
Are committee papers distributed in sufficient time for members to give them due consideration?			
Has the committee been quorate for each meeting this year?			
Internal control and risk management			
Has the committee reviewed the effectiveness of the organisation's assurance framework?			

Area/Question	Yes	No	Comments/Action
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?			
Has the committee reviewed the accuracy of the draft annual governance statement?			
Has the committee reviewed key data against the data quality dimensions?			
Annual report and accounts and disclosure statements			
Does the committee receive and review a draft of the organisation's annual report and accounts?			
Does the committee specifically review: • The going concern assessment • Changes in accounting policies • Changes in accounting practice due to changes in accounting standards • Changes in estimation techniques • Significant judgements made in preparing the accounts • Significant adjustments resulting from the audit • Explanations for any significant variances?			
Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?			
Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?			
Internal audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?			
Does the committee review and approve the internal audit plan, and any changes to the plan?			

Area/Question	Yes	No	Comments/Action
Is the committee confident that the audit plan is derived from a clear risk assessment process?			
Does the committee receive periodic progress reports from the head of internal audit?			
Does the committee effectively monitor the implementation of management actions arising from internal audit reports?			
Does the head of internal audit have a right of access to the committee and its chair at any time?			
Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?			
Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*?			
Does the committee receive and review the head of internal audit's annual opinion?			
External audit			
Do the external auditors present their audit plan to the committee for agreement and approval?			
Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?			
Does the committee review the external auditor's value for money conclusion?			
Does the committee review the external auditor's opinion on the quality account when necessary? **[Note: this question is not relevant for CCGs]**			

Area/Question	Yes	No	Comments/Action
Does the committee hold periodic private discussions with the external auditors?			
Does the committee assess the performance of external audit?			
Does the committee require assurance from external audit about its policies for ensuring independence?			
Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?			
Clinical audit **[Note: this section is only relevant for providers]**			
If the committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?			
If the committee is responsible for monitoring clinical audit has it: • Reviewed an annual clinical audit plan? • Received regular progress reports? • Monitored the implementation of management actions? • Received a report over the quality assurance processes covered by clinical audit activity?			
Counter fraud			
Does the committee review and approve the counter fraud work plans, and any changes to the plans?			
Is the committee satisfied that the work plan is derived an appropriate risk assessment and that coverage is adequate?			
Does the audit committee receive periodic reports about counter fraud activity?			

Area/Question	Yes	No	Comments/Action
Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?			
Do those working on counter fraud activity have a right of direct access to the committee and its chair?			
Does the committee receive and review an annual report on counter fraud activity?			
Does the committee receive and discuss reports arising from quality inspections by NHSCFA?			

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Board Assurance Framework - 2021 / 22

Strategic Objective	Strategic Objective Description
1. To give great care	● To provide care which is as safe, effective, accessible and timely as possible ● To focus always on what matters to our patients ● To engage actively with patients and patient groups in shaping services and service strategies ● To learn and change practice so we are continuously improving in line with best practice and local health population needs ● To ensure the services and care we provide are sustainable for the future and meet the needs of our local community ● To offer care in estate and with equipment which meets the highest modern standards ● To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.
2. To be a good employer	● To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: - inclusive values and behaviours - health and wellbeing - training, development, continuous learning and improvement - attractive career opportunities - engagement, listening to concerns and speaking up - attractive remuneration and rewards - compassionate and effective leadership - excellent employee relations.
3. To live within our means	● To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse ● To keep expenditure within the budget associated with that income and also ensuring value for money ● To achieve these within the context of also achieving the same for the Humber Coast and Vale Health Care Partnership ● To secure adequate capital investment for the needs of the Trust and its patients.
4. To work more collaboratively	● To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan ● To make best use of the combined resources available for health care ● To work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally ● To work with partners to secure major capital and other investment in health and care locally ● To have strong relationships with the public and stakeholders ● To work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: - make best use of the human capabilities and capacities locally; - offer excellent local career development opportunities; - contribute to reduction in inequalities; - contribute to local economic and social development.
5. To provide good leadership	● To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk Appetite Statement - 2021 / 22

Context

Healthcare organisations like NLaG are by their very nature risk averse, the intention of this risk appetite statement is to make the Trust more aware of the risks and how they are managed. The purpose of this statement is to give guidance to staff on what the Trust Board considers to be an acceptable level of risk for them to take to ensure the Trust meets its strategic objectives. The risk appetite statement should also be used to drive action in areas where the risk assessment in a particular area is greater than the risk appetite stated below.

NLAG is committed to working to secure the best quality healthcare possible for the population it serves. A fundamental part of this objective is the responsibility to manage risk as effectively as possible in the context of a highly complex and changing operational environment. This environment presents a number of constraints to the scope of NLAG's risk management which the Board, senior management and staff cannot always fully influence or control; these include:

• how many patients need to access our services at any time and the fact our services need to be available 24/7 for them whether we have the capacity available or not
• the number of skilled, qualified and experienced staff we have and can retain, or which we can attract, given the extensive national shortages in many job roles.
• numerous national regulations and statutory requirements we must try to work within and targets we must try to achieve
• the state of our buildings, IT and other equipment
• the amount of money we have and are able to spend
• working in an unpredictable and political environment.

The above constraints can be exacerbated by a number of contingencies that can also limit management action; NLAG operates in a complex national and local system where the decisions and actions of other organisations in the health and care sector can have an impact on the Trust's ability to meet its strategic objectives including its management of risk.

Operating in this context on a daily basis Trust staff make numerous organisational and clinical decisions which impact on the health and care of patients. In fulfilling their functions staff will always seek to balance the risks and benefits of taking any action but the Trust acknowledges some risks can never be eliminated fully and has, therefore, put in place a framework to aide controlled decision taking, which sets clear parameters around the level of risk that staff are empowered to take and risks that must be escalated to senior management, executives and the Board.

The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using their feedback as an opportunity for learning and improving the quality of our services.

The Trust recognises it has a responsibility to manage risks effectively in order to:
• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

Risk Appetite Assessment

Risk Assessment Grading Matrix					
Likelihood of recurrence	Severity / Impact / Consequence				
	None / Near Miss (1)	Low (2)	Moderate (3)	Severe (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6		
Possible (3)	3	6			
Likely (4)	4		12	16	20
Certain (5)	5	10		20	25
RISK	Green Risk Score 1 - 3 (Very Low)	Yellow - Risk Score 4 - 6 (Low)	Orange - Risk Score 8 - 12 (Medium)	Red - Risk Score 15 - 25 (High)	

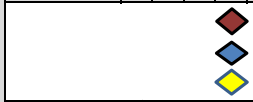
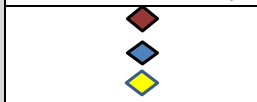
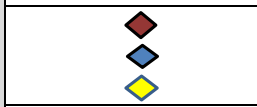
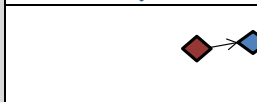
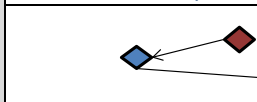
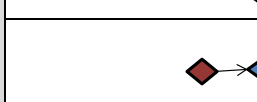
Based on this scoring methodology broadly the Trust's risk appetite is:

• For risks threatening the safety of the quality of care provided– low (4 to 6)

• For risks where there is the potential for positive gains in the standards of service provided – moderate (8 to 12)

• For risks where building collaborative partnerships can create new ways of offering services to patients – moderate (8 to 12)

Strategic Risk Ratings

Strategic Risk	High Level Risk Description	Risk Consequence / Impact Assessment	Risk Appetite	Risk Rating 2021-22 Q1	Q2	Q3	Q4	Target Risk 31.03.22	Owner	Assurance Committee
		Catastrophic 25 / Major 20 18 16 15 / Moderate 12 10 9 8 / Minor 6 5 4 / Insignificant 3 2 1								
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard		Low	15	15	15		15	Medical Director and Chief Nurse	Q&SC
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets		Low	20	20	20		20	Chief Operating Officer	F&PC
SO1 - 1.3	The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy		Low	12	12	12		8	Director of Strategic Development	SDC
SO1 - 1.4	The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate		Low	20	20	20		20	Director of Estates and Facilities	F&PC
SO1 - 1.5	The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care		Low	12	12	12		9	Chief Information Officer	ARG
SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope		Low	16	16	16		16	Chief Operating Officer	F&PC
SO2	The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients.		Low	20	20	20		8	Director of People	WC
SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities		Moderate	12	12	12		5	Chief Financial Officer	F&PC
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital		Moderate	12	12	12		15	Director of Strategic Development	SDC
SO4	The risk that the Trust is not a good partner and collaborator		Moderate	12	12	12		8	Director of Strategic Development	SDC
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives		Moderate	12	12	12		8	Chief Executive	WC

KEY	
	Inherent risk score
	Current risk score
	Target risk score

KEY TO COMMITTEE NAMES

Quality and Safety Committee - Q&SC

Finance and Performance Committee - F&PC

Audit Risk and Governance - ARG

Workforce Committee - WC

Strategic Development Committee - SDC

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.1: To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards nationally.

Risk to Strategic Objective 1 - 1.1: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	3	3	3	3	2
Risk Rating Score	15	15	15	15	10

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment:
1 May 2019

Last Reviewed:
11 January 2022
19 November 2021

Lead Committee:
Quality and Safety Committee

Risk Owners:
Medical Director and Chief Nurse

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy, Risk Management Strategy, Nursing, Midwifery & Allied Health Care Professionals Strategy, Clinical Strategy, Medical Engagement Strategy

Current Controls

- Quality and Safety Committee (Q&SC)
- Operational Plan (approved Trust Board 1/6/2021)
- Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems
- Risk Register Confirm and Challenge Meeting
- Trust Management Board
- Ethics Committee
- PPE Audits
- Quality Board, NHSE/I
- Quality Review Meetings with CCGs
- SI Collaborative Meeting with CCGs
- Health Scrutiny Committees (Local Authority)
- Healthwatch
- Chief Medical Information Officer (CMIO)
- Council of Governors
- SafeCare

Assurance (internal & external)

Internal:
- Minutes of Committees and Groups.
- Integrated Performance Report.
- 15 Steps Challenge.
- Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board.
- Nursing and Midwifery dashboards.
- Ward Assurance Tool.
- Nursing Metric Panels.
- IPC - Board Assurance Framework.
- Inpatient survey.
- Friends and Family Test (FFT) platform.
- Nursing Midwifery and AHP Strategy.
- Risk Stratification Report.
- Board Development Sessions - Monitoring CQC Progress.
- Risk Stratification Report to Q&SC.
- Patient Safety Specialist and Patient Safety Champions Group.
- PPE Audits.
- Health Scrutiny Committees (Local Authority).

External (positive):
- Internal Audit - Serious Incident Management, N2019/16, Significant Assurance.
- Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance.

Planned Actions

Q2 2021/22
- Continue to establish a vulnerabilities team, Aug 2021.
- Ophthalmology Action Plan 2021-22 to be developed by Division of Surgery and Critical Care by August 2021. Chief Operating Officer to provide update to the next Quality and Safety Committee meeting in December 2021. Completed.

Q3 2021/22
- CMIO to review clinical engagement of results acknowledgement, through Digital Strategy Board. Completed, To be implemented in Q4.

Q4 2021/22
- Implementation of End of Life Strategy.
- Risk stratification report with trajectories and continued oversight through Operational Management Group.
- Continue to add metrics as data quality allows.
- Implement supportive observation.
- Develop a NLAG Patient Safety Incident Response Plan by Spring 2022.
- CMIO to implement results acknowledgement.

Q1 2022/23
- Preparation for trust requirements in DOLs by 31 April 2022.

Q4 2022/23
- Delivery of deteriorating patient improvement plan

Ongoing
- Annual establishment reviews across nursing, midwifery and community settings continue
- Update IPC BAF as national changes and requirements
- Continued management of COVID19 19 outbreaks
- Workforce Committee undertaking Workforce Planning linked to Business Planning.

Future Risks

- COVID-19 third surge and impact on patient experience
- National policy changes to access and targets
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times and additional 52 week breaches, due to COVID-19.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Many services single staff/small teams that lack capacity and agility.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Changes to Liberty Protection Safeguards.
- Skill mix of staff.
- Student and International placements and capacity to facilitate/supervise/train

Links to High Level Risks Register

Divisional / Departmental Risks Scoring >15:
- Inability to segregate patients in ED due to lack of isolation facilities (2695794) - Risk Rating 12 (previous Risk Rating 16, before that 20)
- Risk to overall cancer performance - Clinical Support Services (2244) - Risk Rating 16 (previous risk rating 16)
- Deteriorating patient risks - Medicine (2388) - Risk Rating 15, Surgery (2347) - Risk Rating 15, Paediatrics (2390) - Risk Rating 4 (previous risk rating 8, before that 15)

Divisional / Departmental Risks Scoring <15;
- Management of formal complaints (2659) - Risk Rating 12 (previous risk rating 12, before that 15)
- Inequitable division of LD Nurses (2531) - Risk Rating 12 (Previous risk rating 20)
- Mortality performance (2418) - Risk Rating 10 (previous risk rating 15).
- Ceilings of care and advance care planning (2653) - Risk Rating 9 (previous risk rating 12)
- Child Protection Information System (2914) - Risk Rating 6, (previous risk rating 15)

(27 Moderate Risks and 10 Low Risks linked to quality and safety; previously 28 Moderate and 5 Low).

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints.

Adverse impact of external events (ie. Britain's exit from the European Union; Pandemic) on business continuity and the delivery of core service.

Workforce impact on HASR.

Gaps in Controls

- Estate and compliance with IPC requirements - see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Fully funded Learning Disabilities team across both sites
- Attracting sufficiently qualified staff - see BAF SO2.
- Progress with the End of Life Strategy
- Ophthalmology Waiting List
- Delays with results acknowledgement
- Delivery of Oncology Service (further information to be provided at the Q&SC meeting in February 2022, by the Chief Operating Officer)
- Workforce sickness and vacancies (further information to be provided at the Q&SC meeting in February 2022, by the Director of People)

Gaps in Assurance

- Mandatory training
- Cancer Service (further information to be provided at the Q&SC meeting in February 2022, by the Chief Operating Officer)
- Sepsis Web-V Tool
- Risk stratification

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- International recruitment
- Shared clinical development opportunities
- Development of Integrated Care Provider with Local Authority.

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.2: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.2: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	4	4	4	3	2
Risk Rating Score	20	20	20	15	10

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment:
1 May 2019

Last Reviewed:
7 December 2021
24 January 2022

Lead Committees
Finance and Performance Committee

Risk Owners:
Chief Operating Officer

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy,Quality Improvement Strategy, Risk Management Strategy, Learning Strategy, Nursing and Midwifery Strategy, Clinical Strategy

Current Controls

- Operational Plan 2021-22 (Trust Board approved 1/6/2021)
- Operational Management Group (OMG)
- Performance Review Improvement Meetings (PRIMs)
- Trust Management Board (TMB)
- Waiting List Assurance Meetings
- Cancer Board Meeting
- Winter Planning Group
- Strategic Planning Group
- A&E Delivery Board
- Policies, procedures, guidelines, pathways supporting documentation & IT systems
- Cancer Improvement Plan
- MDT Business Meetings
- Risk stratification
- Capacity and Demand Plans
- Emergency Care Quality & Safety Group
- Emergency Department (ED) Performance and Ambulance Handover Group
- Planned Care Board
- Primary and Secondary Care Collaborative Outpatient Transformation Programme
- Divisional Executive Review Meetings

Assurance (internal & external)

Internal:
- Minutes of Finance and Performance Committee, OMG, PRIMS, TMB, Waiting List Assurance Meetings, Cancer Board Meeting, Winter Planning Group, Strategic Planning Group, A&E Delivery Board, MDT Business Meetings, Planned Care Board.
- Integrated Performance Report to Trust Board and Committees.
- 7 Day Services Assurance Framework, action plan.
- Executive and Non Executive Director Report (bi-monthly) to Trust Board.

Positive:
- Audit Yorkshire internal audit: A&E 4 Hour Wait (Breach to Non-Breach): Significant Assurance, Q2 2019.
- Benchmarked diagnostic recovery report outlining demand on services and position compared to peers presented at PRIM, October 2020. No significant differences identified, Trust compares to benchmarked peers.

External:
- NHSI Intensive Support Team
- Audit Yorkshire internal audit: A&E 4 Hour Wait (Breach to Non-Breach): Significant Assurance, Q2 2019.
- Humber Cancer Board

Planned Actions

Q2 2021-22
- Development of an independent sector activity plan (completed)

Q4 2021-22
- Consultant job plans to be updated..
- Workforce and resources to Humber Cancer Board.
- Continued development and implementation of risk stratification for RTT incomplete and completed pathways.
- Develop divisional dashboards.
- Public Health England guidance (cancer diagnosis) reviewed and implemented.
- Further development of the ICP with HUTH.
- Review of clinical pathways linked to HASR programme 1 ICP, 7 specialties.
- Consultant led ward rounds, further development and implementation (ECIST).
- Community 2 Hour Urgent Crisis Response (UCR) service and performance reporting to be implemented.
- Continued development and usage of independent sector through H2.
- Implementation of the Urgent Care Service (UCS) model at DPOWH ED during January 2022. (completed)
- Introduction of Advanced Conscious Sedation and Community Inhalation Sedation in Community Dental Services
- Diversion of Category 3 and 5 EMAS calls to North Lincolnshire SPA to enable local response and avoid admission
- Establishment of pathway for YAS to access the North Lincolnshire SPA in the same way as EMAS
- Implementation of robust tracking for patients risk stratified as high risk, escalation processes to notify patients not treated within risk timeframe.

Q1 2022-23
- Diagnostic breach tracker tool.
- Outpatient transformation plan by 2022.
- Development of Phase 2 three year HASR Plan by 2022.
- Revision and Development of QSIS plans

Q3 2022-23
- Diagnostic breach tracker tool.
- Development of ward 25 at SGH to provide addition single rooms

Q4 2022-23
- Diagnostic and cancer pathways reviewed and implemented.

Future Risks

- COVID-19 third surge and impact on patient experience.
- National policy changes to emergency access and waiting time targets.
- Funding and fines changes.
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times over 18 weeks, 52 weeks, 62 days and 104 days breaches, due to COVID-19.
- Additional patients with longer waiting times across the modalities of the 6 week diagnostic target, due to COVID-19.
- Generational workforce analysis shows significant risk of retirement in workforce.
- Many services single staff / small teams that lack capacity and agility.
- Staff taking statutory leave unallocated due to COVID-19 risk.
- Risk of independent sector providers not providing required capacity due to workforce issues (as they use NHS Consultants).

Links to High Level Risks Register

- Cancer 62 Day Target (2592)
- Risks of non-delivery of constitutional cancer performance (2160)
- COVID-19 performance and RTT (2791)
- Constitutional A&E targets (2562)
- Instability of ENT Service (2048)
- Overdue Follow-ups (2347)
- Shortfall in capacity with Ophthalmology service (1851)
- Accuracy of data of business decision making for RTT (2515)
- Delayed or missing internal referrals (2826)
- Shortage of radiologists (1800)
- MRI Equipment (1631)
- Replacement of X-Ray Room (2646)
- SGH Main MRI Scanner capacity and waiting lists (2499)
- Failure to meet 6 week target for CT/MRI (2210)
- Failure to review ophthalmology patients in specified timescales (2347)
- JAG Accreditation in housing enema room within clinical area (2694)
- Impact on Medicine Divisional business plan / service delivery (2700)
- Paediatric Medical Support Pathway for ECC (2576)
- Breast Oncology Services (2948)
- Depleted Consultant workforce (Breast Team) - (2999)
- Decrease in Max Fax Capacity at HUTH (3009)

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.

Adverse impact of external events (ie. Continued Pandemic) on business continuity and the delivery of core service.

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 52 week waits and Diagnostics Constitutional Standards.
- Capacity to Reduce 52 week, 104 day and over 18 week waits to meet the trusts standard of 0 waits over 40 week in 2022.
- Limited single isolation facilities.
- Lack Review of effective discharge planning.
- Diagnostic capacity and capital funding to be confirmed.
- Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations.
- Urgent Treatment Centre gaps in North and North East Lincolnshire GP rotas (completed)
- Cancer Board and MDT Meetings not quorate. (completed)

Gaps in Assurance

- QSIS Standards improvement plans.
- Demand and Capacity planning for Diagnostics.
- RTT and DM01 not meeting national targets.
- Increase in Serious Incidents due to not meeting waiting times.
- Patient safety risks increased due to longer waiting times.

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.3: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

Risk to Strategic Objective 1 - 1.3: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	3	3
Likelihood	3	3	2	2	2
Risk Rating	12	12	8	6	6

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment:
1 May 2019

Last Reviewed:
24 November 2021
12 January 2022

Lead Committees:
Finance and Performance / Strategic Development Committee

Risk Owner:
Director of Strategic Development

Enabling Strategy / Plan: NHS Long Term Plan, Trust Strategy and Strategic Plan, Clinical Strategy, Integrated Care System

Current Controls

- NLaG Clinical Strategy 2021/25.
- Strategic Plan 2019/24.
- Trust Priorities 2021/22.
- Humber Coast and Vale Health Care Partnership (HCV HCP).
- Integrated Care System (ICS) Leadership Group.
- NHS Long Term Plan (LTP).
- Quality and Safety Committee.
- Acute Care Collaborative (ACC).
- Humber Cancer Board.
- Humber Acute Services - Executive Oversight Group (HASR).
- Health Overview and Scrutiny Committees (OSC).
- Council of Members.
- Council of Governors.
- Primary Care Networks (PCNs).
- Clinical and Professional Leaders Board.
- Hospital Consultants Committee (HCC) / MAC
- Joint Development Board*(JDB)*
- Committees in Common (CIC)
- Strategic Development Committee (SDC)

Assurance (internal & external)

Internal:
- Minutes from ~~Programme Board and~~ Executive Oversight Group for HASR, JDB, CiC, SDC
- ~~Minutes of HAS Executive Oversight Group.~~
- Humber Coast and Vale Health Care Partnership.
- ICS Leadership Group.
- OSC Feedback.
- Outcome of patient and staff engagement exercises.
- Executive Director Report to Trust Board.
- Non-Executive Director Highlight Report to Trust Board

Positive:
- NHSE/I Assurance and Gateway Reviews.
- OSC Engagement.

External:
- Checkpoint and Assurance meetings in place with NHSE/I (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel (Humber).

Planned Actions

Q3 2021/22
- To formulate a vision narrative (PCBC) for Humber Acute Services review that is understood by partners, staff and patients by December 2021 (Draft complete)

Q4 2021/22
- To undertake continuous process of stocktake and assurance reviews NHSE/I and Clinical Senate review
- OSC - reviews.
- NED / Governor reviews
- Citizens Panel reviews
- To undertake continuous engagement process with public and staff.
- Evaluation of the models and options with stakeholders
- Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case

Q1 2022/23
- NHSEI Gateway review
- ICS Board Approval

Q2 2022/23
- Public Consultation

Future Risks

- Change in national policy
- Delays in legilsation.
- Further Operational pressures and demand and Covid-19 recovery waves affecting opportunity to engage.
- Uncertainty / apathy from staff.
- Lack of staff engagement if not the option they are in favour of.
- Out of Hospital enablers and interdependencies

Gaps in Controls

- A shared vision for the HASR programme is not understood across all staff/patients and partners
- Link to SO3 - 3.2 re: Capital Investment

Gaps in Assurance

- Feedback from patients and staff to be wide spread and specific in cases, that is benchmarked against other programmes.
- Partners to demonstrate full involvement and commitment, communications to be consistent and at the same time.
- Alignment of strategic capital

Links to High Level Risks Register

- Clinical Strategy (RR no 2924).
- HASR political and public response to service change (RR no. TBC).

Strategic Threats

- Government legislative and regulatory changes.
- Change in local leadership meaning priority changes.
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.
- Creation of Placed based partnerships
- Strategic Capital allocation

Future Opportunities

- Clinical pathways to support patient care, driven by digital solutions.
- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.
- HASR.
- Joint workforce solutions inc. training and development Humber wide

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.4: To offer care in estate and with engineering equipment which meets the highest modern standards.

Risk to Strategic Objective 1 - 1.4: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	4	4	4	4	4
Risk Rating	20	20	20	20	20

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment:
1 May 2019

Lead Committee:
Finance and Performance Committee

Last Reviewed:
11 January 2022
24 November 2021

Risk Owner:
Director of Estates and Facilities

Enabling Strategy / Plan: Estates and Facilities Strategy, Clinical Strategy, Digital Strategy

Current Controls

- Audit Risk & Governance Committee
- Finance and Performance Committee
- Capital Investment Board
- Six Facet Survey - 5 years.
- Annual AE Audits.
- Annual Insurance and External Verification Testing.
- Trust Management Board (TMB).
- Project Boards for Decarbonisation Funds.
- BLM Capital Group Meeting
- PAM (Premises Assurance Model)
- Specialist Technical Groups

Assurance (internal & external)

Internal:
- Minutes of Finance and Performance Committee, Audit Risk & Governance Committee, Capital Investment Board, Estates and Facilities Governance Group, TMB, Project Board - Decarbonisation.
- PAM
- Non Executive Director Highlight Report (bi-monthly) to Trust Board
- Executive Director Report (6 monthly) to Trust Board
- Specialist Technical Groups

Positive:
- External Audits on Estates Infrastructure, Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts .
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- PAM

External:
- External Audits on Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts.
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark).
- PAM
- ERIC (Estates Return Information Collection)

Planned Actions

Ongoing Actions:
- Continue to produce and revise our 3 year business plans on an annual basis in line with Clinical & Estates & Facilities Strategy. Prioritisation is reviewed and updated as part of the business planning cycle - Action date; ongoing
- Continue to explore funding bids to upgrade infrastructure and engineering equipment - Action date; ongoing
- Allocation of Core Capital Funding assigned to infrastructure and engineering and equipment risks through the monthly E&F governance process - Action date; ongoing

Q4 2021/22
- Estates and Facilities equipment plan produced and implemented as part of the 21/22 core capital annual funding (this may be reprioritised as no current contingency) - Action date; end of financial year 21/22
- To specifically deliver: - the Decarbonisation Funding (£10.1M) project across all three sites by 31 March 2022, - Core Capital Programme, - Transformational Capital Schemes, - BLM Schemes

Q1 2022/23
Start Backlog Maintenance programme
Continue Ward 25 refurbishment
Start Core Capital Programme
Start refurbishment of DPOW ED.
Q2 2022/23
Continue Backlog Maintenance programme
Continue Ward 25 refurbishment
Continue Core Capital Programme
Continue refurbishment of DPOW ED
Q3 2022/23
Continue Backlog Maintenance programme
Complete Ward 25 refurbishment
Continue Core Capital Programme
Continue refurbishment of DPOW ED
Q4 2022/23
Continue Backlog Maintenance programme
Complete Core Capital Programme
Complete refurbishment of DPOW ED

Future Risks

- COVID-19 future surge and impact on the infrastructure.
- National policy changes (HTM / HBN / BS); Ventilation, Building Regulation & Fire Safety Order.
- Regulatory action and adverse effect on reputation.
- Long term sustainability of the Trust's sites.
- Clinical Plan.
- Adverse publicity; local/national.
- Workforce - sufficient number & adequately trained staff
- Without signifcant investment future BLM will increase (BLM figures for 2019/20 = £97M circa, and BLM figures for 2020/21 increased to circa £107M).

Links to High Level Risks Register

There are approximately 22 Estates and Facilities risks graded 15 or above recorded on the high level risk register. Of which there are a significant number of risks pertaining to the physical infrastructure and engineering equipment being inadequate or becoming inadequate. Of particular note, there are a number of high risks relating to workforce, water infrastructure, medical gases, electrical and fire compliance that place increased risk to the Trust's overall strategic ability to provide patient care in a safe, secure and suitable environment.

Strategic Threats

- Integrated Care System (ICS) Future Funding.
- Failure to develop aligned system wide clinical strategies and plans which support long term sustainability and improved patient outcomes. This could prevent changes from being made.
- Prevents changes being made which are aligned to organisational and system priorities.
- Government legislative and regulatory changes.
- Within the next three years a significant (60%) proportion of the trust wide estate will fall into 'major repair or replacement' 6 facet survey categorisation.
- A further breakdown of strategic risk detailed in the 2019/20 6 Facet Survey Report:
22% of SGH total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'.
- 19% DPoW total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'.
- 29% GDH total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'.

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR.
- Insufficient Capital funding.
- Timeline to deliver the decarbonisation projects.

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities.

Future Opportunities

- Closer ICS working.
- Humber Acute Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.
- Expression of Interest Submitted for New Hospital Programme (NHP)

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.5: To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.

Risk to Strategic Objective 1 - 1.5: The risk that the Trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the Trust vulnerable to data losses or data security breaches.

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	3	3	3
Likelihood	4	3	3	2	2
Risk Rating	16	12	9	6	6

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment:
1 May 2019

Last Reviewed:
11 January 2022
24 November 2021

Lead Committees:
Audit Risk and Governance Committee

Risk Owner:
Chief Information Officer

Enabling Strategy / Plan: Digital Strategy

Current Controls

- Digital Strategy
- Strategy and Developmernt Committee
- Finance and Performance Committee
- Upto date Digital / IT policies, procedures and guidelines.
- Digital Strategy Board
- Digital Solutions Delivery Group
- Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.
- Audit Risk & Governance Committee (including external Audior reports)
- Annual Penetration Tests
- Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication
- Trust Management Board (TMB)

Assurance (internal & external)

Internal:

- A Digital Strategy Board reviews progress of the plans to achieve the strategy.
- Highlight reports to Trust Board, Audit Risk and Governance Committee, Strategic Development Committee, Finance and Performance Committee, Digital Strategy Board, TMB.
- Digital / IT Policies all current.
- IT Security Manager in Post
- CIO/Executive Director Report (6 monthly) to Trust Board.

External:

- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Limited Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Limited Assurance, Q3 2019.

Positive Assurance:

The Integrated Performance Report (IPR) has been revised and updated. This was done with NHSE/I who have stated it is now among the leading models for reporting.

Planned Actions

Q3 2021/22

- Patient Admin System Options Appraisal, Board approval for Trust Board by November 2021. PAS project to commence in November 2021. Action completed.
- Development of a comprehensive IT BC / DR Programme including monitoring of adherence to the programme. Results of BC / DR tests recorded and formally reported by 31 December 2021. External Project Manager appointed to undertake further work on the IT BC/ DR Programme to be completed by 30 April 2022.
- Establish Digital Reporting schedule/Work plan for Board Committees (4th Qtr 20/21)

Q4 2021/22

- Recruit Digital Leadership to drive change & engage with frontline (3rd & 4th Qtr 20/21)
- Data Warehouse options appraisal to be approved through governance structures by February 2022.
- Year 2 Digital Aspirant Funds available to support funding Digital Programs (20/21 & 21/22).

Q2 2022/23

- IPR - further development of Digital, Finance and Estates KPIs to be reported, by September 2022.
- Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Plus Accreditation (2nd Qtr 22/23 -July 2022).

Other:

- Secure resources to deliver Digital Strategy and annual priorities (PAS; EPR; Data Warehouse; RPA; Document management; Infrastructure upgrades). Digital Aspirant Funds £5 M secured with additional internal Capital to deliver projects 21/22 & 22/23. Depending on when NHSX releases funds for the Unified Tech Fund, we work with the ICS to bid for funds to continue our "levelling strategy" across the ICS.
- £250k NHS/X/D Cyber Security Capital Funding Bid Approved - Improving Cyber Security and Management over Medical Devices and other unmanaged IT devices on the Trust network.

Future Risks

- COVID-19 surge and impact on adoption of digital transformation.
- National policy changes in some cases in short notice, requiring revisions to work plan.
- Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards.
- IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG specific agenda.
- Ongoing financial pressures across the organisation.

There are eight assertions on the DSPT Improvement plan with the end date of the 31st December. In Dec. NHS Digital announced that due to the increasing impact of COVID-19 and Log4J, organisations were no longer required to submit updated improvement plans by the 31 December 2021. No new deadline was set. Organisations can submit completed plans should they wish.
Of the 8 actions identified on the 20/21 improvement plan NLaG have 2 outstanding:
1.Business Continuity Plans and Asset Register
Two contractors have been secured who will work on these dedicated projects for an 8-week period with a completion date of end of March 2022.

2.Attack Detection and Response
Cyber funding was awarded from NHS Digital in October 2021. Procurement is in progress for an 'Attack Detection and Response (ADR) for Healthcare'. Expected completion end of March 2022.

Once the above two are completed, the Trust will share the completed Improvement Plan with NHS D and request that the publication status for 20/21 be changed to 'Standards Met'.

Links to High Level Risks Register

- Accuracy of Data of Business Decision Making. Finalizing spec to procure new data warehouse. (2515) Low Risk (5).
- Risk of non-compliance with the Data Protection Act 2018 due to the Trust not having sufficient resource and technical tools to conduct forensic searches on use of data. Currently rolling out 365 and discussing wiht NHS D on recommened search tools. (2676) Medium Risk (10)
- Data & Cyber Security: (2) Cyber Infrastructure (2408) - Risk High (16)
- Updated Business Continuity & Disaster Recovery Procedure (2299) Risk Medium (9).

Strategic Threats

- Capital funding to deliver IT solutions and establish a 3 yr plan.
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve.

Gaps in Controls

- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.
- Address the assertions without evidence in the DSPT
- Develop policy and procedure to address the gaps noted in the IT Business Continuity audit in April 2020.
- Achieve DSP Toolkit and mandatory training compliance - in progress (target 4th qtr 21/22)

Gaps in Assurance

- Integrated Performance Report - the Digital and Estates.
- Data Warehouse solution to support outcomes from BI review.

Future Opportunities

- Humber Coast and Vale ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Collaborative working with HASR and Acute Care Collaborative.

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.6: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	4	4
Likelihood	2	4	4	2	1
Risk Rating	8	16	16	8	4

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment:
1 May 2019

Last Reviewed:
24 November 2021
24 January 2022

Lead Committee:
Finance and Performance Committee

Risk Owner:
Chief Operating Officer

Enabling Strategy / Plan: NLAG Winter Planning and Potential COVID-19 Third Wave, Business Continuity Policy

Current Controls

- Winter Planning Group.
- Strategic Planning Group.
- A&E Delivery Board.
- Director of People - Senior Responsible Owner for Vaccinations.
- Ethics Committee.
- Clinical Reference Group
- Influenza vaccination programme.
- Public communications re: norovirus and infectious diseases.
- Chief Operating Officer is the Senior Responsible Officer for Executive Incident Control Group.
- Ward visiting arrangements changed and implemented, Red and Green Zones, expansion of critical care faciliites.
- COVID-19 Executive Incident Control (Gold Command).

Assurance (internal & external)

Internal:
- Regional EPRR scenarios and planning exercises in preparation for 'Brexit' have been undertaken alongside partners, including scenarios involving transportation, freight and traffic around local docks with resulting action plan.
- Business continuity plans.
- Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, Executive Incident Control Group, A&E Delivery Board, Clinical Reference Group.

Positive:
- Half yearly tests of the Major incident response.
- Annual review of business continutiy plans.
- Internal audit of emergency planning compliance 2018/19 (due 2021/22).

External:
- Emergency Planning self-assessment tool.
- NHSE review of emergency planning self-assessment 2019/20.
- Internal audit of emergency planning compliance 2018/19 (due 2021/22).

Gaps in Controls

- Capacity to meet demand (workforce).
- Bed Capacity challenges in Northern Lincolnshire, East Riding and Lincolnshire due to ASC workforce challenges being seen and likely to continue into January 2022
- Mandatory vaccinations of all staff by 31 March 2022 (as per Government requirement)

Gaps in Assurance

- Not undertaking internal audit review of the standards. (completed)

Planned Actions

Q4 2021/22:
- Capacity to meet demand workforce)
- Annual table top exercise (completed)
- Half yearly telephone exercise (completed)
- Mandatory Vaccinations of Staff - engagement and communication, Booster hubs
- Introduction of 24/7 Operational Matron rota for Scunthorpe General Hospital and Diana Princess of Wales Hospital

Ongoing:
- Lateral flow testing staff is ongoing.
- Business Intelligence monitoring re: pandemic.

Links to High Level Risks Register

- Cancer 62 Day Target (2592)
- Risks of non-delivery of constitutional cancer performance (2160)
- COVID-19 performance and RTT (2791)
- Constitutional A&E targets (2562)
- Instability of ENT Service (2048)
- Overdue Follow-ups (2347)
- Accuracy of data of business decision making for RTT (2515)
- COVID-19 Isolation (2794)
- C-19 Equipment (2793)
- C-19 Patient Safety (2792)
- COVID -19 pandemic - surgery & critical care (2706)
- COVID -19 pandemic - community and therapies (2708)
- COVID -19 pandemic - risk to IT Operations (2710) - closed
- Impact on Medicine Divisional business plan / service delivery (2700)
- Risk arising as a result of COVID-19 - clinical support services (2704)
- Breast Oncology Services (2948)

Future Risks

- COVID-19 third surge.
- Availability of dressing, equipment and some medications post Brexit.
- Costs and timeliness of deliveries due to EU Exit.
- Additional patients with longer waiting times RTT, Cancer and Diagnostics due to COVID-19.
- Risk to Oncology Waiting Times due to HUTH operational pressures.

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints.

Future Opportunities

- Closer Integrated Care System working.
- Provider collaboration.

Strategic Objective 2 - To be a good employer

Description of Strategic Objective 2: To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations.

Risk to Strategic Objective 2: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	4		
Likelihood	3	4	2		

Risk Appetite Score: Low (4 to 6)

1 May 2019	Workforce Committee
Last Reviewed: 30 November 2021	**Risk Owner:**

Enabling Strategy / Plan: People Strategy, NHS People Plan, Leadership Development Strategy

Current Controls

- Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, Remuneration and Terms of Service Committee
- NHS People Plan
- NLAG People Strategy approved by the Board June 2020
- NHS Staff Survey - annual
- Collaborative engagement with CCG, forum established to support closer working and transformational changes.
- Holistic requirements of Humber Coast and Vale workforce led by People Lead for Humber Coast and Vale (HCV) Integrated Care System (ICS).
- People Directorate Delivery Implementation Plan 2021-22 (Workforce Committee approved 27/4/2021)

Assurance (internal & external)

Internal:
- Minutes of Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, Remuneration and Terms of Service Committee.
- Workforce Integrated Performance Report.
- Annual staff survey results
- Medical engagement survey 2019
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board

Positive:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance

External:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance

Planned Actions

Q3 2021/22
- Review of staff survey results March/April to inform overall plans for Culture Transformation Board
- Setting up a working group to oversee payment processes to ensure streamlined processes between People/Operations and Finance Directorate
- Set up Culture Transformation Board to develop plans to address issues identified through staff survey, FTSU and other data on staff morale and culture
- Review of Statutory and Mandatory training is underway to clarify what staff need to undertake in line with national benchmarks

Q4 2021/22
- Plans to recruit 120 international nurses before end of December 2022 - funding secured to support
- Review of Recruitment Processess to ensure that they are streamlined, inclusive, responsive and timely - focus on medical recruitment
- Health and Wellbeing plan offer to be finalised and costed for implementation for 22/23
- Introduction of Just and Learning Culture Framework - subject to approval of disciplinary policy

Q1 2022/23

Ongoing Actions
- Implementation of People Strategy by 31 March 2024.
- Delivery against NHS People Plan - ongoing.
- Investment in the People Directorate to develop plans for delivery against the NHS People Plan and NLAG People Strategy - this is now completed
- Continue collaboration between NLAG and HUTH and the HCV wider network.
- Implementation of new directorate structure and recruitment to vacant positions. This is almost complete

Outputs from the currently live Staff Survey and quarterly Pulse Survey
- Continued review of the Health and Wellbeing offer to staff
- Review of the Educational /Leadership Development offer and future roll out of programmes
- A Culture and Engagement deep dive was recently conducted, the findings presented at an Executive Team time out, JNCC, Workforce Committee, and now being socialised more broadly for widening participation from all staff groups
- We held a Board session in July 2021 focused on the role of the FTSU Guardian, the role of unconscious bias in discrimination, and plan a follow up session November 2021 covering the wider Equality Diversity and Inclusion agenda, further awareness of the role and value of FTSU, and the proposed approach to the Culture and Engagement Transformation programme

Future Risks

- COVID-19 third surge and impact on staff health and wellbeing.
- National policy changes.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Provide safe services to the local population.
- Succession planning and future talent identification.
- Visa changes / EU Exit.
- Staff retention and ability to recruit and retain HR/OD staff to deliver people agenda

Other Significant Risks Links to High Level Risks Register

There are approximately 14 staffing risks graded 15 or above recorded on the high level risk register. Of which there are a significant number of risks pertaining to the haematology workforce, staffing (nurse, midwife, medical, radiologists) that place an increased risk to the Trust's overall strategic ability to provide a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) and to provide the levels and quality of care which the Trust needs to provide for its patients.

Strategic Threats

- ICS Future Workforce.
- Integrating Care: Next Steps.
- Future staffing needs / talent management

Gaps in Controls

- Slower international recruitment of clinical staff due to visa backlogs

Gaps in Assurance

- Increase in nurse staff vacancies and conversion of the 50 overseas nursing recruits.

Future Opportunities

- Closer ICS working.
- Provider collaboration.
- International recruitment.

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.1: To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP.

Risk to Strategic Objective 3 - 3.1: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	4	5	5	5
Likelihood	2	3	1	4	4
Risk Rating	10	12	5	20	20

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 November 2021, 31 January 2022

Lead Committees: Finance and Performance Committee

Risk Owners: Chief Financial Officer

Enabing Strategy / Plan: Trust Strategy, Clinical Strategy, ICS

Current Controls

- Capital Investment Board, Trust Management Board (TMB), PRIMs, Model Hospital.
- National benchmarking and productivity data constantly reviewed to identify CIP schemes.
- Engagement with Integrated Care System on system wide planning.
- Humber Acute Services Review (HASR) engagement to redesign fragile and vulnerable service pathways at system and sub system level.
- Monthly ICS Finance Meetings
- Finance Meeting - HASR
- Operational and Finance Plan 2021-22 (approved at Trust Board June 2021)
- Financial Special Measures Meeting with NHSE/I.
- Counter Fraud and Internal Audit Plans.

Assurance (internal & external)

Internal:
- Minutes of Audit Risk & Governance Committee, Trust Management Board, Finance and Performance Committee, Capital Investment Board, PRIMs.
- Non-Executive Director Highlight Report (bi-monthly) to Trust Board

Positive:
- Letter from NHSE/I related to financial special measures and achievement of action plan. On track to deliver the requirements set out by NHSEI.

External:
- Financial Special Measures Meeting - Letter from NHSE/I related to financial special measures and achievement of action plan.
- ICS delivery of H1 financial plan.
- HASR Programme Assurance Group

Planned Actions

Q3 2021/22
- Agree H2 plan, November 21
- Agree Finance metrics for inclusion in the Trustwide IPR
- Develop costed metrics to support HASR P2/P3 work by end December 21.
- Complete FSM actions in line with FSM timetable and agree exist from FSM process - December 2021.

Q4 2021/22
- Develop financial (incl comprehensive CIP plan) and service plan for 22/23 - target by end of Feb 2022
- Agree financial implications of P1 completed specialties for transacting in qtr 4 21/22.
- Secure approval for Acute Assessment Unit Full Business Case January 2022
- Secure agreement of income to cover forecasted costs and containing costs to within forecasted levels.
- To undertake financial planning as part of HCV ICS exercise and agree financial plan for 2022/23.

Q1/Q2 2022/33
- Likely receipt of three year income and expenditure allocations and therefore need to develop plans for 2022-25 to commence planned publication of year two and three allocations.

Future Risks

- COVID-19 third surge and impact on finance and CIP achievement.
- National policy changes.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Savings Programme not sufficient and deteriorating underlying run rate which is execerbated by the elective recovery programme
- Impact of external factors such as problems with residential care, causing hospitals to operate at less than optimum efficiency and cause finaical problems

Links to High Level Risks Register

- Risk of not achieving 2020-21 CIP target - family services (2733).
- Unable to meet CIP delivery - surgery (2599).
- COVID-19 Expenditure (ref: Financial Plan 2021-22)
- Savings Programme (ref: Financial Plan 2021-22)

Strategic Threats

- ICS Future Funding.
- Integrating Care: Next Steps.
- System wide control total.

Gaps in Controls

- Systems plans may not address individual organisational sustainability
- Challenges with HASR, CIP Delivery
- Uncertainty on H2 & application of long term financial framework.
- Clinical strategy required to inform Finance Strategy

Gaps in Assurance

- Integrated Performance Report - Finance.
- Delivery of Cost Improvement Programme Plan.
- Management of finance risks arising from the cost of the pandemic.
- Individual organisational sustainability plans may not deliver system wide control total.

Future Opportunities

- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.2: To secure adequate capital investment for the needs of the Trust and its patients.

Risk to Strategic Objective 3 - 3.2: The risk that the Trust fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades.

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	4	5	5	5
Likelihood	2	3	3	4	4
Risk Rating	10	12	15	20	20

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 14 February 2022

Lead Committees:
Finance and Performance Committee
Strategic Development Committee
Committees in Common

Risk Owners:
Chief Financial Officer
Director of Strategic Development

Enabling Strategy / Plan: Trust Strategy, Clinical Strategy, Humber Acute Services Programme/ Capital Investment EOI and potential SOC for NHP

Current Controls

- Capital Investment Board (Internal Capital)
- Trust (Internally) Agreed Capital programme and allocated budget - annual/three yearly
- Trust Strategic Development Committee
- Trust Board
- Trust Committee(s) in Common
- ICS Strategic Capital Advisory Group
- NHSE/I - HAS Assurance Reviews
- NHSE/I Financial Speciall Measures Assurance Reviews

Assurance (internal & external)

Internal:
- Minutes of Internal Trust Meetings

External:
- Financial Special Measure Meeting with NHSE/I
- NHSE/I attendance at AAU / ED Programme Board
- NHSE/I Assurance Review Feedback
- CiC Minutes

Planned Actions

Q4 2021/22
- Agree forecast spend for current year as part of wider ICS capital planning exercise.
- Find a solution to address BEIXS/Salix funding issues with regards to year end cut off.
- Develop 2022/23 capital plan as part of comprehensive service planning exercise - to be completed by end February 2022
- Secure approval for Acute Assessment Unit, Full Business Case
- Develop HASR Programme 3 proposition to Pre Consultation Business Case stage

Q4 2021 - Q1 2022/2023
- Develop Capital Investment Strategic Outline Case for development of SGH/DPoW
- Develop TiF submission through acute collaboratives for Elective Hub
- Develop integrated bid across N and NE Lincs for implementation of CDH aligned to ICS Core Programme

Future Risks

- National policy changes - implications of three year capital planning
- Lack of investment in infrastructure through Targeted Investment Fund (TIF)
- Inability of Trust to fund capital through internal resource - potential lack of external funding sources
- Inability of Trust to gain Capital Departmental Resource Limit (CDEL) cover for strategic capital investment if not on New Hospital Programme (NHP)
- Not gaining a place on the NHP
- Challenges with estate existing estate continue and significant issues re Backlog Maintenance (BLM), Critical Infrastructure Risk (CIR)

Links to High Level Risks Register

- AAU / ED Business Case approval not yet received
- Salix funding gap
- HASR Capital EOI risk of not being part of Top 30 and subsequent 8

Strategic Threats

- ICS Capital Funding Allocations
- Inability to gain national strategic capital through NHP
- Inability to offset CDEL if non NHS funding sources used for capital investment

Gaps in Controls

- Comprehensive programme of Control and Assurance - potential inherent risk on ability of Trust to afford internal capital for major spend
- Control environment whilst comprehensive may not have ability to influence availability of Strategic Capital - investment funding/affordability
- Control environment may not be able to eliminate or reduce risk of estates condition in the short term

Gaps in Assurance

- Assurance review process does not create a direct link to sources of strategic capital investment
- ICS CDEL may not be sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providers

Future Opportunities

- Provider collaboration and use of Place based funding
- Use of TiF, CDH and Towns Centre funds to support capital spend
- System wide collaboration to major capital development needs.
- Announcement of multi year, multi billion pound capital budgets for NHS
- Gaining a place on the NHP

Strategic Objective 4 - To work more collaboratively

Description of Strategic Objective 4: To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale (HCV) Health Care Partnership (HCP) (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 (LTP): to make best use of the combined resources available for health care, to work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally, to work with partners to secure major capital and other investment in health and care locally, to have strong relationships with the public and stakeholders, to work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: make best use of the human capabilities and capacities locally; offer excellent local career development opportunities; contribute to reduction in inequalities; contribute to local economic and social development.

Risk to Strategic Objective 4: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	4	4	4	3
Likelihood	3	3	2	2	2
Risk Rating	15	12	8	8	6

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 November 2021, 12 January 2022

Lead Committee: Finance and Performance / Strategic Development Committee

Risk Owner: Director of Strategic Development

Enabling Strategy / Plan: NHS Long Term Plan, Trust Strategy, Clinical Strategy, Humber Acute Services Programme, Communications & Engagement Strategy

Current Controls

- Audit Risk & Governance Committee (ARGC).
- Trust Management Board (TMB).
- Finance and Performance Committee (F&PC).
- Capital Investment Board (CIB).
- HAS Executive Oversight Group.
- HCV HCP.
- ICS Leadership Group.
- Wave 4 ICS Capital Committee.
- Executive Director of HASR and HASR Programme Director appointed.
- NHS LTP.
- ICS LTP.
- NLaG Clinical Strategy.
- NLaG Membership of ICP Board NE Lincs.
- Committees in Common (Trust Board approved 1/6/2021)
- Acute and Comunity Collaborative Boards
- Clinical Leaders & Professional Group

Assurance (internal & external)

Internal:
- Minutes of HAS Executive Oversight Group, HCV HCP, ICS Leadership Group, Wave 4 ICS Capital Committee, ARGC, F&PC, TMB, CIB.
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board

Positive:
- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE/I Rolling Assurance Programme - Regional and National including Gateway Reviews.

External:
- Checkpoint and Assurance meetings in place with NHSE/I (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE/I Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Councillors / MPs / Local Authority CEOs and senior teams

Planned Actions

Q3 2021/22
- Identification and approval for management time within existing consultant management Pas (Clinical Leads), approach to be agreed with Chief Operating Officer / Divisional Clinical Directors by December 2021.
- Recruit to Strategic Development - Associate Medical Director to support the ICS collaboration - Dec 21 (interviews Feb 2022)

Q4 2021/22
- HAS two year programme (current to March 2022) - 12 month rolling.
- Options appraisal for HAS Capital Investment to be approved

To undertake continuous process of stocktake and assurance reviews NHSE/I and Clinical Senate review
- OSC - reviews.
- NED / Governor reviews.
- Citizens Panel reviews.
- To undertake continuous engagement process with public and staff.
- Evaluation of the models and options with stakeholders.
- Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case.

Q1 2022/23
- NHSEI Gateway review.
- ICS Board approval.

Q2 2022/23
- Public Consultation.

Future Risks

- National policy changes
- Delays in legislation
- Long term sustainability of the Trust's sites.
- Change to Royal College Clinical Standards.
- Capital Funding.
- ICS / Integrated Care Partnership (ICP) Structural Change.

Links to High Level Risks Register

- Clinical Strategy (RR no.2924).
- HASR political and public response to service change (RR no. TBC).

Strategic Threats

- ICS Future Funding.
- Failure to develop aligned system wide strategies and plans which support long term sustainability and improved patient outcomes.
- Government legislative and regulatory changes.
- Integrated Care: Next Steps and Legislative Changes.
- Strategic capital.

Gaps in Controls

- Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.
- Local Authority, primary care and community service, NED and Governor engagement / feedback.
- ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed.
- Local Authority Chief Executives.
- Interim Clinical Plan with Humber to be progressed.
- Governance arrangements for HAS, clinical leadership, clinical engagement and approval of plans.
- Strategic capital investment options appraisal in progress for HAS for N Lincs and NE Lincs.
- Engagement with the wider system in the clinical strategy, capital and service developments, including attendance at programme boards / clinical sign off of proposed plans.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Hosting of HAS clinical services to support planning.
- Lack of integrated plan and governance structure.
- Alignment with Out of Hospital strategies and programmes.

Future Opportunities

- HCV ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Strategic workforce planning system wide and collaborative training and development with Health Education England / Universities etc.
- Acute and community collaborative.

Strategic Objective 5 - To provide good leadership

Description of Strategic Objective 5: To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk to Strategic Objective 5: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4		
Likelihood	4	3	2		
Risk Rating	16	12	8		

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 30 November 2021, March 2022

Lead Committees: Workforce Committee and Trust Board

Risk Owner: Chief Executive

Enabing Strategy / Plan: Trust Strategy, NHS People Plan, People Strategy, Leadership and Development Strategy

Current Controls

- Trust Board, Trust Management Board, Workforce Committee, PRIMS.
- CQC and NHSE/I Support Teams
- Board development support programme with NHSE/I support.
- Significant investment in strengthened structures, specifically (a) Organisational structure, (b) Board structure, (c) a number of new senior leadership appointments.
- Development programmes for clinical leaders, ward leaders and more programmes in development.
- Communication with the Trust's senior leaders via the monthly senior leadership community event.
- NHSI Well Led Framework.
- PADR compliance levels via PRIM as part of the Trust's focus on Performance improvement.
- Joint posts of Trust Chair and Chief Financial Officer, with HUTH
- Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, HCV HCP and CCG.

Assurance (internal & external)

Internal:
- Minutes of Trust Board, Trust Management Board, Workforce Committee and PRIMS
- Trust Priorities report from Chief Executive (quarterly)
- Integrated Performance Report to Trust Board and Committees.
- Letter from NHSE/I related to financial special measures and achievement of action plan.
- Chief Executive Briefing (bi-monthly) to Trust Board

Positive:
- Letter from NHSE/I related to financial special measures and achievement of action plan.

External:
- CQC Report - 2020 (rated Trust as Requires Improvement).
- Financial and Quality Special Measures.
- NHS Staff Survey.

Planned Actions

Q3 2021/22
- Continued contribution to the Trust Priorities quarterly report, by Q2 2021 and supporting People Plan which outlines plans to scope out a Leadership Development Programme for leaders at all levels by December 2021.
- A Trust-wide Leadership Deep Dive is scheduled for review with the Executive Team and Workforce Committee in November/December 2021, to set out an integrated programme of leadership development pathways and activities supporting the Culture and Engagement Transformation Programme and feeding in to our aims for talent identification and succession development. The scope includes a range of initiatives addressing: establishing more effective line manager skills in leading people for existing line managers (building on the work of the HRBPs).

Q4 2021/22
- Compliance and performance improvement to be monitored at PRIMS by 31 March 2022.

Leadership Development Framework to be completed - scoped and costed - to be submitted to Board in April

Q1 2022/23
- Introduce a leadership and career development portfolio governance board in 2022 with representation from all stakeholder staff groups, whose purpose is to ensure any and all leadership development programmes we design in-house, commission, or subscribe to, align with our People Strategy aims of attracting, developing and retaining leaders as a preferred employer. From April 2022, subject to funding
- Providing further knowledge and skills for all leaders and managers towards building a culture of compassion-centred, collective leadership. This programme, modular in approach, will include Leading with Kindness, Courage and Respect, underpinned with processes and skill development in difficult conversations, embodying the Trust values, and improving what it feels like for staff to work at NLaG. From April 2022, subject to funding

Q2 2022/23
- Refreshing of the coaching model with the move towards a Coaching and Mentoring Bureau, offering staff at all levels, opportunities for coaching and mentoring. All participants on leadership development programmes will have a coach for the duration of their development course. We aim to introduce mentoring, both peer to peer, role and career, and reverse, during 2022 with some small scale pilot programmes including a pilot EDI-centric reverse mentoring programme to further strengthen inclusion. September 2022, subject to funding

Q3 2022/23
- Refresh of our PADR process referred to in the Training & Development submission, will include process components and skills training to enable identification of talent, development of potential, and proactive planning for succession. Refer to the Leadership and Career development draft schematic in the Appendices for concept. December 2022
- Introducing a managerial core skills programme for newly appointed managers 2022 and beyond. December 2022

Q1 2023/24
- As part of both leadership development and succession planning, we will be seeking collaborative team working across the ICS for the introduction of a HCV Shadow Board programme. From April 2023

Future Risks

- COVID-19 third surge and impact on finance and CIP achievement.
- National policy changes.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Current vacancy for the Head of Education which is currently being covered by temporary resource

Strategic Threats

- Non-delivery of the Trust's strategic objectives;
- Continued quality/financial special measures status;
- CQC well-led domain of 'inadequate'.
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives;
- Failure to obtain support for key changes needed to ensure improvement or sustainability;
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.

Gaps in Controls

- No investment specifically for staff training / courses to support leaders work within a different context and to be effective in their roles as leaders within wider systems.

Gaps in Assurance

- Financial Special Measures
- Quality Special Measures

Links to High Level Risks Register

None

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration
- System wide collaboration to meet control total
- HASR

Northern Lincolnshire and Goole NHS Foundation Trust

<table>
<tr><td>Name of the Meeting</td><td>Trust Board - Public</td></tr>
<tr><td>Date of the Meeting</td><td>5 April 2022</td></tr>
<tr><td>Director Lead</td><td>Helen Harris, Director of Corporate Governance</td></tr>
<tr><td>Contact Officer/Author</td><td>Alison Hurley, Assistant Director of Corporate Governance</td></tr>
<tr><td>Title of the Report</td><td>Board Assurance Framework (BAF) 2021-22 Quarter Three</td></tr>
<tr><td>Purpose of the Report and Executive Summary (to include recommendations)</td><td>The Trust Board is asked to:

a) to review the strategic risks which remain at 15 and above as of quarter three, and consider whether any actions are required (as per the table below);

<table>
<tr><th>Strategic Risk</th><th>Current Risk at Quarter 3 position</th><th>Target Risk by 31 March 2022</th></tr>
<tr><td>SO1-1.1</td><td>15</td><td>15</td></tr>
<tr><td>SO1-1.2</td><td>20</td><td>20</td></tr>
<tr><td>SO1-1.3</td><td>12</td><td>8</td></tr>
<tr><td>SO1-1.4</td><td>20</td><td>20</td></tr>
<tr><td>SO1-1.5</td><td>12</td><td>9</td></tr>
<tr><td>SO1-1.6</td><td>16</td><td>16</td></tr>
<tr><td>SO2</td><td>20</td><td>8</td></tr>
<tr><td>SO3-3.1</td><td>12</td><td>5</td></tr>
<tr><td>SO3-3.2</td><td>12</td><td>15</td></tr>
<tr><td>SO4</td><td>12</td><td>8</td></tr>
<tr><td>SO5</td><td>8</td><td>8</td></tr>
</table>

b) receive for assurance the Board Assurance Framework (as at Appendix A) which details the progress against the delivery of the Trust's strategic objectives;

c) note the above Sub-Committees have considered the Board Assurance Framework at their meetings;

d) note the report below, the controls, assurances, planned actions and underpinning high level risks associated with each strategic risk.</td></tr>
<tr><td>Background Information and/or Supporting Document(s) (if applicable)</td><td>N/A</td></tr>
<tr><td>Prior Approval Process</td><td>✓ TMB – 21.02.22
✓ Quality & Safety Committee – 25.01.22
✓ Finance & Performance Committee – 18.02.22
✓ Workforce Committee – 30.11.21
✓ Risk Management Group – 15.03.22
☐ Divisional SMT
☐ Other: Click here to enter text.</td></tr>
</table>

Which Trust Priority does this link to	✓ Pandemic Response ✓ Quality and Safety ✓ Estates, Equipment and Capital Investment ✓ Finance ✓ Partnership and System Working	✓ Workforce and Leadership ✓ Strategic Service Development and Improvement ✓ Digital ✓ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s)	N/a	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	☐ Information ✓ Review ☐ Other: Click here to enter text.

Board Assurance Framework (BAF)
Quarter 3 Review (1 October – 31 December 2021)

1. Purpose of the Report

1.1 To present the quarter three BAF to the Trust Board. The BAF triangulates relevant information on the risks to the delivery of the board's Strategic Objectives, highlighting risks, controls and assurances. It is an essential tool to support the Board in seeking assurance against delivery of key organisational objectives. It is envisaged that through appropriate utilisation of the BAF the Trust Board can have confidence that they are undertaking thorough oversight of strategic risk. The BAF is utilised to support the Board in receiving confidence about the likely achievement of each of its Strategic Objectives.

1.2 The Trust Board Sub-Committees are responsible for reviewing the relevant objectives and risks and providing assurance to the Trust Board on progress.

1.3 The Trust Board is responsible for setting its assurance framework, to capture the key risks to achieving the Trust's strategic goals, and detail the level, or lack of, assurance during the year as to what extent the level of risk is being managed.

1.4 The Trust has in place a 'ward to Board' process for risk management, which allows for the BAF to include reference to relevant risks from the High Level Register where they may impact on the achievement of the Trust's strategic goals.

2. Background

2.1 Following the Trust Board meeting on 7th December 2021 the following actions were agreed and have been completed:

- Add annual targets to the risk scores for each strategic risk;
- To review and consider additional sub-categories for Strategic Objective 2. Following a meeting with the Chief Nurse, Director of People and Director of Corporate Governance it was agreed to move the safe staffing element from Strategic Objective SO2 to SO1-1.1.

2.2 Further developments include the separation of planned actions on a quarterly basis for each Strategic Objective. This is to provide an easy reference against required actions at set timescales**.**

2.3 The Risk Appetite Score is now included in the description section for each Strategic Objective (see column H, rows 5 to 8 for each spreadsheet).

2.4 The Enabling Strategy / Plan is also included (see column L, rows 5 to 8).

2.5 All strategic risks have been reviewed by their associated Board Sub-Committee with the exception of the Strategic Development Committee. This will be addressed as part of their initial programme of works.

2.6 End of year risk ratings have been added to the Strategic Risk Ratings spreadsheet for easy reference as noted in Section 3 below.

2.7 Please note that the blue text in the updated BAF signifies updated information and red illustrates text to be deleted once this has been reviewed and approved at the Trust Board.

3. Summary of Current Risk Ratings by Strategic Objective Risk

3.1 The full BAF is available at Appendix A, and the Strategic Objectives are detailed below with the current risk ratings for quarter three:

Strategic Risk Ratings

Strategic Risk	High Level Risk Description	Risk Consequence / Impact Assessment (Catastrophic 25 · Major 20 18 16 15 · Moderate 12 10 9 8 · Minor 6 5 4 · Insignificant 3 2 1)	Risk Appetite	Risk Rating 2021-22 Q1	Q2	Q3	Q4	Target Risk 31.03.22	Owner	Assurance Committee
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard		Low	15	15	15		15	Medical Director and Chief Nurse	Q&SC
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets		Low	20	20	20		20	Chief Operating Officer	F&PC
SO1 - 1.3	The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy		Low	12	12	12		8	Director of Strategic Development	SDC
SO1 - 1.4	The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate		Low	20	20	20		20	Director of Estates and Facilities	F&PC
SO1 - 1.5	The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care		Low	12	12	12		9	Chief Information Officer	ARG
SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope		Low	16	16	16		16	Chief Operating Officer	F&PC
SO2	The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients.		Low	20	20	20		8	Director of People	WC
SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities		Moderate	12	12	12		5	Chief Financial Officer	F&PC
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital		Moderate	12	12	12		15	Director of Strategic Development	SDC
SO4	The risk that the Trust is not a good partner and collaborator		Moderate	12	12	12		8	Director of Strategic Development	SDC
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives		Moderate	12	12	12		8	Chief Executive	WC

KEY	
◆	Inherent risk score
◆	Current risk score
◆	Target risk score

KEY TO COMMITTEE NAMES

Quality and Safety Committee - Q&SC
Finance and Performance Committee - F&PC
Audit Risk and Governance - ARG
Workforce Committee - WC
Strategic Development Committee - SDC

4. Strategic Objectives – Current and Target Risk Ratings

4.1 The table below demonstrates the current risk rating of each Strategic Objective against the target risk rating by the end of March 2022:

Strategic Objective	Current Risk at Quarter 3 position	Target Risk by 31 March 2022
SO1-1.1	15	15
SO1-1.2	20	20
SO1-1.3	12	8
SO1-1.4	20	20
SO1-1.5	12	9
SO1-1.6	16	16
SO2	20	8
SO3-3.1	12	5
SO3-1.2	12	15
SO4	12	8
SO5	8	8

4.2 The Risk Ratings for each Strategic Objective have been reviewed and the Trust Board are required to note that several strategic risks remain at a high level of 15 and above, as detailed in the table above.

5. Recommendations

The Trust Board is asked to:

a) review the strategic risks which remain at 15 and above as of quarter three, and consider whether any additional actions are required (as per section 3.1);

b) receive the complete BAF (at Appendix A) which details the progress against the delivery of the Trust's Strategic Objectives;

c) note the above Sub-Committees have considered the BAF at their meetings;

d) note the detailed report, the controls, assurances, planned actions and the underpinning high-level risks associated with each strategic risk.

NLG(22)050

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Gill Ponder, NED / Chair of Finance & Performance Committee	
Contact Officer/Author	Lee Bond, Chief Financial Officer	
Title of the Report	**Finance & Performance Committee – Minutes of the meeting held on 22 December 2021**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Finance & Performance Committee held on 22 December 2021 and approved at its meeting on 18 February 2022	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Finance & Performance Committee
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ☐ Estates, Equipment and Capital Investment ✓ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **22 December 2021 – via Teams Meeting**

PRESENT:	Gill Ponder	Non-Executive Director / Chair of F&P
	Simon Parkes	Non-Executive Director
	Fiona Osborne	Associate Non-Executive Director
	Peter Reading	Chief Executive
	Lee Bond	Chief Financial Officer
	Shaun Stacey	Chief Operating Officer
	Shauna McMahon	Chief Information Officer
	Jug Johal	Director of Estates & Facilities
	Ian Reekie	Lead Governor
IN ATTENDANCE:	Dr Kate Wood	Medical Director (For item 6.1)
	Anne Sprason	Finance Admin Manager/PA to CFO (Minutes)

Item 1 12/21 Apologies for absence were noted from: Stuart Hall, Helen Harris and Brian Shipley

Item 2 12/21 **Quoracy**

Gill Ponder noted there were sufficient Executive Directors and Non-Executive Directors in attendance to ensure quoracy.

Item 3 12/21 **Declarations of Interest**

Gill Ponder referred to a new process that required any new declarations of interest to be notified to her as Chair, prior to the start of the meeting.

There were no new declarations of interest made.

Item 4 12/21 **To approve the minutes from the previous meeting held on 24 November 2021**

The minutes from the meeting held on 24 November 2021 were reviewed and agreed as an accurate record.

Item 5 12/21 **Matters Arising**

All actions from the minutes were included either on the agenda or the action log.

5.1 Action Log

The action log was reviewed.

5.1 (24 11 21) – CQC Report – Weekend sessions in Echocardiology to reduce backlog to be updated in report. Shaun Stacey advised that Cardiology were picking up additional work which needed to be incorporated into respective reports, but there had been delays with the data feeding through. Once that had been done the Committee would be able to see improvements. **Item closed**.

7.2 (24 11 21) – Civils Infrastructure – As part of the planning process, Estates priorities and operational impact to be reviewed to ensure Trust Board were sighted on the short-term risks. Also, clarity required on the actions possible, funding needed and the choices that the Trust would have to make when allocating funding. Jug Johal advised that two pieces of work were being actioned i.e. business planning and building a 5-year BLM plan which would cover both actions. The due date was changed to February to allow time for that to be done.

8.3 (24 11 21) – Planned Care – Levelling up of waiting lists with ICS; more detail to be included in the IPR. Shaun Stacey advised that discussions were still ongoing with ICS, but there were 40 patients a week from outside of the health area i.e. 20 from York and 20 from HUTH that week. The patients had been electronically transferred to the respective services. More capacity had been offered but this came with consequences and doing everything to mitigate.

Shaun Stacey noted that whilst parameters had been agreed with the ICS, the risk was that taking long waiters from other regional trusts as part of the levelling up process would lead to NLAG's waiting lists increasing. Information would be provided from February on the levelling up status, noting the difficulty in being able to distinguish which trust were transferring patients. It was agreed to close the item on the action log and add to regular monthly reporting from February.

Action: Shaun Stacey

8.3 (24 11 21) – Cancer Performance – Improvement programme with Q&S oversight. Shaun Stacey to provide a Q&S report to the F&P Committee for information.

Post Meeting Note: The report was circulated on 23 12 21. **Item Closed.**

6 – (24 11 21) – Finance Report M07 – Virtual Ward Expenditure. Lee Bond advised that the information formed part of the Nursing Establishment review and was due to be discussed with Ellie Monkhouse later that day. Item to be carried forward to February.

Lee Bond highlighted that one of the key developments that NHSE/I mandated was a bigger push of virtual wards to create more capacity. Funding was earmarked with recommendations on the number of people managed through the virtual ward route. It would feature more prominently in the new financial year.

6 – Finance Report M07 – CIP recurrent shortfall against forecast outturn. Lee Bond confirmed that he had answered this query from Fiona Osborne and responded direct. **Item closed**.

All other items were included on the agenda. Following review, the action log was noted.

5.2 Formal Confirmation of Deputies for each Executive Director of the Committee

Gill Ponder asked for formal confirmation of Executive Director Deputies and the following were advised:

- Lee Bond – Brian Shipley, Deputy Director of Finance
- Shaun Stacey – Abdi Abolfazl, Deputy Chief Operating Officer
- Jug Johal – Simon Tighe, Deputy Director of Estates & Facilities
- Shauna McMahon – Chris Evans, Associate Director of Information Systems

5.3 Action Plan from Committee Self-Assessment

The action plan from the F&P Committee Self-Assessment exercise had one outstanding action for review in December 2021; this related to the Highlight reports for Trust Board.

Fiona Osborne suggested that the question should be asked of the Board if sufficient assurance was given through the highlight reports.

Shaun Stacey suggested that a 360^0 view was required from those board members who did not attend the Committee. Given that a workplan was in place and reviewed throughout the course of the year, any additional referrals from other Committees added the approval of the by the Trust Board and the fact that minutes were provided, he was unsure what else could be provided. A 360^0 view could be undertaken once a year although noted that this was not an auditable measure as it was a retrospective review.

Ian Reekie stated that the highlight report was provided to the Board and was the primary source of assurance for Governors. He confirmed that the report served that purpose very well.

Shauna McMahon agreed and noted comments from Ian Reekie that the highlight report was sufficient assurance for the Governors.

Gill Ponder stated based on comments made a note would be added to the action plan and the item closed; the question would be posed to the Trust Board if sufficient assurance was gained from the Highlight Reports provided.

Action: Gill Ponder

Item 6 12/21 Presentations for Assurance

6.1 CQC Progress Report

Dr Kate Wood attended the meeting to present the report on behalf of Jennifer Moverley and highlighted there were 77% of actions either Blue or Green; eight actions had been approved and uploaded to the CQC in November; four previously red actions were now amber and an additional three actions had been added. There had been three actions moved to Q&S from F&P as discussed at the last F&P Committee.

There were 27 actions assigned to the F&P Committee i.e. 9 Amber; 3 Green; 13 Blue; there were no Red actions and 2 retired/on hold.

Fiona Osborne referred to the 62-day cancer waiting time target (top of Page 19) in Breast and the issue with Oncology at an ICS level which had led to a change of work for breast clinicians. She noted that this was a country wide issue and asked if there was anything to be addressed from NLAG's perspective. Shaun Stacey explained that the admin support had been reviewed and it had been identified that more investment was required. The oncology service had been centralised and waiting times had improved but the overall demand across Humber and the loss of an Oncologist had created a further challenge. The Cancer Alliance had reviewed the service with other alliances within the system which had resulted in approximately seven actions that the Alliance would jointly work on. Shaun Stacey noted that there was a gap of Oncologists both within this region and the North of England with only a small number coming out of their training programme. There was an international programme which would see Oncologists being brought in and supported to train which was a medium to long term plan. This was being led by the Cancer Alliance closely supported by the Oncology senior team at HUTH.

9.30am There were no further questions and Dr Kate Wood left the meeting.

Item 7 12/21 **Estates & Facilities**

7.1 BAF Risk Review – Sustainability

Jug Johal presented the report and highlighted specific issues to note including the £40.3m awarded for the Energy Performance Contracts (EPC2 and EPC3). EPC2 related to Goole and was expected to be completed by March 2022. EPC3 related to the Scunthorpe site and an extension to the original timescale had been granted for six-months to 31 March 2022. Discussions had been held between Jug Johal, Lee Bond and NHSE/I, SALIX and BEIS regarding extending the funding into 2022/23.

9.33am At this point Jug Johal had to unexpectedly leave the meeting and it was agreed that as a detailed report had been provided, any questions from the Committee should be sent through to Gill Ponder who would pick up with Jug Johal outside of the meeting.

Action: All

Item 8 12/21 Review of Monthly Performance and Activity Delivery (IPR)

8.1 Unplanned Care

Shaun Stacey presented the report and highlighted issues to note.

- Continued pressure on moving patients through the system and the ongoing challenge of workforce impacted on patient flow, ED waits and deteriorating ambulance handover times.
- The new UCS model had gone live in SGH and had shown a reduced wait with 98% of attends showing activity within 4 hrs and a reduction in unnecessary waits with patients streamed effectively.
- Slow decision making continued in the Medical division with some in surgery division
- Discharge to assess time was still holding in top three for region and top six in the Country.
- LOS remained below the national figure, but flow problems continued.
- Concern in managing flow given ambulance position, but it was understood it was a similar position across the region
- There was an ability to have an ED Care Team visit and assess issues within ED but the preference was to manage in-house if possible.

Gill Ponder queried the graphs in particular the discharge letters and Shaun Stacey acknowledged that the discharges needed to be completed in a timely way and work was underway to encourage more use of the electronic system. The “before noon” discharges were a challenge as not identifying those that could be discharged before midday. On non-acute wards, the decision to discharge also had delays which was another reason for changing the structure and through job-planning every ward would have a consultant seeing patients every day; this was to be implemented from January 2022. There were still problems with partner organisations which was proving difficult to resolve.

Fiona Osborne referred to the access and flow on cancer (page 11) that 100 pathways had already been analysed, noting that performance had not changed for some time and asked what the trajectory was for improvement.

Shaun Stacey explained the delays to specialist test access with the biggest internal risk being Colo-rectal and whilst investment had been made to look at pathways, it was now struggling to manage the flow of patients through the system. He had asked Q&S to focus on that area for a qualitative view. Shaun Stacey confirmed the trajectories would be part of planning.

Lee Bond referred to the number of discharges (page 8) and was unclear when he looked at the headlines because ED was showing poor performance, but LOS was better than target. In view of this apparent anomaly, he asked where the flow problem was manifesting itself.

Shaun Stacey explained that the numbers told a positive story but not on a daily basis and went on to explain the numbers within the report.

In terms of the SPC charts, Shaun Stacey explained that they were set above the national parameter and, when added to the regional figures, the Trust were better placed. He commented that the discharge lounge was not being used as productively as it could be and ward rounds had identified that decisions were not being made to send people home which needed to be reviewed and solved; having the daily consultant rounds should address that. There were blockages due to stranded patients, although numbers were low in the system, but bed occupancy levels compounded the problem. It was more challenging to discharge in North Lincs due to issues with nursing home closures which reduced bed access by 100+ beds. Issues with A&E delays were also contributing factors.

8.2 Integrated Urgent & Emergency Care / AAU Scheme and Patient Flow

Gill Ponder asked if the same model was used across the Trust and if the policy was embedded and there was evidence of that. Shaun Stacey explained that through discussions it had been noted that several clinical staff and partner organisations had not adopted the policy and the SOP and work had been undertaken to address the issue. He added that on average there were 42 admissions each day which required 42 available beds but were not able to use ED as an extension for that; new unit when it opened would result in better flow. Exit from the hospital was a major barrier, with 30-50 patients a day unable to leave hospital when they no longer met the criteria to reside.

Lee Bond noted there were a list of constraints including care homes, over which the Trust had no control, but some were in the gift of the organisation e.g. the speed patients moved from ward to discharge lounge once that decision was made and asked if there was an ability to list those constraints and rank them into those that could be addressed and priority order. He also asked how the Committee could be assured that patients were not coming to harm noting the information contained within the IPR on 4 hr metric and 12 hr breaches, noting that from April the measures would be moving to 12 hrs in the department as a key metric and asked how the Trust compared against that.

Shaun Stacey explained that reporting on 12 hrs on the daily SITREP had deteriorated, which was being monitored. It was known which items could be ticked off and the programme flow improvement team were working through those. He noted that there were Band 8 matrons looking at flow, medicine checking on discharge and improving flow by using consultant rounds twice a day. The other issue was space as specialty patients tended to remain in hospital longer than acute patients, but that required working with partners as they were the major player.

Fiona Osborne commented that the pilot at SGH in A&E was showing great results and on average patients seen within 4 hours. Shaun Stacey explained that it did not directly link to LOS in ED and had a target date of mid-January for DPOW to implement the same model, but there were still some issues to be sorted, including GP involvement.

8.4 Planned Care

This item was taken before item 8.3, as it related more to the discussion on urgent care than item 8.3

The elective position was still holding along with 52-week waiters and overall waiting times Diagnostics waiting times were improving, apart from non-obstetric ultra-sound, which was expected to improve over the next 2 months. Improvement seen in outpatient follow ups, but it was not where it was expected to be on the improvement trajectory; work was ongoing on that but Shaun Stacey was not hopeful that the expected improvements would be fully achieved by the end of the year.

8.3 OPD Transformation Programme

Shaun Stacey presented the report and acknowledged that Jackie France and the team had done a tremendous job considering Covid and other issues that had gone on and had made an impressive effort, including winning a Forward Healthcare Award. The Trust continued to see improvement in the roll out and hoped that in 2022/23 every speciality would be using the service. Non face to face appointments continued but more work needed to be done on the software platform, supporting clinicians to use it more and the culture of face to face appointments being the norm to increase take up. The Trust were still not using PKB apart from in cardiology and it was proving difficult to increase that, but there was some really good work going on.

Gill Ponder referred to the introduction of digital letters and the increase in DNAs to 10% and asked if there was any evidence that the increased use of digital letters correlated with the increase in DNA's. Shaun Stacey explained that the team felt that the increase in DNA's was more due to patients being concerned about attending hospital due to anxiety about Covid, but he agreed to talk to Jackie France about providing that information.

Action: Shaun Stacey

Ian Reekie commented that virtual consultations seemed to get bad press nationally, so it was pleasing to see the results of the survey that showed that 93% of patients found them more convenient. Patients had also responded favourably on feeling listened to during non-face to face appointments and on the opportunity to ask questions, with 41% saying that they preferred them to face to face appointments. Shaun Stacey commented that it reflected on Jackie Frances' team to reassure patients and in the main it worked well. As the use of non-face to face consultations had reduced, it was agreed that it might be helpful to share the patient feedback with clinicians who believed that patients did not like not being seen face to face, as it was more productive and more convenient for many patients.

Action: Shaun Stacey

Shauna McMahon stated that virtual consultations were a real collaborative effort in this region, due to good relationships with partner organisations. She also believed that patients had an appetite to do virtual and digital activities, including receiving digital letters.

Fiona Osborne congratulated the team on winning the award and commented that new ways of working and cultural change were the hardest to achieve and asked how the team were approaching that.

Shaun Stacey explained that it was a slow process which had commenced in 2018 when parameters were set. People who used the service were positive and the team tried to encourage clinicians to use it to change some patients' perceptions. Whilst technology was becoming more advanced there was still the need for face to face clinics but a balance of the two was needed.

8.5 Monthly Deep Dive – Diagnostics

Shaun Stacey presented the report and highlighted that improvements could be seen across most services, with Non-Obstetric Ultrasound (NOUS) having a plan in place to improve over the next 2 months.

Fiona Osborne queried the lack of ventilation in the scan rooms and Shaun Stacey explained that ventilation was part of the work as new scanners were commissioned. If new standards for ventilation in existing clinical environments were introduced, it would affect turnaround times.

Gill Ponder noted considerable improvements made and congratulated the team on that and she commented that when the planned improvements to NOUS were achieved, it would significantly improve service to patients as MRI and CT waiting times had improved enormously.

Item 9 12/21 Finance Report – M08

9.1 Lee Bond presented the report and highlighted issues to note as follows:

- The Trust reported a £0.30m surplus for November which was £0.79m worse than plan. The YTD position was now £0.20m deficit, which was £0.18m worse than plan. There were currently no material variances.
- Income was £0.93m worse than plan in month with the main issue being elective recovery fund which was £0.5m behind plan and almost £1m below what the Trust should have received for reducing the backlog of elective work. Additional costs were being incurred to do that work
- Medical staffing continued to be with overspent by £0.65m in month, similar to previous months.
- Nursing was in balance however there were two concerns i.e. underspend in midwifery, which could affect quality of care and nursing spend against Covid particularly with reduction of Covid funding by 60% in 2022/23. A meeting had been arranged for later that day with Ellie Monkhouse to understand those issues.
- £45m spent on bank and agency in year; £3.8m medical staffing and nursing £4m which was seeing an increase year on year. Medical spend could be attributed to elective work and not getting paid for same. Nursing vacancies were still a problem and whilst the Trust were mostly using compliant bank and agencies, there was still some non-compliance which was getting worse. The medical side was more about market rates due to the strong position relative to supply and demand.
- CIP forecast £10.5m due to increased requirement in H2 for the ICS. £1m of the increased requirement was forecast to be delivered but that still left a gap of £0.5m. The position was reasonable given pressures and the challenges requiring operational teams to focus on delivering care for patients.
- ERF was variable due to system performance which resulted in no funding in October or November, despite the Trust achieving the base minimum thresholds. Discussions

were taking place about any other opportunities to access funding for that work.

- Capital spend to date was £24.64m which was circa £46m behind plan. The grant funded schemes were currently behind plan by £34.8m with regard to energy efficient schemes and talks were continuing with NHSE/I, Treasury and BEIS to come up with a legitimate way for BEIS to allocate income to place contracts for work that would continue into 2022/23 to enable completion of the schemes particularly at SGH. Lee Bond was confident that available capital would be spent by year end.
- Balance sheet was in a reasonable position and cash flow was not an issue. The only concern was getting the AAU FBC approved at national level and Brian Shipley was currently working through 40+ financial questions, with a further 40+ questions on estates and commercial schemes, which all had to be submitted later that day.
- The underlying financial position was steady at £20.5m and the emerging financial framework for the next financial year looked to be changing considerably.

Fiona Osborne asked if the financial framework would be an additional section within the finance report and Lee Bond advised as soon as the planning guidance was released he would circulate and provide a summary of the main changes and key points for the next meeting.

Action: Lee Bond

Gill Ponder raised an issue following a conversation with the Surgery team in relation to the income position which had moved by circa £600k from what had originally been reported. Lee Bond thought it could be a timing issue rather than a discrepancy and agreed to clarify.

Action: Lee Bond

Post Meeting Note: The issue had been with the Power BI report which understated the Surgery Division H2 activity and was subsequently rectified and showed an improved position.

Simon Parkes asked about the SALIX issue and if Lee Bond was confident that it would be resolved. Lee Bond explained that conversations were taking place with relevant parties on whether the funding could be rolled over into the next financial year, if not then the Trust would need to apply for the next available round which could be another year away, but he was cautiously optimistic.

9.2 Capital Investment Board Minutes

The minutes from the last CIB had been provided and were noted.

9.3 Recovery Support Programme for finance (RSPf) – Letter for Information

Lee Bond advised that a further meeting with NHSE/I had taken place and had discussed the M08 position. Whilst there was risk in the wider system, there was optimism over the ability to hit current targets. However, NHSE/I had recognised that the financial position could be affected by current Covid projections.

In terms of exiting FSM, the recommendation would be made to the regional team and then to the national team if they had confidence in the organisation to lift financial special measures. Lee Bond explained that the Trust could not come out of special measures completely until quality measures were also lifted.

9.4 Finance Cost Efficiency

Lee Bond presented the report and explained that a Costing Standards Group was in place, but attendance had proved difficult. The reference cost submission had been done but national problems with the software had caused difficulties. The team were now working through the recommendations from the previous year, including job planning which would help drive medical staffing spend and apportion it to the correct activities. Two reports had been received for both NLAG and HUTH and a summary was being prepared to compare both organisations for each Finance & Performance Committee. The benchmarking returns had also been received for both organisations and a summary would be provided for the F&P meeting in February. The data would be used as part of planning for the next financial year.

Action: Lee Bond

Gill Ponder noted a requirement to submit more frequent information and asked if there was a role for robotic gathering of information. Lee Bond explained that the national reference cost submission was not frequent enough and was trying to move away from tariff based and focus more on costs. There was a move towards quarterly submissions, but he agreed it would have to be an automated information flow. Lee Bond stated he welcomed any move to increase frequency but it would be a major learning curve and they would have to work with the IT information team to ensure that the information was available on a regular basis.

Shaun Stacey agreed with Lee Bond adding that bar codes could be used and scanned but he agreed automation was the key, as it was a recurrent theme every year. He suggested discussing attendance at the Costing Standards Group outside of the meeting.

Action: Shaun Stacey / Lee Bond

Shauna McMahon noted that working with HUTH and the new PAS system would help in collation of information and more efficient reporting and confirmed automation was on the radar for Digital Services.

9.5 HASR Review – Financial Principles and Neurology Update

Lee Bond presented the report which provided the financial arrangements that underpinned the transfer of the out-patient Neurology service from NLAG to HUTH as part of the P1 HASR programme.

Lee Bond explained that as activity was moved from one organisation to another the costs would be moved with it. Neurology service was the pilot speciality to provide a single Humber service. This had been a joint effort between the teams and the report was provided for information and noting.

Item 10 12/21 Digital Strategy

10.1 BAF Deep Dive – SO1 1.5

Shauna McMahon presented the item and referred to the BAF document provided at Item 11 for information, specifically pages 4/5.

Shauna McMahon stated that she was proud of the work the team had undertaken over the last year. The risk rating had been 16 and was now at 12 and the team would be looking ultimately to reduce it to the 4-6 range; any lower would involve significant investment that was unlikely to be affordable, but 4-6 would be a level of risk that the

Trust could reasonably accept. She advised that the Digital Strategy had been approved and people were now in the new posts created. A revamp of the governance arrangements had taken place and now included a Digital Strategy Board and a Digital Solutions Delivery Group.

Shauna McMahon highlighted that Digital Services had had good outcomes from audits; had undertaken upgrades to the data warehouse and PAS systems and had revamped the IPR, which had been praised by NHSE/I. Reports were taken through ARG Committee regarding penetration testing and Cyber security. The Windows 7 replacement process had achieved the target of having less than 50 or 1% of devices on Windows 7 The target for unsupported Windows 10 versions to be removed would also meet the required standards by January 2022.

Additional resource had been obtained to focus on business continuity and disaster recovery. The Trust had performed well in a recent table-top exercise, but some areas for improvement had been identified.

There had been an increase over the last few years in medical devices running on the network and the Trust had successfully sought funding to ensure more security for those medical devices. The driver over the next few years was to move towards more digital use and an aspiration to be paperless.

The Data Protection Toolkit had been submitted.

Gill Ponder asked if the Committee were content with the risk rating given.

Simon Parkes agreed it was appropriate and commented that the target risk should be considered in terms of moving to a digital solution against not moving and if achievable but using digital more and more gave many opportunities. Shauna McMahon confirmed that the risk rating was “doable” but would like to get it lower in the longer term.

The asset register was being reviewed and brought up to date, but difficulty was centralising contracts, having an inventory and identifying where different applications were within the organisation. Shauna McMahon highlighted the current issues with JAVA and explained that they were being tracked daily to identify where patches could be put in place.

Shauna McMahon stated that given the starting point with significant numbers of devices using Windows 7 and different unsupported server versions, the service was in a good position.

Item 11 12/21 **Board Assurance Framework (BAF)**

The BAF had been provided for information.

Gill Ponder asked the Committee if there had been any issues raised during the meeting that would question the BAF risk ratings; none were highlighted.

Item 11 12/21 **Items for Information**

12.1 Performance Letters to Divisions following PRIMs Meetings

The letters from November 2021 had been provided for information and were noted.

12.2 Finance & Performance Committee Workplan V3

The workplan had been amended to take out Strategic Risk 3.2a which had been moved to the newly formed Strategic Development Committee.

It was also noted that as sub-committees had been stood down in January due to operational pressures, the workplan would be further amended to reflect that.

Action: Anne Sprason

Item 13 12/21 **Any Other Business**

There were no matters raised.

Item 14 06//21 **Matters to highlight to other Trust Board Assurance Committees**

There were no items to highlight to other Trust Board Sub-Committees.

Item 15 12/21 **Matters for Escalation to the Trust Board**

The following items were noted:

- Ongoing challenge with ambulances and waits in ED on majors. Also add comment on changes to drive improvement.
- Ongoing cancer challenge around 62-day performance and the deterioration linked to Oncology pressures. Recognition of work being undertaken to try and achieve national standard for treatment.
- Diagnostic improvements
- Outpatient area patient feedback on non-face to face consultations at odds with internal perception of patient dislike of virtual consultations
- New financial framework for 2022/23.

Gill Ponder agreed to pull together the highlight report for the Trust Board and circulate to members of the Committee for agreement.

Action: Gill Ponder / All

Item 16 12/21 **Review of Meeting**

Due to time constraints, Gill Ponder asked if there were any issues that anyone wished to raise about the meeting. There were none.

Item 17 12/21 **Date and Time of next meeting**

Due to the standing down of the meeting in January because of operational pressures, the next meeting was scheduled to take place on **Friday, 18 February 2022 from 9.00am - 12.00pm**

Attendance Record 2021/22

Name	Apr 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	March 22
Neil Gammon	✓	✓										
Gill Ponder	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Linda Jackson	Apols	✓	✓	Apols	✓	Apols	Apols	-	-			
Stuart Hall	✓	✓	✓	Apols	Apols	Apols	Apols	Apols	Apols			
Andrew Smith	✓	✓	✓	Apols	✓							
Michael Whitworth				✓								
Fiona Osborne					✓	✓	✓	✓	✓			
Simon Parkes						✓	✓	✓	✓			
Lee Bond	✓	Apols	Apols	✓	✓	✓	✓	✓	✓			
Peter Reading	✓	✓	Apols	Apols	✓	Apols	Apols	-	✓			
Shaun Stacey	✓	✓	✓	Apols	✓	✓	✓	✓	✓			
Jug Johal	✓	✓	Apols	Apols	Apols	✓	Apols	Apols	✓			
Ivan McConnell	Apols	✓	Apols	✓	✓	✓						
Shauna McMahon	✓	✓	Apols	✓	✓	✓	✓	✓	✓			
Helen Harris	✓	Apols	-	Apols	-	✓	-	-	Apols			
Brian Shipley	✓	✓	✓	✓	✓	✓	Apols	✓	Apols			
Simon Tighe	-	-	✓	✓	✓	-	✓	✓	-			
Ab Abdi	-	-	-	✓	-	-	-	-	-			
Ian Reekie	✓	Apols	✓	Apols	✓	Apols	✓	✓	✓			
TOTAL ATTENDEES	**12**	**11**	**8**	**8**	**11**	**10**	**8**	**9**	**9**			

NLG(22)051

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	5 April 2022	
Director Lead	Kate Wood, Medical Director Ellie Monkhouse, Chief Nurse Mike Proctor, Non-Executive Director	
Contact Officer/Author	Mike Proctor, Chair of Quality & Safety Committee	
Title of the Report	**Quality and Safety Committee (QSC) minutes from January and February 2022 meetings**	
Purpose of the Report and Executive Summary (to include recommendations)	The paper includes the minutes of the Quality and Safety Committee (QSC) meetings for January and February 2022	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 25th January 2022 from 1.30pm to 3pm
Via MS Teams

Present:

Mike Proctor	Non-Executive Director **(Chair of the meeting)**
Maneesh Singh	Associate Non-Executive Director
Fiona Osborne	Associate Non-Executive Director

In attendance:

Dr Kate Wood	Medical Director
Dr Peter Reading	Chief Executive
Ellie Monkhouse	Chief Nurse
Angie Legge	Associate Director of Quality Governance
Jan Haxby	Director of Quality & Nursing SIRO, CCG
Diana Barnes	Governor
Jennifer Moverley (item 010/22)	Head of Compliance & Assurance
Graham Jaques (item 016/22)	EPR & Business Continuity Manager
Helen Harris (item 013/22)	Trust Secretary
Jane Warner (item 007/22)	Associate Chief Nurse Midwifery
Laura Coo	PA to the Medical Director **(for the minutes)**

001/22 Welcome and Apologies for Absence

Apologies for absence were received from: *Shaun Stacey*

002/22 Opening remarks

Mike Proctor informed that, due to ongoing Covid-19 pressures, the meeting was an abridged Quality and Safety Committee and the agenda was slightly shorter than usual and Angie Legge and Mike would provide an update to Board.

Mike noted that the Cancer and learning item (7.5) would not be discussed today as a paper had not been received however within the BAF there was reference to a cancer paper being brought to this committee next time. Fiona Osborne wondered if there was any support that could be given to Denise Gale given that she was supporting reports going to multiple committees and suggested that the same approach that Kate Wood was taking in providing the same report to various

meetings could be applied. Mike thought perhaps the paper going to the Cancer Network the following day could be used to inform the QSC on Cancer issues thereby reducing the managerial burden.

The Mental Health Act and strategy update paper (10.2) was distributed for information and interest as there was further work in progress to complete the document. Peter Reading added that the paper was taken to TMB the previous day and was approved but Peter asked for it not go the public Trust Board yet as although it was rich in content there remained some sections to fully work through with partner organisations. Peter suggested that Ellie Monkhouse's nursing strategy paper could be used as a template for the approach of the paper.

003/22 Declaration of Interests

There were no declarations of interest.

004/22 To Approve the Minutes of the Previous Meeting held on 17 December 2021

Fiona Osborne requested for the end of the second to last paragraph of page two to have a sentence added to say, *'Fiona asked for status of actions and Debbie said she would look at adding something in'.*

Page 5 second paragraph Fiona asked if the sentence could be extended to say, '*Fiona was surprised to see mental health featuring as it was a difficult subject to measure'.*

Page 5 last paragraph Fiona asked for the sentence that mentioned could be improved further to be changed to say *'digital solutions can only work instead'*

The minutes were otherwise accepted as a true and accurate reflection of the previous meeting.

Matters Arising

005/22 Ophthalmology Update

Mike Proctor referred to the update distributed which was taken as read.

The update demonstrated improvement in Ophthalmology which was already monitored through the Quality Governance Group (QGG). It was agreed that it was not necessary to have continued updates to this Committee and that any exceptions or concerns would be escalated via the QGG highlight report.

006/22 Simplified reporting

Kate Wood informed the Committee that following the discussions at the December QSC the decision was made to take a standard approach.

Regular Reports

007/22 Family Services with Maternity / CNST

Jane Warner joined the meeting at 1.40pm

Jane Warner referred to the document distributed which was taken as read and provided a summary of the key points but apologised for the omission of the divisional governance report with the assurance on Paediatric services. For the purposes of this paper the Committee were acting as a delegate of the Board.

Kate Wood commented that it was important that this Committee continued to keep tracking the progress on Ockenden, part two would be coming out in the next couple of months so the Committee needed to provide continued oversight and support.

Maneesh Singh thought the report was very thorough but found it difficult to know whether there were any areas that were struggling or not.

Jane Warner had nothing that she felt particularly anxious or worried about, the time scales were much shorter and the ask much larger, but Jane felt more confident going into year four. There was a lot of work around pre-term birth and there was also a lot of training required. The team were keen to go back to face to face training but then this had been hampered by the Omicron wave. Jane also acknowledged challenges in enabling the Trust to get the compliance that expected for CNST. The team now had some admin support in a Project Manager role. The team met fortnightly and for saving babies lives, the team met weekly each Thursday.

Ellie Monkhouse had read the emails about the updates prior to the meeting and was a little confused as this was the update for maternity and CNST and was the quarterly maternity update. They would not be able to cover Paediatrics as well, Ellie thought that sat under the Divisional update. Angie Legge clarified the workplan referred to two reports - Maternity CNST and Divisional update. Ellie confirmed the Committee would receive both updates in the fullness of time.

Kate asked Jane how they were getting on with recruitment to the roles and were they able to recruit with the additional Ockenden funding. Jane confirmed they had some money for various elements, the Midwifery element did have a number of vacancies of approx. 25wte and they were experiencing problems recruiting to those posts. They had found that midwives were moving between the local trusts Hull, Lincoln etc. as a result the problem was difficult to resolve. Although there had been some greater numbers of training, the Trust would not benefit from those for a few years and were going to look at international recruitment. The consultant interviews were going ahead, and they had received some funding to support the training element which was great news and they were able to go out to recruit an educator and admin support to support their training.

Peter Reading had visited the Division and had spoken to some of the more mature midwives and wondered if it was possible to do some age profiling and look at opportunities such as retire and return. Jane had already done that, the retirement age was 55 but for retire and return the number of hours they could return was limited, they would not allow any body to come back for more than 24

hours, our agreement locally was for 18 ¼ hours. It would cause some issues for Jane for example if a Midwife came back for 12 hours which would be 1 shift would have to consider holidays as well as training before they would be competent to carry out their jobs.

008/22 Delivering Midwifery Continuity of Carer at full scale

Ellie Monkhouse referred to the paper distributed which was taken as read and set the scene.

Jane Warner noted that within Women's Services, for continuity of care, women would be deemed to have a clear person responsible for their care, those that did not come under that would be under a tertiary care centre such as Sheffield. Studies had proven that if women knew their Midwife (continuity of care) it would be better for the women.

The expectations would be that a small number of midwives would follow the women through their pregnancy. They already had a few teams where this was working quite well, when they worked well there were not more than eight midwives per team, and it followed an availability model. The document showed it was an implementation plan for our organisation to roll that out and the appendix showed it would be done in four waves and in three teams. They would be geographically based and were for the most vulnerable women, with two teams at Grimsby and one at Scunthorpe but it would eventually be rolled out for everybody. There would be some core staff who would not be part of a team. They would require some investments and needed more staff ideally looking at a further 15/16 Midwives, but the team did not know where we would be able to recruit those additional staff. To make this work it did need those initial building blocks and one of those was about having the correct staffing. There was a strategy to deliver it which Ellie was leading on and they were looking for this Committee's approval of the implementation plan.

Fiona Osborne thought it was a very good plan and knew the first deadline would be missed but given the conversations about Midwives etc asked if the deadlines were realistic. Jane felt the way it had been set out meant it could be done safely. Maneesh Singh asked if they were looking for approval to say the plan was in place or that it was going to be achieved.

Mike Proctor clarified that the Committee was asked to approve the plan but could not determine the level of investment required or approve this. This was clearly a matter for the full Board.

The committee accepted the plan and Mike Proctor thanked Jane for her time.

009/22 Review of action log

25/21, Feb 21 - Ophthalmology performance – to be monitored through Quality Governance Group. Action closed.

Cancer report to be added to the action log for a report at the February meeting

010/22 CQC Improvement plan update

Jennifer Moverley referred to the report distributed which was taken as read and highlighted the key points.

There continued to be a focus on any actions that were rated as red and on ensuring mitigations were in place where actions had not yet been achieved.

- Two actions had moved from green to amber.
- The oxygen prescription was due to sustained poor audit results and would be reaudited at pace.
- One action had been signed off linked to baby abduction.
- There were no red actions and 10 amber actions.
- CT5 Community nurse staffing – additional CNRNS from December
- 18 EoL – had been delays due to the scale but the bluebell model was in place and self-assessment was happening
- Medicine – delayed by operational pressures now had an additional Governance Lead in post
- 15P – Boards were in place but did not include everything that was required so additional spot checks would be carried out.
- 19P – Medical Records staffing now moved to green
- 7ED – significant plans and mitigation were in place and the pilot had started
- 29S – checking equipment in Theatres, from spot checks it was found that compliance was not very good so spot checks would be repeated soon

Kate Wood thanked Jennifer for the work within the divisions for pulling this together to improve the quality of care the Trust provided. Kate liked that there was now that transparency and sense check to ensure actions were sustained or not, everything was checked and if not new went through it again.

CQC were not expected in January but further than that we really did not know for sure.

Peter Reading picked up the point about Theatres and equipment and wondered whether it was cross referenced with the culture in Theatres and if there was any link to Jennifer's work and that of the Never events. Angie Legge advised that the equipment checklist was something different and Angie did not think NLaG Theatres were any different to any other organisations and there was not a clear evidence base to say one process for accountable items was safer/better than another. There had been discussions about commissioning an ergonomist in to look at the processes to see whether the process could be made safer by looking at how staff interacted with that process. NHSE/I had kindly agreed to fund that piece of work which Angie needed to check before it went through. The ergonomist would touch on culture but would not look at the potential culture of how for example the interactions worked between the nurses, ODP's and surgeons. Maneesh Singh would be interested to see how that worked and would discuss with Angie outside of the meeting. The practice that Peter and Kate Wood had pursued was that they did not hesitate to get outside scrutiny so some oversight would be helpful. Peter noted that a cultural concern had been identified through the number of never events, Angie agreed and said she would speak with the division about their actions to address that.

Kate added that the Surgery and Critical Care Division were taking these events incredibly seriously and had two whole sessions planned to investigate things across the multi-disciplinary teams .

Jennifer Moverley left the meeting at 2.27pm.

011/22 IPR

Kate Wood referred to the report distributed which was taken as read and invited any comments or questions.

Fiona Osborne asked about the 30 days readmission rate and if there were any themes or detail. Kate would need to refer to our Operational colleague to answer that who unfortunately was not present. Still needed to work through what was covered and obviously in some areas the turnover was rapid. Where there were early discharges it had been noticed that it increased the chances of re-admission.

Ellie Monkhouse agreed with what Kate had said but it corresponded with the Omicron surge and 30 days threshold is generous when individuals have chronic conditions.

Mike Proctor found the executive summary helpful and thanked Kate and Ellie for the report.

012/22 Quality Priorities

Angie Legge referred to the paper distributed which was taken as read.

The paper had been brought to the Committee for a decision and she asked for the Committee to support the recommended Quality Priorities for 2022/23.

The priorities had been developed with a view to enable focussing our resources on several key areas, there was a national requirement to develop Quality Priorities which specified the Trust had 3 measurements under each of the three Darzi domains. The report included some recommendations towards the end (page 10-11) which were the ones they thought as a team would be most relevant. This had been out for patient consultation; the patients wanted waiting lists to remain, but Angie had suggested taking it out as it was already a priority within the Operational team and well monitored, so inclusion here was duplication. In respect of diabetes, Angie noted that there had been a considerable amount of work in diabetes and performance was largely good, hence the recommendation to remove this. It was recognised that the issue of blood sugar monitoring in A&E was still not quite embedded at 100% but the audit on that would continue.

Following up on what Angie had said, Fiona Osborne commented that as this Committee had seen a progression of how this list had been put together, and the development of this list with the explanation as to how things would be monitored, she fully supported it.

Mike Proctor commented about some of the metrics set, as he was concerned there was a risk, we might set the organisation up to fail. Peter Reading agreed with Mike's comments and thought a conversation with the relevant people about more appropriate metrics would be very helpful.

013/22 BAF

Helen Harris referred to the report distributed which was taken as read and summarised the key points.

The overall risk rating had not changed. The Trust Board had previously asked for yearly target risk rating to be included which had been added up to March 24, they included the risk appetite score included in the BAF itself and the enabling plans.

Helen drew members attention to the gaps in controls; due to operational pressures Helen had been unable to get a further update from Shaun Stacey or Christine Brereton prior to submitting the report.

Mike Proctor added that the Oncology services report would be a presented to the next Quality and Safety Committee. Mike asked if the one about workforce sickness and vacancies should include further knowledge of the compulsory vaccinations linked in.

Looking at the areas affected by the vaccinations Peter Reading wanted to make sure things were not duplicated however Mike though it was important to note how they impacted quality of care and be able to reflect on the mitigating issues.

014/22 Nursing Assurance Report

Ellie Monkhouse referred to the report distributed which was taken as read and summarised the key points.

The report contained assurance about how it had felt for staff working through the pandemic and the Omicron surge. Ellie drew members attention to the fact that they were trialling some OPEL levels across the Trust with regards to the decision making they were used daily with the oversight of the Chief Nurse or Deputy to agree the overall OPEL level for the Hospital and Community nurse staffing levels. Peter Reading had sat in on one of those sessions discussing clinical judgement and safe care.

Over had 60 new volunteers had joined the organisation, most of the new volunteers were in the lower age range.

Ellie noted that C2 had triggered in falls for the second consecutive month but that it was one of the areas that had staffing issues.

Ellie drew members attention to the safer staffing self-assessment carried out. Ellie had added in a RAG rating to those areas. In respect of item 4.8 on risk appetite, Ellie asked if we had reviewed our risk appetite in line with the pandemic. Ellie asked for Helen Harris's opinion and guidance on this.

Helen outlined the review early in 2021, looking at the BAF and the Trusts risk appetite statement, Helen agreed that a great deal had changed during the pandemic and acknowledged it was worth another review of the risk appetite and would catch up with Ellie and Peter Reading outside of this meeting. Peter agreed thinking of the current pressures that had changed the way we regarded risk and what we needed to do. Fiona Osborne picked up on that point and thought this probably needed a more regular review as the major impacts arose.

015/22 Key SI Update including Maternity

Angie Legge referred to the report distributed which was taken as read, noting there were no new maternity Serious Incidents but there was a new Never Event which had been discussed with the CQC report.

016/22 Oxygen major incident action plan update

Graham Jaques joined the meeting

Angie Legge referred to the paper distributed and gave some context.
A major incident was called in November 2020 relating to the Medical Gas Pipeline System and the concern about the lack of capacity to deliver oxygen to our patients through the pipelines. This investigation report had been taken to the Private Trust Board, and there had been a separate report by another agency.

This paper identified the current position with regards to the action plan. There were several actions that were complete and a couple they had been told were complete but had not seen sufficient evidence to be able to close them.

Angie asked for members views on Appendix two, this was a request by the action owner to amend the action about a quarterly report on EPRR. This had been put in place as the investigator felt there was insufficient evidence of assurance on EPRR to the Board subcommittee level.

From an EPL perspective Graham Jaques felt some of the actions to manage the risk were not appropriate to NLaG i.e. if the evidence was to monitor the medical gases was not sure what a regular update on EPRR would achieve hence his request that this be about medical gases going through the route from Medical Gas Committee rather than a wider EPRR report.

Peter Reading thought the incident part of what happened was almost secondary, and it could be argued that it was a quality and safety issue as the crisis was linked to the needs of the patients but ultimately the crisis was the lack of pipework which would go through Finance and Performance (F&P) and Medical Gases Committee. The Medical Gases committee reported to the Health and Safety Committee which then reported to TMB.

Kate Wood agreed that the Medical Gases Committee should monitor it. It was not about medical gases per se it was about business continuity and surge planning so it would be more linked to ARG so asked how often they reported to ARG.

Graham added that as we saw the Omicron variant emerging, they acknowledged that risk to reaffirm the processes and thought it was the timeliness' of these things that was key. They were well documented through the winter plan considering proportionality and appropriateness. Peter still believed the underlying problem was the pipework which sat with F&P but picking up Kate's point agreed we ought to write to each of the three Committee chairs to say that we needed to ensure oversight of this particular issue. The issue about involving clinical practice was separate. Mike Proctor supported Peter's suggestion.

Graham added for assurance a deep dive was carried out for medical gases and when the findings were submitted, we had one of the highest assurances when measured against the core standards.

Action: The monitoring of actions should be sub-divided between Board sub-committees; QSC, ARG and F&P according to their remits. MP to report this to the Board.

Kate thanked Graham for leading the Trusts emergency responses we could not have done a lot of it without him.

Highlight reports

016/22 Quality Governance Group (QGG)

Not discussed

Items for information

017/22 Quality Governance Group (QGG) minutes

018/22 Mental Health Act and Strategy Update

019/22 Any Other Business

020/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

To be agreed outside of the meeting.

021/22 Meeting review

Not discussed.

022/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 22 February 2022
Time: 1.30pm – 4pm
Venue: Via MS Teams

The meeting closed at 3.04pm

Annual Attendance Details:

Name	Oct 2021	Nov 2021	Dec 2021	Jan 22	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022
Michael Proctor		✓	✓	✓							
Michael Whitworth	✓	✓									
Fiona Osborne	✓	✓	✓	✓							
Maneesh Singh	✓	✓	✓	✓							
Dr Kate Wood	✓	✓	✓	✓							
Ellie Monkhouse	✓	✓		✓							
Dr Peter Reading	✓	✓	✓	✓							
Angie Legge	✓	✓	✓	✓							
Helen Harris		✓		✓							
Jan Haxby	✓			✓							
Jennifer Moverley	✓	✓	✓	✓							
Shaun Stacey			✓								
Ian Reekie		✓									
Diana Barnes	✓		✓	✓							

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 22nd February 2022 from 1.30pm to 3.30pm
Via MS Teams

Present:

Maneesh Singh	Associate Non-Executive Director **(Chair of the meeting)**
Fiona Osborne	Associate Non-Executive Director
Linda Jackson	Vice Chair

In attendance:

Dr Kate Wood	Medical Director
Dr Peter Reading	Chief Executive
Ellie Monkhouse	Chief Nurse
Angie Legge	Associate Director of Quality Governance
Diana Barnes	Governor
Ian Reekie	Governor
Shaun Stacey	Chief Operating Officer
Jennifer Moverley (item 037/22)	Head of Compliance & Assurance
Iona Johnson (item 032/22)	General Manager for Family Services, Community and Therapies
Denise Gale (item 035/22)	Associate Director of Cancer
Hayli Garrod (item 034/22)	Acting Head of Quality Assurance
Mr Kishore Sasapu (item 031/22)	Deputy Medical Director
Laura Coo	PA to the Medical Director **(for the minutes)**

023/22 Welcome and Apologies for Absence

Apologies for absence were received from: *Mike Proctor and Jan Haxby*

024/22 Opening remarks

Maneesh Singh welcomed the group and advised that he would be chairing the meeting in Mike Proctor's absence meeting. Maneesh acknowledged the operational pressures and formally noted a thank you from the Non-Executives for the hard work by front line staff.

025/22 Declaration of Interests

There were no declarations of interest.

026/22 To Approve the Minutes of the Previous Meeting held on 25 January 2022

Item 006/22 – Kate Wood noted that it should say '*following the discussions at the December QSC the decision was made to take a standard approach'*.

Item 007/22 - Ellie Monkhouse referred to the fourth paragraph and noted that it should say the ask was '*larger'* not smaller. Ellie was also not sure that the first sentence of the next paragraph was relevant and suggested it was removed.
Item 007/22 – Fiona Osborne suggested that a sentence should be added at the beginning of the section to say *'the Committee were acting as a delegate of the board'* so that it was clear for audit purposes.

Item 010/22 – In the last paragraph of page five, Kate Wood requested for the words '*and bringing in'* to be removed.

Item 010/22 – In the first paragraph of page six it talked about two whole days but should be two whole sessions.

Item 011/22 - Fiona Osborne commented that an action should have been noted for Kate Wood to provide some detail around the 30-day admission date but as it hadn't been recorded, Fiona would raise it again.

Item 016/22 - Kate Wood thought it was agreed that ARG was going to take oversight of the oxygen action plan and just wanted to ensure we were consistent in our approach. Peter Reading thought the minute was accurate as he recalled being disappointed at the lack of clarity and decision making should not be what this committee fell into. His suggestion was to identify ARG as the parent committee for the report but if there were safety issues or estate issues then we would ask that committee to monitor it. The risk was that there would be duplication of effort and a lack of clarity otherwise. Linda Jackson had asked Simon Priestley to ensure he kept hold of the action plan for oxygen and to confirm there was a workplan.

Attendance record - Fiona Osborne attended the meeting

The minutes were otherwise accepted as a true and accurate reflection of the previous meeting.

Action: Laura Coo to update the previous minutes with the amendments noted above.

027/22 Matters Arising

There were no matters arising.

028/22 Review of action log

Maneesh Singh asked if it was worth keeping the Ophthalmology action on the action log as there had been some work in the independent sector which may be of interest.

Angie Legge's understanding was that the Quality Governance Group (QGG) would keep oversight of that and it would only be discussed at this Committee by exception.

029/22 Regional submission Ockenden

Ellie Monkhouse referred to the paper distributed which was taken as read, and for all members to take note on behalf of the Board.

Maneesh Singh thanked Ellie for bringing it to everybody's attention.

030/22 Nursing assurance report

Ellie Monkhouse referred to the report distributed which was taken as read. The reporting for December showed when the Omicron wave had just started and of the Christmas period. Taking everything into account Ellie thought they did incredibly well and that was credit to our staff. There was higher sickness on Amethyst and C2; both Wards had been identified in the Trust special measures' regime. The report showed they had managed to maintain a degree of safety and quality over this difficult time.

Fiona Osborne noted the fact that the vacancies were down as a concern in Medicine, yet before Christmas it was looking positive about the overseas recruitment and asked if that was still the case and how big the problems was. In response Ellie advised that the current rate was sitting around approximately 13/14 % and that was due to combination of things; age of workforce, tiredness and fatigue, people moving to other Trusts but they had managed to maintain an average of 10/11% with overseas recruitment. They were going through their recruitment campaign for newly qualified nurses and had appointed 72 which was the highest appointed so far. They were also starting to work through conversions from Nursing Associates to Registered Nurses. Medicine had traditionally struggled, but they were starting to make inroads and with a bit of effort Ellie was confident it would improve.

Fiona asked if Ellie would be able to give an update on establishment reviews. With Lee Bond's support Ellie was hoping it would get through board processes for April, but they were still working through that and the risk assessment, there was a lot of work going on behind the scenes.

Linda Jackson thought it was a great report although worrying in part and asked about the Health Care Assistant (HCA) vacancies as they made up approximately half of our vacancies. The numbers had increased but they took a bit of knock with the vaccinations. Looking at it from a nursing point of view they had done an onboarding programme and were doing some work with the Princess Trusts trying to get some of the younger generation into health care. They had already managed to get a more diverse age range of volunteers. Whilst it was great to be part of the process, the indeed campaign was not necessarily the best for all locations particularly for our Trust and Ellie did not think it would be something the Trust would actively pursue. Ellie added that they were trying to maintain our agency as a bank pool too so that we always had people available.

Regular Reports

031/22 Risk Stratification & Clinical Harm

Kishore Sasapu joined the meeting at 1.54pm

Kishore referred to the update distributed which was taken as read and noted that the reports were starting to become uniformed.

NLAG were performing well in risk stratifying new referrals, Outpatient reviews, and Inpatients. However, further work continued to improve risk stratification in patients waiting with no due date and those who were overdue their review / follow-up Out-patient appointments, especially if they were 'unbooked'. In addition, work was still needed to reduce the number of patients whose Risk stratification had expired.

There continued to be a large PTL hence a risk existed. Things had been put in place to mediate that risk for overdue follow ups with no booked appointments and they sought assurance from the divisions at PRIMs and OMG to make sure that was happening.

Medicine were on target and were assured that by the end of March they would be caught up with all overdue follow-ups however the figures did not show that. Kishore was assured they were not carrying any risk, as the patients were being risk stratified and they were not coming across any patients coming to any harm. Having said that there were problems with capacity therefore a business plan was being put together to help address this.

Maneesh Singh asked if Cobra was up and running. Kishore advised that it was running. In May 2021 Colin Farquharson and Jackie France presented a paper for a different process, amalgamating both the clinical harm and risk stratification processes. The numbers were being tracked.

Maneesh commented that it looked like there were outliers for TIAs as there appeared to be a lot of patients waiting to be risk stratified in that area. There were still 25% of patients in overdue follow ups who needed risk stratification.

Kate Wood noted that this report was in evolution and asked if it would it be the same report that went to F&P. Kate had wanted some assurance for those patients within our waiting lists. The way that was working was that we would not know that until the patients had been seen in clinics. Kishore clearly articulated that it was not just about numbers but people and that the process had mitigated the risk significantly.

Shaun Stacey made an observation that the TIA was probably directly related to acute transient ischaemic attacks and was still a very manual exercise using a lot of people to track it. Their risks would be known but just needed to make sure the admin team pulled them through.

Action: Shaun Stacey to pick that up with Jackie France's team.

The understanding of clinical harm and waiting lists had improved a lot since 2018, Shaun was aware we were leading this and what had been achieved was quite innovative and had never seen this done at any other Trust. His compliments went to everybody who had been involved in the work and he felt there was a real opportunity to promote this.

Fiona Osborne though the report was excellent and gave detail coupled with how Kishore had articulated it. Knowing movements and understanding the trends month

on month would give us a sense of the people underneath that information to form a better understanding of the patients.

Linda Jackson echoed Fiona's phrase as there had never been this level of data before. Although from a lay person's perspective Linda found some of the information confusing it would be better to have a bit more of an explanation. Kishore agreed and they were trying to make it user friendly.

Shaun Stacey would ask Richard Peasgood to work with Kishore to present it in a simpler format. This was about the age and population demographics and making sure we were treating the right people at the right time.

032/22 Community update

Iona Johnson joined the meeting at 1.50pm

Iona referred to the report distributed which was taken as read and highlighted the key points.

The Division had finalised a significant piece of work to review and unpick the Community block contract with North Lincolnshire CCG. The partnership approach had been very positive and had seen an acknowledgement at Exec level that the funding for community services fell £1.1m short when compared to demand.

Several risks on the risk register were related to capacity, morale and health and wellbeing of the teams. These risks arose from the redesign of the patient pathways resulting in more care being provided in the community combined with imbalanced capacity and demand and on high vacancy rates.

100% of patients had a risk stratification attached to their referrals.

The number of PALs and complaints received had reduced to the within expected range.

There had previously been some challenges with Wheelchair Services, Community Dental and Neurological Therapy but the changes had been positive.

There were ongoing recruitment challenges in the dietitian roles and had been a huge amount of work around the EoL programme.

Finally, they were continuing to work on access performance perspective and needed to reduce the waiting times for Paediatric therapy. The continence service had some challenges but had some investment secured for that service, had recruited, and seen the waiting times reduced from 52 weeks to 37 weeks and hoping that would reduce again.

Iona invited any comments or questions

Iona had cited demand and capacity as a problem and Fiona Osborne noted that recruitment was not quick and asked with the mitigation within the report were, they confident they were sufficient in addressing the fatigued. Iona replied that in September a community allocation tool was introduced which showed where patients

were waiting for visits and it enabled them to see where the gaps were. They were doing everything they could to reduce the pressure on the staff.

Kate Wood asked if the £1.1 million was new money coming into the community or if it was money being recycled. There had been conversations about a system pot and recognition that more of that needed to go to Community and Therapies. The reason Kate had asked was that if a funding gap of £1.1 million was identified in one place would it be moved from somewhere else, but Iona clarified how that gap was going to be closed was yet to be determined.

Kate noted that EOL did not seem to feature prominently in the report, and the report usually had more detail relating to EOL.

Angie Legge asked if the Committee wanted a further update on EOL to come next month or when community next attended. Maneesh Singh and Kate requested for it to be at next month's meeting.

Linda Jackson felt the wording in the report could be a little misleading, but that there was an acknowledgement that there was a funding issue, but it was to be determined where the future funding was coming from

For clarity in response to Fiona's earlier question Ellie Monkhouse wanted to provide a bit more assurance. This Division were championing the professional nurse advocate role, it was a big national model for back into practice, and that would help the fatigue as well as getting the support. Secondly, in relation to EOL, reassessment of pain remained an issue, which had greater impact than EOL, and the acute pain nurses were working towards reassessment of pain being added onto WebV.

Ellie commented that she thought the part about the vacancies was positive and was testament to the team that they had been working below what their establishment should be whilst maintaining levels of quality and safety.

Ian Reekie very much welcomed the recognition for the shortfall of funding which had been ongoing for years and asked if this would preclude us from going down the route of virtual ward which he felt would increase the work.

Iona added that for the first time Community Services had featured very heavily in the operational planning guidance and there was funding for virtual wards. The allocation for the mobile ward was going to be 6 million shared between the providers and for us to be able to change our pathways there needed to be investment and they were confident they could access some of that funding. Discussions had already started to develop an Acute Respiratory virtual ward.

Maneesh thanked Iona for the update.

Iona Johnson left the meeting at 2.41pm

033/22 Key SI Update including Maternity

Angie Legge referred to the report distributed which was taken as read. Angie apologised as the monthly SI report had cited three new maternity incidents however

one of those (885) was for Paediatrics so it was two and Angie was happy to take any questions.

Kate Wood added that there were extensions because of the workforce and operation pressures. Kate Wood or Kishore Sasapu chair the Never events and actions were taken immediately to reduce the risk of recurrence which mitigated the investigation time.

Picking up on the old SI's and the retained swabs, particularly because of all the effort put in a few years ago, Linda Jackson asked what was happening with that. Angie commented that in many ways it was good that the WHO checklist was not the problem as this showed the work done previously had been successful. But given there had been two retained item Never Events, there was a feeling we needed to look at the issue differently, hence an Ergonomist had been brought in to look at whether the process for counting and recording retained items was optimised for safety and human behaviours.

034/22 QIA Update

Hayli Garrod referred to the paper distributed which was taken as read which was a brief update of the progress so far from April 2021. There were no new QIAs for the last quarter. The Trust had moved from having eight approved to 12 approved. four excluded and since this paper had been submitted had another one withdrawn. Given that most QIAs came in a specific annual time frame, Hayli recommend for this update to be less frequent and suggested every six months. All agreed.

Action: Laura Coo to update the workplan

035/22 Cancer & Learning

Denise Gale referred to the document distributed which was taken as read. The report showed a comparison and contrasts for cancer services and NLaG against other Trusts. They recently did a deep dive report which looked at some of the constraints on a diagnosis basis; between the two reports it showed how it affected ability to improve the backlog.

From a learning perspective there was a lot of work to do, what was not so clear was what the Divisions did with the information and how they took that to improve their pathways. Family services tended to look at all the root cause analysis and what could be done to improve. For Medicine and Surgery, they were not aware of any formal process. Denise thought the gaps were where the learning happened. 60% of our breaches were down to capacity either in workforce, diagnostics, or clinical capacity. The reason we do not achieve the 28-day diagnosis was because there was not the workforce to turn them out.

Maneesh Singh had concerns in diagnosis and asked if there was some sort of one stop shop. For tumours there was a one stop, but they did not have that in Colorectal or upper GI and they had to address the number of patents over 62 days without diagnosis. 60% of the backlog was non-cancer where clinical staff wanted to wait further before ruling out cancer; a high percentage of those were Colorectal. The team were working on reducing the delay after the first appointment by reducing the diagnostic tests. . A high proportion were confirmed oncology patients. Treatment

was not provided directly by NLAG and therefore not in our control. Even if we had faster diagnosis and we hit 100%, they would not get treated on time.

Fiona Osborne thought the report was very useful, picking up on those Divisions that were able to utilise the report, Fiona asked if Denise had an opportunity to address that with the Divisions and push it forward. Denise advised that this had been developed over years and Denise felt it was now at a level where they could use it.

Shaun Stacey reiterated that this had been a journey for the best part of three years now and they had met regularly with the Divisions. Shaun discussed the system for the process that the Divisions could follow, getting the faster diagnosis etc was important but the simple basic change could enable us to change. If the report from F&P was triangulated which Denise would share, it would be easier to see what challenge was, and Shaun thought, there was a qualitative opportunity to improve cancer services. The innovation was there in some cases, but it was those basic principles of cancer PTL management, which was very difficult for the clinicians, but as an organisation the rapid internal way of managing cancer was managed well. The report showed one of the biggest differences between us and HUTH. He suspected if we moved the repeat investigations, we could improve the outcome, but our clinicians had not changed in the last three years.

Peter Reading resonated 60% of the colorectal cohort was waiting for over 60 days and then found not to have cancer, and for him what was frustrating was that three years on the Colorectal issue remained the same. The question was how we could change those behaviours, and what were we going to do about it as Peter did not think it was being tackled internally and believed external intervention would be best.

Ellie Monkhouse felt some of the narrative conversation was helpful but wanted to know what the impact on quality and safety was as it had been a very performance related conversation and wondered why it had come to this Committee. I t was very difficult as it was very process focused. Maneesh added that performance was so closely related to quality and safety, there was a huge overlap and was glad the Committee had spent a bit more time on it.

Fiona commented that the report that went to F&P was excellent and summed up everything they needed to know but Ellie was right that the one thing that was missing was the summary on what this Committee needed to know.

Kate Wood made a comment about performance and quality and how they were so tightly interlinked. We were not hearing of any harm to our patients due to waits as Kishore Sasapu had said in his update on clinical harm, so we needed to be careful that the assumption was not made that long waits equalled harm to our patients. We did need to ensure all our resources were in the right place but needed to be careful that we did not say outpatients were being harmed as there was no evidence of this.

Kate did not like separate reports going to different committees and thought the same information should be presented in a uniformed approach and made a plea for us to start having cross cutting reports.

Linda Jackson also felt it was not clear what this committee wanted to get from this paper so for Linda those 60% of Colorectal patients for example was something that

needed to be picked out here. There was certainly a lot that needed to be focused on in that area.

Peter Reading noted that this again raised the fact that performance and finance no longer sat together, performance was a quality issue not a finance issue and a lot of time was wasted as delays diagnostics etc were being treated as performance issues. Peter believed the Committee structure would benefit from further consideration to optimise discussion. Maneesh agreed there really was a big overlap.

Linda concluded that this needed further discussion outside of this meeting and it should be discussed at their regular meeting with Shaun Stacey.

Maneesh thanked Denise for attending and providing the update.

Denise Gale left the meeting at 3.31pm

036/22 Potential Deviations from National Documentation

None to discuss

037/22 CQC Improvement plan update

Jennifer Moverley referred to the report distributed which was taken as read.

Jennifer highlighted the changes since the last report.

- One action had moved from red to amber: surgery mandatory training
- Five actions have moved from amber to green: maternity record keeping, Paediatric record keeping, EoL Mandatory training , EoL appraisals and theatre checklists .
- Three actions had moved from green to blue: Surgery VTE assessments, diagnostics seven days radiologist shortages and diagnostics reporting results
- EoL care given as best practice , bluebell model under review
- Oxygen prescription and audit results multiple actions in place and would be reaudited this month (two actions)
- Storage of confidential records – awaiting a repeat audit
- Information on boards in Paediatrics – assurance report going for sign off

Jennifer Moverley left the meeting at 3.24pm

038/22 IPR

Kate Wood referred to the report distributed which was taken as read and asked for any questions.

Fiona Osborne mentioned the percentage of patients readmitted within 30 days. Shaun Stacey informed the Committee that in May 2021 both Paediatrics and Women's services undertook some changes in their approach to ward attenders and those patients were admitted on eCamis, therefore the data in the report was an error it was showing that a ward attender had been admitted and they were trying to iron out that error which was driving that data anomaly and would hopefully be able move the position back and move the Trusts position back to well within the national guidance. This was picked up at the beginning of February and as part of a review

hoped it would be corrected within two months by June. Fiona thought it was helpful but asked for Shaun's team to update the commentary to reflect that.

Maneesh Singh asked about the VTE risk assessment and emergency section rates he was aware of recent national communication regarding monitoring caesarean section rates.

With regards to VTE Kate Wood had provided several updates; the work was ongoing, and she had nothing further to add and had spoken to Shauna as there was no point every month flagging that it needed to be discussed

With regards to maternity, a letter had been received and had asked for it to be removed from the IPR until there was a national agreement as to what the matrix should be. Ellie Monkhouse agreed with Kate and thought there could be other things included which would be better indicators of safety such as third-degree tears for example.

The SJR data was not correct as there was a lag in the reporting rather than the actuality as they were now up to date.

Highlight reports

039/22 Quality Governance Group (QGG)

Angie Legge referred to the highlight report which was taken as read. Kate Wood commented that one thing which needed to be mentioned from the highlight report was the National Lung Cancer Audit and NLaG was an outlier in the management of lung cancer. Stuart Baugh was doing some work on that and felt this was about more about the delayed diagnosis in lung cancer but was it was a real concern for our patients that there was a lack of understanding as to why the Humber Coast and Vale Alliance was performing the worst in the country and it was unclear what the driver was for the poor performance. Angie Legge added that it was going to be discussed again at QGG but was happy for it to come back to QSC too.

Linda Jackson commented about the length of time it had taken to get the National Audit findings to us but Angie noted that it was a feature with a lot of the National Audits at the moment, but agreed it was not helpful as the data was then out of date.

040/22 Mortality Improvement Group (MIG)

The highlight report was distributed and taken as read.

Items for information

041/22 Quality Governance Group (QGG) minutes

042/22 Mortality Improvement Group (MIG) minutes

043/22 Any Other Business

044/22 Ockenden

045/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

- Risk stratification
- The funding gap in Community and Therapies needed further exploring
- Cancer needed to be discussed further outside of this meeting
- National Lung Cancer Audit and Lung Cancer outcomes in our region

046/22 Meeting review

Not discussed.

047/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 22 March 2022
Time: 1.30pm – 4pm
Venue: Via MS Teams

The meeting closed at 3.37pm

Annual Attendance Details:

Name	Oct 2021	Nov 2021	Dec 2021	Jan 22	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022
Michael Proctor		✓	✓	✓							
Michael Whitworth	✓	✓									
Fiona Osborne	✓	✓	✓	✓	✓						
Maneesh Singh	✓	✓	✓	✓	✓						
Dr Kate Wood	✓	✓	✓	✓	✓						
Ellie Monkhouse	✓	✓		✓	✓						
Dr Peter Reading	✓	✓	✓	✓	✓						
Angie Legge	✓	✓	✓	✓	✓						
Helen Harris		✓		✓							
Jan Haxby	✓			✓							
Jennifer Moverley	✓	✓	✓	✓	✓						
Shaun Stacey			✓		✓						
Ian Reekie		✓			✓						
Diana Barnes	✓		✓	✓	✓						

Name of the Meeting	**Trust Board**
Date of the Meeting	Tuesday 5 April 2022
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jo Loughborough, Senior Nurse Patient Experience
Title of the Report	**Patient Experience Report – Q3**
Purpose of the Report and Executive Summary (to include recommendations)	Proposed new style report, containing a summary of Q3 data and updates relating to Patient experience agenda
Background Information and/or Supporting Document(s) (if applicable)	Includes overarching national survey action plan
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: QSC
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ✓ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

Patient Experience Report

FY 21/22 Qtr. 3

Northern Lincolnshire and Goole NHS Foundation Trust

Contents –

PATIENT EXPERIENCE STRATEGY

2021-2024

Draft Strategy – awaiting additional input /final approval

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

The aim of our Patient Experience strategy is to embrace all of the opportunities which our people and technology provide to us to enrich our intelligence, through the breadth of information and the timeliness of feedback.
We will aim to translate the feedback we hear into opportunities in order to show our patients that we are responsive to their feedback and that we care about their views, by turning information into service developments and by supporting opportunities for our staff to learn.

- Improving the accessibility to provide feedback for all groups
- Implementing a person centred complaint process
- Enhance frontline communication through delivery of training in Sage & Thyme
- Our patient experience team will embrace technology to improve

We will actively listen to patients, carers, families

We will drive change in response to feedback

- Develop patient led quality improvement at ward level
- Departments will share their learning with staff and patients
- Improve the evidence of learning outcomes from complaints and Pals
- Share learning widely - internally and externally

Outstanding Communication

- Lead by example in every aspect of delivering patient experience roles
- Collaborative reporting, which is accessible to all
- Utilising onsite visual, social media and electronic platforms to celebrate successes
- Prioritise staff well-being to enable them to care effectively

We will shape the culture around us to be person centred

We will ensure consistency of experience for all people, across all services

- Monitor equality of experience
- Expand the roles of volunteers across the Trust
- Utilise the Family Liaison Assistant role
- Explore standardisation of inpatient ward routines to enhance patient experiences
- Support training in management of complaints at all levels

Kindness • Courage • Respect

Patient Experience Strategy Update - Q3

Volunteers - Through a successful recruitment campaign there are now 60 recruits going through the process.

A successful NHSEI bid will see additional 2.0 WTE 6-month band 3 roles to support training and wellbeing support of volunteers

Currently a business case is being developed for the long-term establishment of the Volunteer Team Co Ordinator, this is currently an NHSEI funded post until June 2022. It has significantly impacted on the quality and expansion of both recruitment and training within voluntary services.

Complaints - Sustained levels of closed complaints within timescale continues 75-87% (KPI 85%).

A full review of the Managing Feedback from Complaints policy is underway following the first year's progress. Re opened complaint pathway and the management of complaints from those who are bereaved will form the major part of the review. Feedback and engagement from divisions and the central complaints team will contribute to the review to ensure changes are reflective of experiences over this last year. Complainant feedback has been collated over the course of the year and will be used too.

PALs - Engagement has taken place with the central team to understand what can be done to remove delay in processes. A "Live" handbook is being created with fortnightly updates to ensure key staff contacts are correct, which has been a major cause of lost days in the PALs process. Introduction of an operational PALs role will be implemented to provide daily visible support. Collaboration between PALS and ECC at DPOW has seen work to improve their PALs positon commence.

Discharge - Theme from national surveys and within complaints. Patient experience to link into new quality of discharge project

End of Life - Trial of bedside family communication booklet and review of flags for complaints and PALs

Patient Experience Data - Summary Q3

FFT - Response rates remain low. SMS in ECC indicates that only a 65% of those identified have correct mobile number so improvement team asked to support repeating previous work undertaken in another team in ECC. IWGC asked to shorten survey. Extracting learning remains difficult due to low rates.

Complaints - Sustained rates of closed complaints in timescale but further work needed through review of policy to address re opened complaints. There were 3 PHSO referrals in Q3 with 0 upheld. Complaint numbers and complexity increasing month on month.

PaIs - Q3 position improved and weekly reports being sent to divisions now. Medicine division remain the division with most concerns.

Compliments - Q3 numbers remain low at 134, in line with previous months. Plan to review reporting system in Q4

INSIGHTS - High scores across all wards with 1 ward achieving 9.9 average over 3 months - **B6**

Theme Summary:

Care was one of the highest reported themes across all patient feedback, this included families not being updated, pain management and poor discharge planning.

Treatment was also a high occurring theme, with reports of pathways not being correctly followed and access to treatment delayed.

Actions:

Family Liaison assistant role continues, and support from patient experience team across Trust. Pain audit in place

Discharge projects commenced. Review of treatment actions to feed into learning group.

Friends and Family Test - Q3

Northern Lincolnshire and Goole NHS Foundation Trust

Date
01 October - 30 December

Your average score for all questions this period

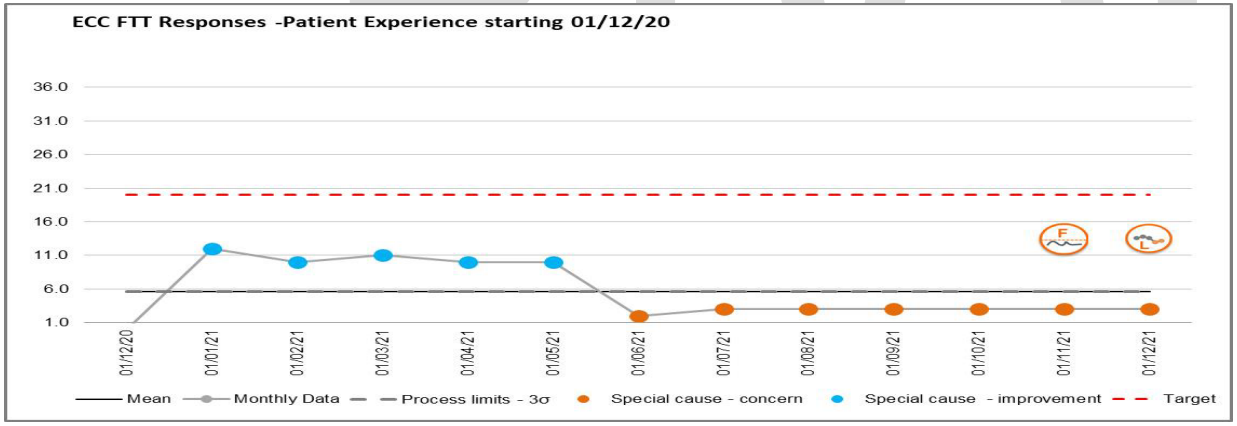
4.48

Reviews this period

1682

Your Experience Scores

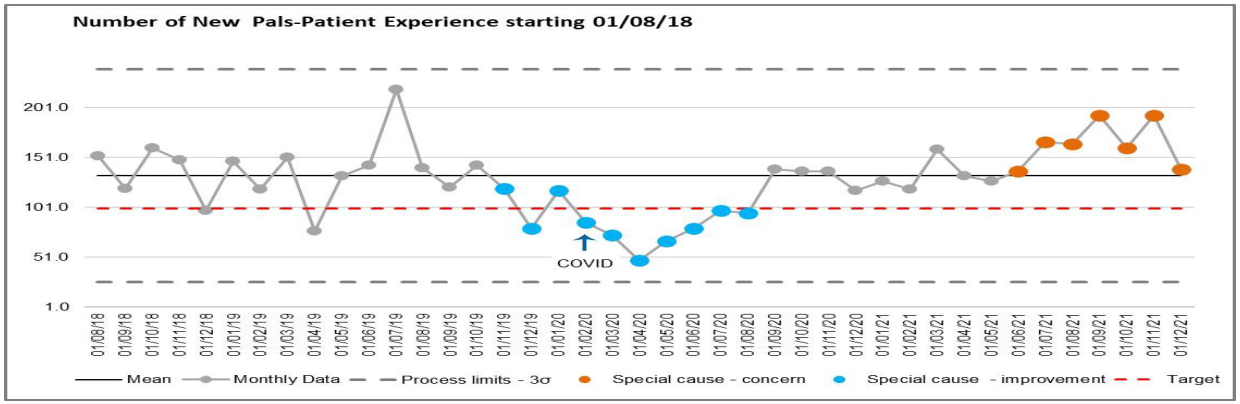
5 star score	% Positive experience	% Negative experience
4.30	82.3%	13.9%

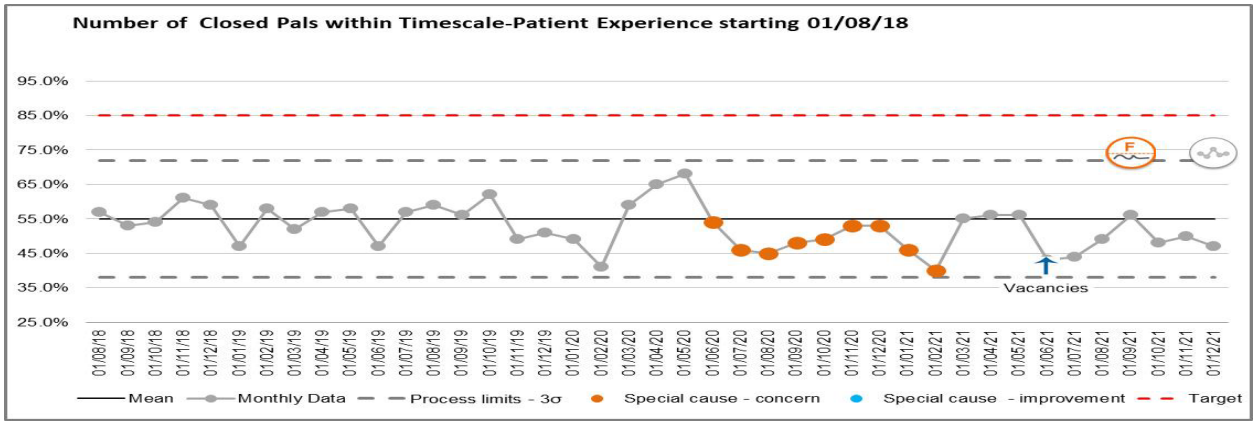


Response rates across all areas remain low. Regional benchmarking indicates that ECC, outpatient and community submissions are the areas for continued focus. However, low rates are evident across many Trusts compared to pre pandemic levels.

SmS responses in both ECC departments have not achieved the expected improvement. An internal review has established that telephone number records may only be at 65% and be paying a contributing factor to messages sent out, combined with the length of the survey template. Both internal Trust teams and the provider, IWANTGTREATCARE, have been asked to review their relevant issues.

PALs - Q3





PALs concerns continue to rise.

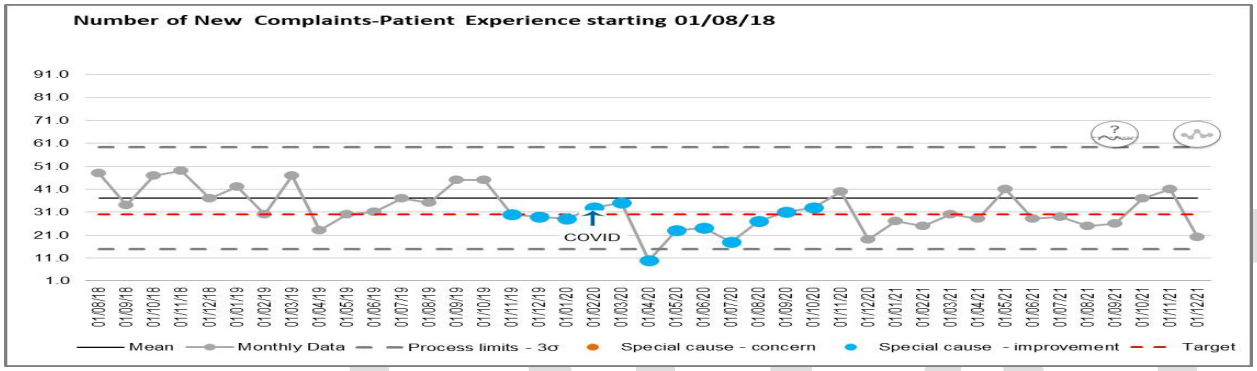
The PALs central team have now stabilised from recruitment and are creating improved processes, in line with formal complaint modelling.

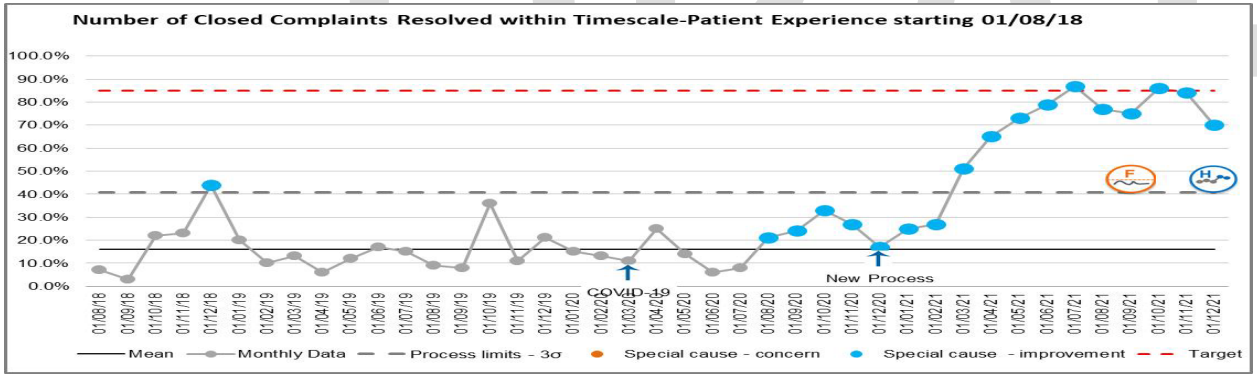
Fortnightly Support and Challenge Meetings are established and weekly divisional reporting.

Medicine, as the largest division, continues to have the highest number of concerns, both new and open.

There has been a reduction in ECC DPOW PALs over Q3, which was an area for concern. Collaborative work between central PALs team and ECC team have reduced backlog and introduction of some Family Liaison shifts appears to be impacting positively.

Complaints - Q3





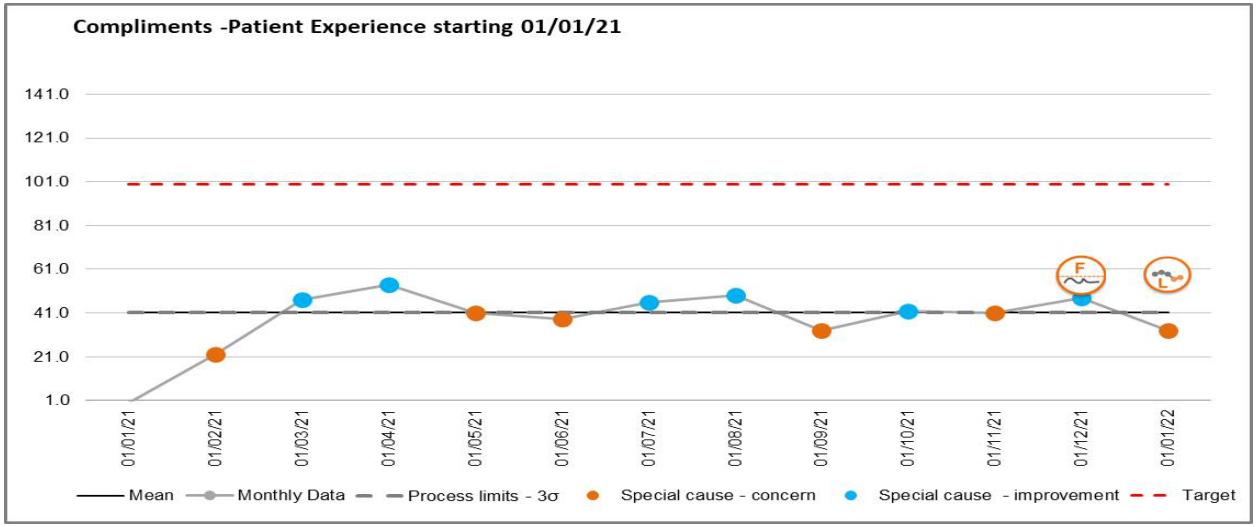
	Average length of timescale Q3
Med	28
SCC	33
FS	30
CTS	25
CSS	0

There was a noted increase in new complaints and triage notes that the complex nature of these is increasing. This has a direct impact on the challenges of maintaining timescales. The sustained picture of timeliness continues but with a noted reduction in December. This was due to 2 longstanding complex cases.

All divisions average length of time to respond across Q3 remains below the 60-day time frame.

Changes to systems, from Datix to Ulysses impacted on the provision of service as the central team became responsible for creating processes and pathways. This work is progressing well and mitigation in place to manage the time required for this essential piece of work.

Compliments - Q3



Extracts

Thank you so much for the care and support you gave to my brother (name omitted) and myself. With your help I was able to fulfil his wishes.
He was a very proud man and you respected that which means so much to us all. You were only in our lives for a week, but you will be in my heart forever. **Community**

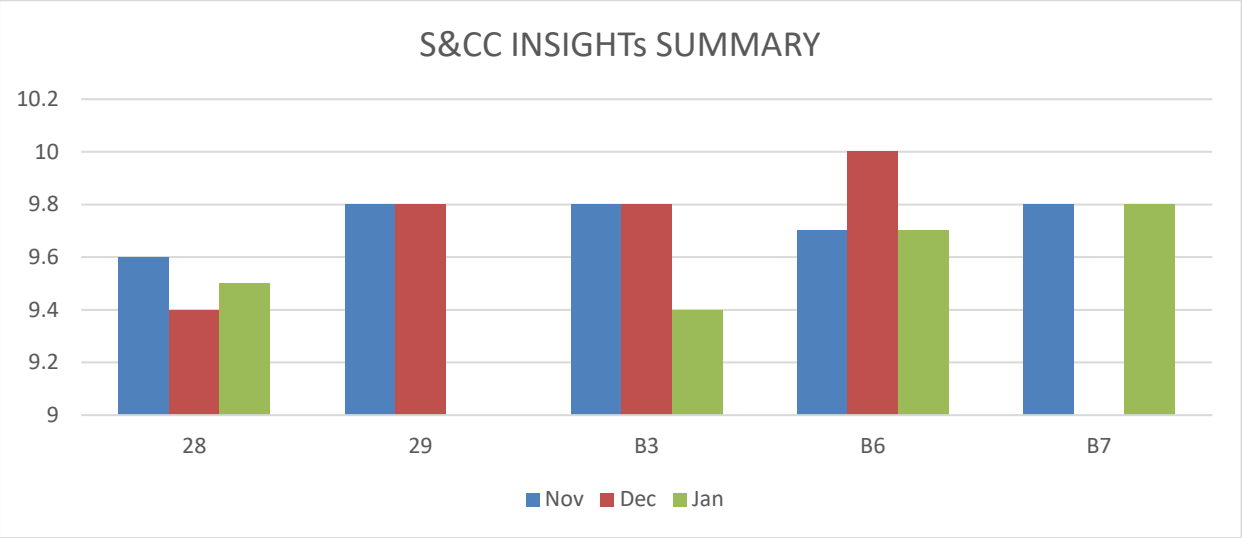
Good morning, I just wanted to pass on our thanks to the midwifery team at SGH. I've just had my first baby and every single person I came across in hospital gave the most outstanding care and were selfless and kind from start to finish. Thank you to all the midwives, porters, HCA's, student midwives, doctors etc. for making our experience as pleasant as it could have been. They all have my total admiration for doing what they do day in day out, many of them said "I'm just doing my job" but it takes such a special person to do what they do with a smile on their face. Special thanks to Beth the midwife and Dr Talapatra for safely delivering my baby. **SGH**

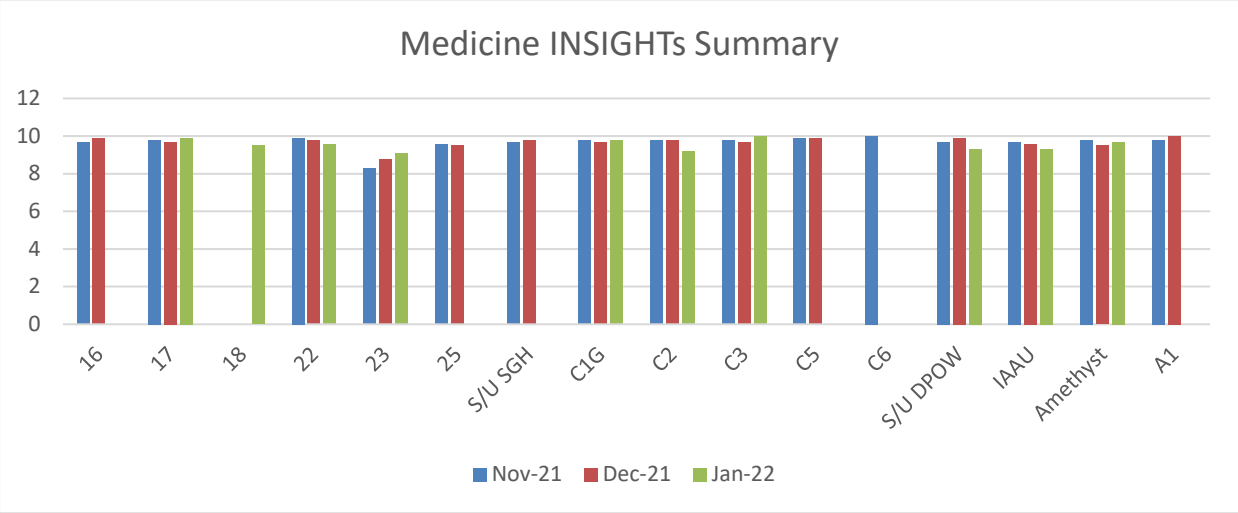
The Trust currently supports recording of compliments in 3 formats: via PALs, social media, and direct ward entries.

The systems to support this are due for review as it is thought that compliment numbers remain below levels. This is in comparison to thank you card numbers seen on wards and entries to system.

Positive feedback is an essential element of team cultures and therefore supporting recording and sharing of these.

INSIGHTs - Q3





10 patients are surveyed monthly on our adult inpatient wards. This real time data, taken by the Patient Experience Team, helps indicate areas for improvement and celebration.

Scores are weighted in line with CQC survey weighting and the question foundations are derived from national survey feedback, and some local intelligence.

Findings are discussed monthly at Nursing metrics meetings as part of triangulation conversations.

Q3 highlighted ward 23 and ward 28.

Themes: Staff Introduction, Understanding Information and Feeling Involved, Moves at Night

National Surveys & Local Surveys Update - Q3

	Action complete and evidence available	0	Joint Actions for Med/S&CC	
	Action complete; evidence being compiled	14	Actions for Med- ECC Team	
	Action on track; will progress to timescale	7	Actions for FS	
	Action off track and subject to escalation	0		
	Not scheduled to have started yet.	0		
	Suspended			

This key indicates which question action relates to which division – for your ease.

Action plan lead: Melanie Sharp

Date: 26/10/2021 V1 28/2/2022 V2

Patient Experience Overarching Action Plan for National Inpatient Survey /Urgent Emergency Care Survey

Action Number	Issues	Outcome Aim	Actions	By whom	Comments	Target Date	RAG	Evidence/Monitoring
1	**PERSON CENTRED CARE**							
UECQ16	**Understood explanation of condition and treatment**	To develop shared decision-making culture to provide consistent and person-centred experience	To ensure nursing and medical plans of care are created, agreed, and shared, in partnership with patients,	**Medicine – ECC Team**	Feb 22 – Med - Focus on updated ED documentation and UCS. Use of Patient information leaflets, Safety netting advice & Discharge documentation	March 31st 2022		Documentation review PALS / Comp / CCG's
NIPQ22	**Staff did not contradict each other about care**			**Medicine /Surgery & CC**	Feb 22- SCC - Surgical pathways Pre assessment and consent all in place to	March 31st 2022		WATS, 15 steps Monitoring of incidents Patient records

	and treatment		families & carers.		ensure understanding. Continue collaborative working between nursing, medical and MDT team. Feb 22- Med - Consistency in care through aim of reduction in patient transfers to help improve Effective board rounds / ward rounds to ensure information flow Continued recruitment to substantive post to drive down ad/hoc staff usage and minimise issues.			annual audit PALS / Comp / CCG's Insights Survey Nursing metrics Patient moves data
NIPQ23	**Was involved in decisions about care and treatment**			**Medicine /Surgery & CC**	Feb 22- SCC - Surgical pathways Pre assessment and consent to be used to involve patients in discussions, all surgical procedures consulted and consented with patient and supported with CNS teams where appropriate. Good collaborative working between nursing, medical and MDT team ensures patient remains at centre Mental capacity assessment used, and support sought when	March 31st 2022		15 steps Monitoring of incidents Patient records annual audit PALS / Comp / CCG's Insights Survey WAT

					necessary from specialist teams Feb 22- Med - Consistency in care through reduced patient movement to support feeling involved Effective board rounds / ward rounds to encourage communication with patient			
MATQC20	**Able to get help when needed (during labour and birth)**			**Family Services**	Feb 22 - 100% of women receive 1 to 1 care and this is monitored monthly by Matrons and as part of the CNST Reassurance to be given to all women to use call bell at any time	March 31st 2022		Monthly audit Patient records
MATQC24	**Had confidence and trust in staff (during labour and birth)**			**Family Services**	Feb 22 -Actions plans from PALS/Complaints and shared with staff to reflect and learn from Feb 22- Good news stories shared with staff	March 31st 2022		Better births strategic meetings minutes MVP meetings Better Birth - Continuity teams x 3 providing all antenatal, intrapartum, and postnatal care. Pals/Complaints MVP -Patient surveys

								and consultations Findings discussed at quarterly MVP meeting
UECQ31	**Staff helped control pain**			**Medicine – ECC Team**	Feb 22 – Med - Updates made to Symphony system including prescription charts to improve compliance /learning Ongoing CQC action including reassessment of pain in place Linked into the Deteriorating Patient Group and EoL group for pain management to explore where further improvements needed	March 31st 2022		WAT 15 Steps Documentation review Pain Audit Complaints/PALs
2	**INFORMATION**							
NIPQ24	**Right amount of information given on condition or treatment**	To equip patients, families & carers with information to help the management of their conditions or treatments	To create robust processes to ensure patients, families & carers have information regarding their condition or treatment	**Medicine /Surgery & CC**	Feb 22- SCC & Med - Patient information leaflets available and staff able to provide All surgical procedures consulted and consented with patient giving opportunity to ask questions Discharge information and letters provided to all patients Mental capacity assessment used to ascertain if family need to be involved or	March 31st 2022		Patient information review Governance processes to identify information gaps Complaints /PALs Insights Survey

					additional measures used for patient CNS input as appropriate			
UECQ21	**Right amount of information given on condition or treatment**			**Medicine – ECC Team**	Feb 22 – Med - Continued development of UCS at SGH supporting effective use of resources and providing patients with self-support tools where necessary Patient information leaflets given Safety netting advice provided Discharge documentation shared with patient	March 31st 2022		Documentation review PALS / Complaints / CCG's
MATQB5	**Given enough information about where to have baby**			**Family Services**	Feb 22 Discussed at Booking appointment Information leaflet IFP0071 provided – Where will you have your baby Hospital or Home – revisited at Birth plan for Low risk women Link to Humber Coast Vale website at 16 weeks onwards showing options of where to have baby	March 31st 2022		Patients notes pg. 29 Documentation records

MATQC10	**Involved enough in decision to be induced**			**Family Services**	Feb 22 – QIP project re Induction of Labour – MVP involvement and will include service user feedback – Meetings commenced and ongoing	March 31st 2022		QIP meetings Complaints /PALs
3	**ENVIRONMENT & FACILITIES**							
UECQ31	**A&E department was very or fairly clean**	To provide a clean and welcoming space for patients, families, and carers	To ensure areas are clean and well equipped for their required purpose, enhancing the patient experience	**Medicine – ECC Team**	Feb 22 – Med - There have been challenges with managing Covid zoning within both ED's. Environmental change should be made to the depts. to support this. Additional cleaning and support have been provided to maintain cleanliness.	March 31st 2022		Matron and Unit Manager WAT E&F cleaning inspection report Dept cleaning logs IPC environmental reports
C&YPQ11	**Parent felt that there were enough things for child to do**			**Family Services**	Feb 22- Covid restrictions playroom was closed to reduce footfall in clinical area and activities were planned around what could be done at the bedside. Play specialists visit children to ensure their play needs are met but this is limited	March 31st 2022		FFT Awaiting Play specialist consultation
C&YPQ46	**Parent able to prepare food in the hospital**			**Family Services**	Feb 22- Covid restrictions meant parents room was closed to reduce footfall in clinical area in SGH	March 31st 2022		FFT/Complaints /PALs

					and at DPOW. Once restrictions lifted parents room reopened at SGH. . However, in DPOW this has not been possible and further work is needed with help from Health Tree Foundation bid to upgrade facilities. If further lockdown then parent access would be reduced to single occupancy at any one time			
MATQD7	**Found partner was able to stay with them if they wanted (in hospital after birth)**			**Family Services**	Feb 22- Due to Covid restrictions – Only 1 birth partner permitted, once in established labour and can staff for 6 hours after the birth or until stable. Previously at DPOW partners can stay overnight unfortunately due to covid restrictions this has not yet been reintroduced. Visiting is updated responsively to safety advice from national guidance	March 31st 2022		Information at Booking and birth plan
4	**DISCHARGE**							
NIPQ34	**Felt involved in decisions about discharge from hospital**	To create an informative and involved discharge experience for	To ensure processes capture that patients, families &	**Medicine /Surgery & CC**	Feb 22-SCC & Med - Patient individual circumstances reviewed and discussed with the patient and family as part of the admission	March 31st 2022		WATS, 15 steps Monitoring of incidents and complaints /PALs Patient records annual audit

		patients, their families, and their carers.	carers are actively involved throughout discharge planning in a shared decision-making culture.		pathway and D2A process with the support of MDT assessments of needs Feb 222 SCC & Med - A discharge training and QI event is planned across Divisions and sites to focus on process, policy and quality of discharge planning, and auctioning to ensure safe, timely discharge that is planned involving patients and/or their NoK and partner organisations and providers. The Chief Nurse and QI teams are supporting this work that is being developed with the Divisions. This work is currently being planned and should commence in April '22 covering all elements of the PE plan concerning discharge.			QI and training work 15 steps Insights Survey
NIPQ35	**Family or home situation considered at discharge**			**Medicine /Surgery & CC**	Feb 22- SCC & Med - Patient individual circumstances reviewed and discussed with the patient and family as part of the admission pathway and D2A process with the support	March 31st 2022		WATS, 15 steps Monitoring of incidents and complaints /PALs Patient records annual audit

					of MDT assessments of needs			
NIPQ37	**Given enough notice about when discharge would be**			**Medicine /Surgery & CC**	Feb 22 _ SCC & Med - Patient individual circumstances reviewed and discussed with the patient and family as part of the admission pathway and D2A process with the support of MDT assessments of needs	March 31st 2022		WATS, 15 steps Monitoring of incidents and complaints/PALs Patient records annual audit
NIPQ40	**Knew what would happen next with care after leaving hospital**			**Medicine /Surgery & CC**	Feb 22- SCC & Med - Patient information leaflets available Discharge information and letters provided, and additional information given to relatives when required. Follow up with GP or outpatients provides another point of contact and leaflets have contact number on. Ongoing support when required through community services	March 31st 2022		WATS, 15 steps Monitoring of incidents and complaints Patient records annual audit
NIPQ41	**Told who to contact if worried after discharge**			**Medicine /Surgery & CC**	Feb 22- SCC & Med - Patient information leaflets contain post discharge contact advice Discharge information and letters provided, and	March 31st 2022		WATS, 15 steps Monitoring of incidents and complaints /PALs Patient records annual audit

					additional information given to relatives when required. Follow up with GP or outpatients provides another point of contact Ongoing support when required through community services			
NIPQ42	**Staff discussed need for further health or social care services after discharge**			**Medicine /Surgery & CC**	Feb 22- SCC & Med - Patient individual circumstances reviewed and discussed with the patient and family as part of the admission pathway and D2A process with the support of MDT assessments of needs	March 31st 2022		WATS, 15 steps Monitoring of incidents and complaints/PALs Patient records annual audit
UECQ42	**Enough information to care for condition at home**			**Medicine – ECC Team**	Feb 22- SCC & Med - Patient information leaflets support this and discussions prior to discharge Safety netting advice & discharge documentation Appropriate referral for ongoing care	March 31st 2022		Documentation review PALS / Complaints / CCG's

MATQF15	**Given enough information about their own physical recovery**			**Family Services**	Feb 22- Patient information given regarding physical recovery in discharge pack and personal care plan Long term vision is to establish obstetric physiotherapist Community midwife available post discharge for any concerns All patients are given contact numbers if they have any concerns and can contact the midwifery teams direct or community team	March 31st 2022		Within handheld records postnatal advice given patient leaflets given at discharge for specific conditions monitored by community midwife feedback from MVP PALS/Complaints

The divisional teams are responsible for the actions in the attached plan. This is being monitored monthly through PEG and escalation through QGG. Evidence of progress through monitoring will be sought as part of this process.

Key Points: -

ECC – There appears to be adequate resources available to support discharge information – Next step – how accessible is this for staff or patients?

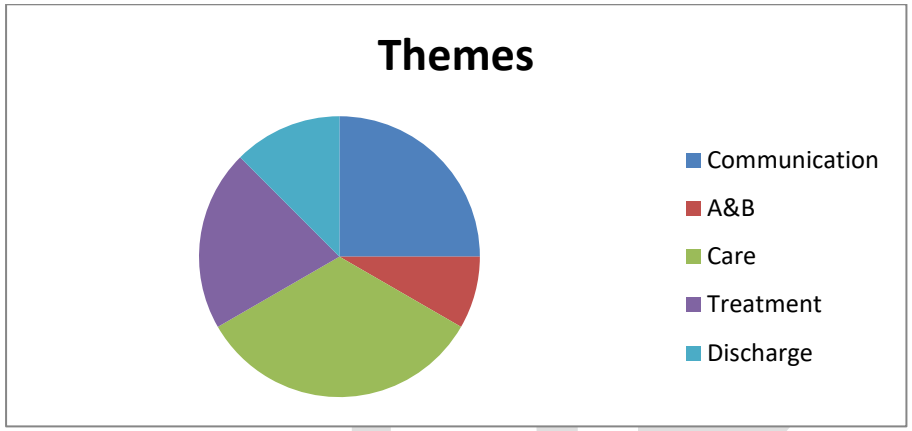
- Pain management appears to be monitored thoroughly – Next step evidence of quality improvement

Medicine & SCC – Continued work regarding discharge processes – Next step – evidence of quality improvements

Maternity – Impact of Covid restrictions has influenced feedback – Next step – continued monitoring of Complaints/Pals as restrictions change to evidence improvement

Children & Young People – Covid Restrictions has impacted - Next step - continued monitoring of Complaints/Pals as restrictions change to evidence improvement

Themes & Learning - Q3



Learning

- Patient leaflet not sent out due to new electronic letter system meaning patient did not have full opportunity to review information pre procedure
- Further work being undertaken to ensure all paper leaflets being uploaded as electronic links

- Patient property losses
- Review of policy and campaign to raise profile planned Q4

- Verbal consent process only in colposcopy clinic
- Launch written consent process with immediate effect
-
- Closing of patient pathway where 2 pathways running parallel
- Collaborative review of processes to identify risk and possible trust wide solutions

Risks

- There are currently 4 “live” moderate risks on the register, relating to:
  - Management of Complaints
  - Implementation of electronic systems to support FFT
  - Loss of Family Liaison Assistant role
  - Patient Experience Team activity and capacity

These risks are reviewed in the Chief Nurse Performance Meeting monthly.

Plans for Q4

We will actively listen to patients carers and families

- ✓ Launch revised Managing Feedback from Complaints, PALS, and Compliments Policy
- ✓ Plan and implement trust wide “drop in “session for all FFT queries and information
- ✓ Undertake full site review for FFT
- ✓ Establish next steps as Trust for Patient and Public Engagement Trust wide will be managed and understand strategic plan
- ✓ Embed local survey processes

We will drive change in response to feedback

- ✓ Develop learning report from Ulysses
- ✓ Create Patient Experience Triangulation meetings

We will ensure consistency of experience for all people, across all services

- ✓ Refresh Lead Investigator training for complaints
- ✓ Band 3 Volunteer Support Officers to commence in post for 6 months to enhance training and wellbeing of volunteer
- ✓ Volunteer Co Ordinator identify next recruitment priorities and continue to review and expand diversity of volunteer base

We will shape the culture around us to be person centred

- ✓ Review Patient Story programme
- ✓ Refresh “You said, we did “methodologies

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	5 April 2022
Director Lead	Dr Kate Wood
Contact Officer/Author	Dr Liz Evans – Guardian of Safe Working Jane Heaton – Associate Director, Strategic Medical Workforce
Title of the Report	**Guardian of Safe Working – ¼ Report for the period 1st October 2021 to 31st December 2021**
Purpose of the Report and Executive Summary (to include recommendations)	The note the quarterly report – for information Exception report data from 1st October 2021 to 31st December 2021 in line with the Doctors in Training contractual obligations. There was an increase in the number of exception reports this quarter up from 75 reports from previous quarter to 84 during this last reporting quarter. The majority of the reports were in connection with working hours. There were 7 reports for missed educational opportunities
Background Information and/or Supporting Document(s) (if applicable)	TCS 2016/2018 – Junior Doctors
Prior Approval Process	✓ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: JDF
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	n/a

Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
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5.	**To provide good leadership**
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

Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Quarterly Report

Dr Liz Evans
Guardian of Safe Working
6th January 2022

1. Executive Summary

Exception reports for the quarter 1st October 2021 to 31st December 2021 saw a slight increase from 75 to 84 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.

Exception Reports

Current numbers of Doctors in Training within NLaG is as follows:

Number of Training Posts (WTE)	268
Number of Doctors/Dentists in Training (WTE)	206.38
Number of Less than full time (LTFT) Trainees (Headcount)	14
Number of Training post vacancies (WTE)	28.72
Number of Trainees by Site (Head Count)	
SGH	95
DPOW	100
Goole	0

Source Finance data

During the period of this quarterly report (1st October 2021 to 31st December 2021) there have been a total of 84 exception reports submitted through the allocate exception report system.

This showed an increase of 9 exception reports from the last quarter (1st July 2021 to 30th September 2021).

Of the 84 exception reports submitted, 66 of these were linked to hours. This showed a decrease of 1 report 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 (October 2021 – December 2021)

Exception Reports Open (ER) between 1st October 2021 – 31st December 2021	
Total number of exception reports received	84
Number relating to hours of work	66
Number relating to pattern of work	3
Number relating to educational opportunities	7
Number relating to service support available to the Doctor	8
Number initially relating to immediate patient safety concerns	2*

*Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an immediate safety concerns (ISC). ISC is not an exception by itself.

Exception Report Outcomes (ER) between 1st October 2021 and 31st December 2021	
Total number of exception reports resolved as at 31/12/2021*	80
Total number of exception reports unresolved as at 31/12/2021*	15
Total number of exception reports where TOIL was granted	41
Total number of exception reports where overtime was paid	26
Total number of exception reports resulting in a work schedule review	4
Total number of exception reports resulting in no further action	13
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."

2. Immediate Safety Concerns

During this quarter there were 2 exception reports submitted where the Doctors raised an immediate safety concern in addition to either a concern around working hours or clinical supervision. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there 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.

The two safety concerns this quarter concerned staffing. One was due to a lack of consultant cover and the other due to a lack of cover at a junior level. Both of these issues have been addressed and the situations resolved.

3. Work Schedule Reviews

During this quarter there were 4 work schedule reviews required. The results of these reviews are not yet available.

4. Trend in Exception Reporting

This quarter showed, as the previous ¼ report had, exception reports relating to educational opportunities were again due to service delivery, for example doctors have reported the inability to attend clinics either due to the clinic being converted to telephone consultations or the doctor required on the Ward due to service commitments.

5. Fines Levied against Departments this quarter

During this quarter there were 0 fines levied against Departments. The money from the previous fines has been spent following discussion with the Junior Doctors Forum.

6. Communication and Engagement

Work continues to look at the communication and engagement with our Doctors in Training.

The Guardian of Safe Working/Junior Doctors Forum has been up and running now for 6 months, has formal terms of reference, agenda and notes. Work to improve engagement and attendance at the forum is ongoing. The time of the JDF has been changed to lunchtime following consultation with some of the juniors at induction, which has had a positive impact on attendance.

The Guardian of Safe Working has started a drop-in session to allow for face to face contact with the Doctors in Training. In addition there is a regular quarterly newsletter which is circulated via e-mail.

7. Support for the Guardian Role

There is a dedicated administrative resource for the Guardian of Safe Working which sits within the Medical Director's Office.

The Trust's Guardian of Safe Working, Dr Liz Evans, Specialty Doctor in Anaesthetics at DPOW commenced in this role in June 2021.

8. 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.

Continued engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to resolve most issues as and when they arise.

Further training requirements for the Educational Supervisors has been identified and it is planned this will take place during 2022.

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.

Dr Liz Evans - Guardian of Safe Working

Date: 6th January 2022

NLG(22)054

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Michael Whitworth, NED & Chair of Workforce Committee	
Contact Officer/Author	Michael Whitworth, NED & Chair of Workforce Committee	
Title of the Report	**Workforce Committee Minutes – November 2021**	
Purpose of the Report and Executive Summary (to include recommendations)	Workforce Committee Minutes of the meeting held on 30 November 2021	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday 30 November 2021 at 14:00 hours via Microsoft Teams

Present:

Michael Whitworth	Non-Executive Director (Chair)
Nico Batinica	Head of People Systems and Governance
Christine Brereton	Director of People
Paul Bunyan	Associate Director of Workforce
Alison Dubbins	Associate Director of Leadership, Culture and OD
Claire Low	Deputy Director of People
Robert Pickersgill	Governor, Membership Office
Michael Proctor	Non-Executive Director and Deputy Chair
Peter Reading	Chief Executive
Maneesh Singh	Non-Executive Director
Kate Wood	Medical Director

In Attendance:

Diane Hughes	Associate Director, Special Projects (rep for Nursing)
Jennifer Moverley	Head of Compliance and Assurance (agenda item 9)
Wendy Stokes	Executive Personal Assistant to Director of People *(taking minutes)*

1 Apologies for absence

Apologies were received from Linda Jackson, Ellie Monkhouse, Jenny Hinchcliffe, Fiona Osborne, Simon Parkes, and Shaun Stacey

2 Declarations of Interest

The Chair invited members to bring to the attention of the committee any conflicts of interest relating to specific agenda items. There were no declarations of interest.

3 Minutes of the previous public meeting held on Tuesday, 28 September 2021

The minutes from the previous meeting held on Tuesday, 28 September 2021 were accepted as a true and accurate record.

4 Matters arising from the previous minutes

No matters arising

4.1 Review of action log

Action 91 – To provide an organisational structure chart with names once the restructure has been finalised
The People directorate organisational structure chart is not yet finalised, the directorate is still recruiting to posts.

Action 92 – Ensure future FTSU Reports reflect how FTSU complaints are linked into exiting processes where relevant
After the discussion of agenda item 7 it was agreed to remove this item from the action log.

Action 93 – Table the Disciplinary Policy at a future meeting when finalised for Trust Board oversight
A time out session takes place next week with trade unions to finalise the policy and hopefully this can be tabled in January prior to sign off at Board. It was agreed to keep this item on the action log until the policy is presented to the committee. Kate Wood asked if the policy involved doctors, and if so, the BMA should be involved. It was confirmed that elements of the MHPS policy will sit in the disciplinary policy and the policy will need to go to the local JLNC as well as JNCC.

Action 94 – Medical Education Report
The Chair discussed this with Kate Wood outside of the committee and a meeting is also being held with Kate, Christine, and Silas. The Junior Doctors Forum, chaired by the BMA and the Guardian of Safe Working, has met three times and from a junior doctor's perspective the main concern is visibility of senior members of staff. Junior doctor attendance at meetings has improved and they can deal with concerns when they arise.

From an educational perspective the Guardian of Safe Working hours is refreshing training around exceptional reporting. Gastro has been highlighted by the national training survey and they are under enhanced monitoring by the GMC. There is good engagement and the operational teams are being brought together with the training teams. Gastro have been driving things forward and a survey is underway with Health Education England to find out if anything further can be done, and they will report back to the GMC in January. Junior doctors are most worried about operational pressures out of hours and there has been a huge investment from medicine to increase the number of twilight and night shifts. The biggest operational challenge is that patients are getting sicker, and the workload has increased. If proper training is not given to trainees their posts can be taken away by the Deanery. The process of losing trainees gets flagged up by the GMC when in enhanced monitoring and the trust could be serviced notice in January.

It was agreed to remove this action from the action log and put Medical Education onto the agenda for the April/May meeting.
Action: Wendy Stokes

5 People Strategy – Implementation Plan Q2 Update

The implementation plan is divided into three areas: workforce, leadership, and culture to align with the People Strategy. A number of objectives have been set for 2021/2022 and reviewed on a quarterly basis. The People directorate structure is finalised, and the consultation is closed. The directorate is focusing on recruiting to posts and the full benefit of that will not be seen until all persons have been recruited.

Significant progress has been made around the job evaluation process. This has been on the risk register, the trust received an internal complaint from trade unions colleagues, and an external

review has taken place. The review identified a number of flaws within the process and training is being provided to enable more people to be able to undertake job evaluation panels, including trade unions.

The committee asked about retention and leadership training. Christine Brereton stated there are some concerns regarding retention and work is underway to gather information from the staff survey and there will be a workstream around retention initiatives. The trust is still on track scoping out a leadership programme for December this year. This is a Board priority; they are looking at pilot areas and will report back in before March 2022. Diane Hughes added that a lot of lessons have been learned from international nurse recruitment and the different cultures. They are beginning to build those communities and some international nurses are coming to NLaG from other trusts for the first time and that is a positive thing. The committee asked what the driving factor was for people coming from London and can the trust utilise that to attract more staff. Diane added it is the cost of living, support provided and word of mouth from colleagues who have previously come to NLaG. Some nurses even want to bring their families across that are in the nursing profession. Christine confirmed that collective discussions have started around nursing workstreams and workforce planning through the apprenticeship route. The trust is also 'growing its own' staff and looking at retention of its current workforce. That will all come together under one plan.

The Committee has an interest in retention and asked about 'growing its own'. Christine Brereton confirmed that it would be covered under the Workforce deep dive when that is next scheduled for the Committee.
Action: Wendy Stokes

6 People Strategy – Leadership Update

Alison Dubbins reported that work was underway to understand what leadership training/assessment was already in place within the Trust. The deep dive analysis had emerging evidence that some foundation skills where in place in its leaders and there was a mixed level of confidence in its first line and senior leaders. There is a core suite of people leader skills such as understanding policies and procedures and some technical skills. The education, training and development team undertake an annual training needs analysis of people skill sets and that informs the trust what to put into the suite of programmes. Underpinning culture skills in leaders is missing and they are needed to be able to conduct robust performance discussions on a daily/weekly basis. Formal PADR processes need to be able to capture accurate contemporary and relevant talent development behaviour as well as robustly addressing struggling or poor performance. The mechanics are simple, it is about equipping managers/leaders with the skills they need to apply consistently and in a compassionate way. That will become the development plan for next 12 months to inform both the culture transformation work, as discussed at the last committee and the leadership development programme.

The PADR process will need consultation to refresh the current approach and to feed into robust succession planning. Coaching and mentoring needs to be developed to make sure there is supervision. The trust will try and run programmes concurrently and the key factor will be the capacity to undertake those pieces of work. Work has been developed on a potential emerging leadership strategy. This will hopefully be discussed with the Exec Team in January. The trust is talking to an external provider regarding a values-based leadership programme. A programme for leaders was delivered to Trust Board and Exec Team and that will be used as a pilot evaluation and rolled out in a modular structure over the next two years to all people leaders, if approved and investment secured.

The Chair liked the idea of going through the tiers of management as there is real value to people learning together. Alison Dubbins agreed, and confirmed that they have decided on a multidisciplinary and multidivisional approach. Alison and Nico met with the informatics and quality team regarding how the trust will know it is making a difference, and that should be evident when the trust is finding people to fill vacancies, sickness absence pinned to stress is reduced and when more robust health and wellbeing offers are built as part of the Culture Transformation Board. Christine Brereton confirmed that they will be developing people metrics to support culture, leadership and health and wellbeing to be enable the trust to monitor progress in line with the model hospital/system performance metrics.

Alison added that 666 people will go through the programme at some point and the values programme is to be rolled out to the whole workforce. There is a need to redesign the programme and that is part of a 3 to 5 year plan. Skills in the trust are patchy, not just in NLaG, it is a symptom of organisations that promote on technical confidence and assume they can transfer into people's skills.

Peter Reading liked the idea of mixing people from different levels and professions. He supported that and felt it was well worth doing. Peter went on to highlight it is important to be able to engage and communicate at all levels. People do need managerial training and that is the frustration when promoting from within. Peter also suggested when recruiting for band 7 posts and above the trust really needs to advertise externally. Christine agreed and added that feedback from the Executive Team will be considered before shaping trust programmes.

Kate Wood highlighted the Emerging Clinical Leaders programme for young consultants who do not have formal leadership roles. Christine confirmed that there would be an overarching leadership strategy which would take account of all strands of professional, generic, and valued based leadership. It was not the intention to remove effective leadership programmes if they were delivering but to have this all under one strategy so that it could be monitored, and the trust could understand its ROI.

7 Freedom to Speak Up (FTSU) Q2 Report

Previous discussions had taken place about the high number of patient safety issues and the process for dealing with those issues was made clear. The Chair asked if there was any indication in the report that the trust has a high number again and was the trust an outlier.

Liz Houchin highlighted the main themes were behaviours, process, staffing levels and worker safety. There have been forty concerns and an increase in staff raising concerns openly and confidentially. There has been one anonymous concern and feedback is being received. Regarding the patient safety issue in Q1, a meeting has been held with Angie Legge to discuss themes and incidents and she will take forward any actions and organisational learning.

There can be a tendency for staff to comply with safety and quality and that is not the same thing. The committee had no doubt about staffing levels and pressures and a lot of staff are probably not delivering the quality of care they would like. Diane Hughes stated regarding ward pressures staff are really giving a good quality of care to patients.

The Chair felt the solution was for Liz Houchin to continue meeting with Angie Legge and bring any issues back to this committee if needed. Christine added that people are escalating things quite quickly and as part of leadership development the trust must equip its managers to deal with levels of conflict and instill the workforce with the confidence that they will be listened to. Regarding how leaders feel when FTSU issues are raised against them, the FTSU guardian will also ask

managers about how the process was for them. It was confirmed that FTSU themes will be used to inform the culture work through Alison and her team.

The Chair added that he would also like to see things that haven't gone so well, to see the balance and if the impact on others can be raised that will play more attention on how that lands with the recipient.
Action: Liz Houchin

8 BAF

Christine Brereton reported that Helen Harris had undertaken a review and prepared the BAF report. There is some work to be done on SO2 in terms of workforce, by looking at trying to split that down and run BAF around different elements. The Chair added that breaking that risk down will provide an opportunity to identify the financial risk with bank and agency costs. Issues are being managed daily and the strategic risk is when those issues are getting worse. The Chair suggested putting the staff morale barometer into the performance report and it was confirmed that is in development.

9 CQC Update

Jennifer Moverley reported that there were 145 actions across the trust, 76% green or blue, on track or signed off. Each action is aligned to a committee and this committee has 26 actions. A report will be presented at committee meetings going forward.

There are 7 red actions including mandatory training in surgery, medicine, paediatrics and maternity. Most are within 1-2% for core training and information governance training is 15% below the target with medical being the lowest. Appraisals in surgery, medicine and ED are between 70% to 75%. There are 6 amber actions including end of life, mandatory training, appraisals and seven-day services.

It was confirmed that mandatory training and appraisals data is fed into the PRIMs meetings and there has been a real focus on this for a while with managers and individuals.

10 Workforce Performance Report – Trust and Directorate

All data is produced in SPC charts in acceptable levels of tolerance. NHS England is also pushing this format out to all trusts as NLaG is ahead of the curve on the People data.

10.1 Vacancy Position

The trust vacancy rate is 9.4% with unregistered at 7.8%, registered at 9.4% and medical at 14.5%.

10.2 Turnover

Staff turnover rate is at 9.84% slightly above the 9.4% target and in line with the themes discussed.

10.3 Retention

Nothing discussed

10.4 Sickness Absence

The trust sickness absence rate was at 6.4% last month.

10.5 Mandatory/Statutory Training Completion

Stands at 92% against the target of 90%.

10.6 PADR Completion

Non-medical compliance stands at 80%, below the trust target of 85%. Medical staff compliance stands at 83%.

The informatics team and Nico have worked on the metrics and a demonstration will be presented to PRIMS going forward to support divisions to become compliant. Data will be live and refreshed quickly, rather than waiting for monthly reports. The recruitment metrics and engagement work will be presented at the next workforce committee meeting and all metrics will be shared with NEDs once completed. The next piece of work is to look at targets to see if they are set at the right level. NLaG is looking at its peers and that analysis will be key.

The leadership academy framework is about the way activities are monitored and engaged upon and that is very much in scope when working on a module of core skills for people leaders.

The Committee felt that the narrative is a bit thin in parts. This is part of an assurance programme and process and they agreed that background context is important.

11 Sickness Absence – Deep Dive

Paul Bunyan led on the presentation of a deep dive on sickness absence. The presentation provided a snapshot of sickness. Data could be split in different ways and operational managers need sight of that to understand what their sickness is and what they can do. This information has not been available previously in the trust.

Paul Bunyan confirmed that short-term sickness was for anything up to 29 days and long-term sickness was for anything over 30 days.

The committee commented that the 40% Covid vaccination rate for medical staff was disappointing. Paul explained that was based on the information the trust has as an organisation and some medical staff will have gone to their GP for their vaccination.

The Chair asked if staff could access back care policies and videos. Paul replied that type of information and detail has never been available before and that will be part of the journey in the next twelve months. Alison added that the trust is part of the health and wellbeing trailblazer pilot part 2, using the Humber Coast and Vale resilience hub to deepen and strengthen vulnerabilities around anxiety and depression. Looking to fund a data analysis to include extrapolating data and linking that with the mandatory training team. The trust offers mindfulness sessions to relieve stress and care camp staff attend critical care to highlight to staff what is available and to raise the profile through the app and communications. NHS employers have a legal duty to their employees and the committee asked if there is a risk to the trust. Christine replied that employers must take reasonable steps to avoid harm, so that employees have the right working environment, support, and the mechanisms in place to raise concerns. There is a real issue nationally following the Dido Harding findings back in May 2015 around psychological harm to staff and there is still some work to do on that. The Chair felt that the deep dive was useful.

12 Workforce Policy and Procedures

Paul Bunyan reported that the revised Disciplinary policy review is in line with the Dido Harding letter from May 2015 which focusses on HWB of individuals during the formal process. The main driver is the development of a Just and Learning Culture, to deal with any issues involving staff in a different way to give better outcomes for both staff and the trust. The number of formal disciplinary cases in the trust has decreased and nearly nonexistent. The next step is to showcase the policy in a workshop scenario with trade unions on 06 December and bring the policy back to this committee for approval, as it is part of the recommendations made by Dido Harding that this policy is approved at Board level. This will follow formal approval through JNCC and TMB

The Managing Attendance policy is being put through the same process and is to be reviewed with the trade unions.

The Substance Misuse policy needs minor changes and will need ratification. Paul stated the issue of randomised testing for staff is still an outstanding issue. This will be considered as part of its development.

13 Staff Lottery Committee

The Staff Lottery Committee Annual Report is for noting by the committee. The current providers contract expires in May 2022 and the trust is looking at other providers. Options and an implementation plan will be taken to the Lottery Committee meeting in January/February for a decision to be made.

14 Compulsory Vaccination

It is the Government's intention to mandate Covid vaccinations for all health care workers by 01 April 2022. This is already in place for social care workers and there is a process in place to manage that. The vaccine is for all frontline staff (definition of that is still being worked through) and if that goes through Parliament by 15 December 2021 staff will need to have had their 1st vaccination by 03 February 2022 and their 2nd vaccine by 01 April 2022. National guidance is still awaited, and this is to be discussed further at the SRO Covid Project Group meeting tomorrow. The first task will be to set in place a communications plan and campaign to encourage people to take up the vaccine by highlighting the benefits and informing them this is Government legislation. The worst-case scenario is potentially dismissal if redeployment into another role not requiring the vaccine cannot be found. This is not without its challenges and couldn't have come at a worst time with Covid and winter pressures. An external person has been brought in to project manage the programme working directly to Paul Bunyan with Christine Brereton as the SRO.

The trust has stood down its booster vaccination hubs because not enough staff were coming through and the trust didn't want to waste vaccines. There are lots of resources in the community to enable staff to get their vaccinations. This will be continually reviewed.

15 Trust Board Highlight Report

The Chair confirmed he would give a summary of the meeting and there was nothing to be escalated.

16 Any Other Urgent Business

Mike Proctor raised a concern around the vaccination programme in York. A big GP group,

consisting of around twenty practices, has set up a centre to provide vaccinations. They are paying staff £25 per hour, instead of the usual £15 per hour, and their staff are voting with their feet which is causing them an issue. Mike asked If there was anything similar in NLaG that could lead to the trust losing bank staff. Paul confirmed that all local provision is provided by GP practices through normal staffing and the ICS hubs. Their staffing models are to use band 5 or band 6 nurses. Diane Hughes stated that she was not aware of those rates of pay and was aware that several NLaG bank staff did chose to work in the Hub.

Christine Brereton highlighted that it was Claire Low's last day at NLaG. Christine thanked Claire for all the support she has provided and wished her well in her secondment at ULHT.

16.1 Dates of meetings in 2022

Nothing discussed

16.2 Annual Workplan

Nothing discussed. The workplan will be reviewed and brought to the next meeting for sign off.

17 Date, time and venue of next meeting:

Tuesday, 18 January 2021 at 14:00 hours via Microsoft Teams

The meeting closed at 16:28 hours

NLG(22)055

Name of the Meeting	Trust Board in Public	
Date of the Meeting	5th April 2022	
Director Lead	Christine Brereton – Director of People	
Contact Officer/Author	Liz Houchin – Freedom To Speak Up (FTSU) Guardian	
Title of the Report	FTSU Q3 Report	
Purpose of the Report and Executive Summary (to include recommendations)	Report is the Q3 report and gives an update from last board, an overview of number of concerns raised, national and regional updates and the proactive work undertaken by the Trust's FTSU Guardian, and future plans for FTSU. It is for approval and assurance	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	As outlined in the paper	
Recommended action(s) required	✓ Approval ☐ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

***Board Assurance Framework (BAF) Descriptions:**

1.	**To give great care**
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: 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.
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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.
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1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Q3– October – December 2021

Liz Houchin
31st January 2022

Contents

1. Executive Summary

1.1 This paper provides an update regarding NLaG activity for Q3 2021-22 (which covers the period October –December 2021). Within this paper the results of the National Guardians Office publications are presented alongside NLaG information to provide national and regional comparison and context.

2. Strategic Objectives, Strategic Plan and Trust Priorities

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

3. Introduction / Background

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

4. Assessment of FTSU Concerns Raised

4.1 In Q3 2021-22 the number of concerns received was 46. Three concerns were raised anonymously in Q3; however, there are a higher number of concerns being raised openly indicating that staff confidence in raising concerns is improving.

4.2 The Q3 figure of 46 is the highest quarterly number this year. The NGO recognise that Q3 is often the quarter when most concerns are raised during a year, this may be linked to increased awareness of the role because of 'Speak Up' month in October.

4.3 The main themes raised were around process, behaviour and patient safety/quality.

Model Hospital is now recording data per 1,000 WTE. It indicates that in Q2 2021-22 the number of patient safety cases recorded for the Trust was 1.64, which is higher than the national average of 0.48. These concerns related to staffing levels and concern that these were impacting on patient safety. The number of concerns where Bullying & Harassment was indicated during Q2 was 0.55, the national average for this period was 0.72.

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

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

Q2. 2021-2022 (July- September 2021)			Q3. 2021-2022 (October-December 2021)
Concerns	**40**		**46**
Themes	Behaviour / relationships	22	17
	Bullying & Harassment	3	2
	Culture	1	2
	Leadership	0	2
	Patient Safety/Quality	9	13
	Process/Systems	14	26
	Personal Grievance	1	1
	Worker Safety	16	10
	Staff Safety	2	0
How Raised	Openly	19	27
	Confidentially	20	16
	Anonymously	1	3
Perceived detriment		0	0

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

Report Breakdown by Division and Role.

Q2. 2021-2022(July-September 2021)			Q3. 2021-2022 (October - December2021)		
Role	**Division**	**Number**	**Role**	**Division**	**Number**
Doctor	1 x Medicine 1 x S&CC	2	Doctor	7 x S&CC	7
Nurse	2 x POE 3 x Chief Nurse 2 x S&CC 3 x Medicine 1 x C&T	11	Nurse	7 x Medicine 1 x S&CC 1 x W&C	9
HCA	1 x POE 4 x Medicine 1 x S&CC	6	HCA	1 x Medicine 1 x CSS 1 x C&T	3
Midwife	2 x W & C	2	Midwife	1 x W&C	1
Admin	2 x POE 1 x Chief Nurse 1 x Medicine 2 x S&CC 1 x Digital Services 2 x Corporate Services 1 x Finance	10	Admin	1 x S&CC 1 x Medicine 4 x CSS 2 x C&T 1 x POE 3 x Corporate Services 1 x Not Known	13

AHP	1 x C&T 1 x Medicine 1 x S&CC	3	AHP	2 x Medicine 1 x CSS 2 x C&T	5
Other	3 x E&F 1 x C&T 1 x CSS 1 x Corporate Services	6	Other	3 x Not known 1 x C&T 1 x Chief Nurse 2 x Corporate Services	7

4.6 FTSUG Feedback /Evaluations received:

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback has been provided by staff that have spoken up and has been predominantly positive. In Q3 one staff member who completed the feedback said that they would not speak up again.

Quarter 2021-22	Feedback received	Would you speak up again? Yes
Q1	9	8
Q2	15	15
Q3	6	5
Q4		

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

I am leaving this trust. I hope you make an effort to address racism in this trust and at least try to educate staff in this department as I know they don't think they did anything wrong. Just don't let this happen to other people please.

At times I felt that I have not been listened to and so by meeting and speaking with FTSUG an opportunity was given for me to bring my concerns to the right and appropriate management.

4.7 Case Study

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

FTSUG received an email from a staff member who had witnessed that a locum doctor had not behaved in line with the Trust values on several occasions in terms of how they had spoken to other colleagues. When asked what outcome they would like, they said that they wanted the doctor to be made aware of the impact their behaviour had on others. FTSUG contacted the clinical lead for the area to make them aware, clinical lead responded to say that the doctor was no longer working for the Trust but they got in touch with the agency to share this feedback to the doctor. Staff member was pleased with the outcome.

5. Regional and National Information and Data

5.1.1 National update

The National Guardian's Office reported 20,388 cases were brought to Guardians in 2020-21; this is an increase of almost 3500 from the previous year. Data for 2021-22 to date has not been released.

The NGO have amended patient safety to patient safety/quality as there is growing recognition that staff report concerns which identify as patient safety when the underlying issue is that staff feel that they cannot provide quality care but it is not unsafe. This is something that the Guardian has experienced.

The National Guardian Freedom To Speak Up policy is being reviewed, with a provisional release date of April 2022, the Trust Freedom To Speak policy is due for review in March 2022 but permission has been given to extend the review date for the Trust policy to September 2022. This will ensure that the Trust policy meets the requirements of the National Guardian's Office.

The new National Guardian (Dr Jayne Chidley-Clark) started in December 2021.

The third module in the HEE/NGO FTSU training package has been delayed and will be released in March 2022 and is called 'Follow Up' and will be for senior leaders.

Q3 data for 2021-22 has been submitted to the NGO by the Guardian.

5.1.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. Recent meetings have included a presentation by a regional HEE GP trainer about supporting GP trainees and ensuring trainees are aware of the Guardian role and how to contact them. There have also been discussions about the mandatory COVID vaccination and the increasing number of concerns Guardians are receiving regarding this and how to support staff.

6. Proactive work of the FTSUG during Q3

- Monthly 1 to 1's with DOP/CEO/Patient Safety Lead
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at Network Meetings
- Board Development Session completed
- October 'Speak Up' month campaign – walk rounds, virtual drop in sessions, Monday message, round up of the month, feedback stories
- Attendance at Regional Guardian meetings
- Walk round with Trust Chair at DPOW

Future Plans

- Work to define the future work of combined Champions to include Pride and Respect, FTSU and Health and Wellbeing is ongoing by the People Directorate
- Input into the Cultural Transformation Working Group
- Continue to work with the Divisions to ensure that learning from concerns is embedded into practice.
- Continue to raise profile of the Guardian – including work on a new FTSU screensaver for the Trust
- Work with the Health & Wellbeing Guardian
- Work with OD Business Partners
- Input into revamped Induction and Management Training packages
- Attendance at all network meetings

7. Conclusion

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

8. Recommendations

The Trust Board is asked to:

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

Compiled By: Liz Houchin,
Date: 31st January 2022

NLG(22)056

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Simon Parkes, NED / Chair of Audit, Risk and Governance Committee	
Contact Officer/Author	Lee Bond, Chief Financial Officer	
Title of the Report	**Audit, Risk & Governance Committee Minutes from 21 October 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Audit, Risk & Governance Committee held on 21 October 2021 and approved at its meeting on 24 February 2022.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: ARG Committee
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ✓ Finance ☐ Partnership and System Working	✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ **Oversight of entire BAF process, completion and achievement**
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

MINUTES

MEETING:	Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**	
DATE:	**21 October 2021** via MS Teams	
PRESENT:	Simon Parkes	Chair of ARG Committee / Non-Executive Director
	Michael Whitworth	Vice Chair of ARG Committee / Non-Executive Director
	Gill Ponder	Non-Executive Director
IN ATTENDANCE:	Lee Bond	Chief Financial Officer
	Helen Harris	Director of Corporate Services
	Mark Surridge	External Audit – Director (Mazars)
	Mike Norman	External Audit – Auditor (Mazars)
	Helen Kemp-Taylor	Managing Director / Head of Internal Audit (Audit Yorkshire)
	Tom Watson	Internal Audit Manager (Audit Yorkshire)
	Danielle Hodson	Assistant Internal Audit Manager, (Audit Yorkshire)
	Sally Stevenson	Assistant Director of Finance – Compliance & Counter Fraud
	Nicki Foley	Local Counter Fraud Specialist
	Rob Pickersgill	Deputy Lead Governor
	Angie Legge	Associate Director of Quality Governance (Items 12.2 & 12.3)
	Hayli Garrod	Head of Quality Assurance (Items 12.2 & 12.3)
	Sue Meakin	Data Protection Officer (Item 12.5)
	Ivan Pannell	Head of Procurement (Items 12.6 & 12.7)
	Richard Winter	Director / Head of Use of Resources, NHSE/I (Observer)
	Lauren Short	Finance Administrative Assistant

Sally Stevenson reminded the Committee that the meeting was being recorded for the purposes of producing the minutes, in the absence of Anne Sprason, and would be deleted once the minutes were completed.

Item 1 10/21 **Welcomes and Introduction**

Simon Parkes welcomed everyone to the meeting and advised that Richard Winter from NHSE/I would be in attendance as an observer. Lauren Short, Finance Administrative Assistant, was also in attendance as a development opportunity for her to gain experience of the meeting.

Simon Parkes introduced himself to those who had not met him previously and advised that it was his first meeting as the new Chair of the ARG Committee. He advised that there were a lot of papers on the agenda and as all papers had been circulated well in advance of the meeting there would be a brief opportunity to update on any changes since papers had been written and would then move straight into questions.

Item 2 10/21 **Apologies for Absence:**

There were no apologies to the meeting. *Post meeting note: Stuart Hall gave his apologies.*

Item 3 10/21 **Declarations of Interests**

There were no declarations of interest made but for completeness Simon Parkes advised that he was the Deputy Vice Chancellor at the University of Lincoln and a Non-Executive Director at Lincolnshire Housing Partnership.

Item 4 10/21 **Minutes of Previous Meetings**

The minutes of the meetings were reviewed:

22 July 2021 – Public
22 July 2021 – Private
27 August 2021 – Extraordinary Meeting – Public

All minutes were agreed as an accurate record.

Highlight Reports from 22 July and 27 August 2021 were provided and noted.

Item 5 10/21 **Matters Arising/Review of Action Log**

Simon Parkes highlighted there were three outstanding items on the action log, with two of them on the agenda.

7.1 (22.07.21) – LCFS Induction Video – This item had been considered so it was unclear whether it could be closed on the action log. Michael Whitworth thought this should be pursued and he had spoken with Christine Brereton but had not realised there were so many items requested to be included on the induction process.

Lee Bond commented that in respect of the item on the action log, consideration should be given to the level of importance the Committee attached to the issue. If the Committee accepted that the item had been raised and added to the list of requests for inclusion on the induction programme, then he suggested it would probably not feature within the programme. The other option would be to make a more formal recommendation from the Committee to include the fraud video on the induction programme.

Gill Ponder commented that it was a very important issue in her view and required staff being clear from day one what was and was not considered acceptable. Lee Bond added that where an organisation relies on a transient workforce e.g. agency, bank etc. then opportunities for misfeasance or poor practice or even fraud were abound, so he also agreed that it was an important issue.

Michael Whitworth as Chair of the Workforce Committee agreed with the sentiments. He proposed therefore to take the action again in the context that if no satisfactory response was received the Committee would escalate to the Board, particularly in view of the recent fraud survey results and feedback.

Action: Michael Whitworth

Following review, the action log was noted.

Item 3 10/21 **External Audit (Mazars)**

Mike Norman confirmed that the audit programme was on track, subject to confirmation of the final accounts national reporting timeline which he assumed would revert to the original submission date of May. There were also items for the Committee's attention within the appendix and Mike Norman drew the Committee's attention to one which impacted on the annual accounts i.e. IFRS16 reporting requirements. Mike Norman confirmed that the reporting requirements were now confirmed and the Finance team were on track with this new area. Mike Norman also noted that Internal Audit had a more detailed report on technical matters within their report so a slight overlap between the two. Mark Surridge commented on the uncertainty of the accounts timetable for next year.

There were no more issues to raise and no questions raised.

Item 7 10/21 **Internal Audit (Audit York)**

7.1 Internal Audit Progress Report

Tom Watson confirmed there were no changes made since the circulation of the report and highlighted a report from the 2020/21 audit plan that was now finalised.

Tom Watson confirmed that reasonable progress was being made on the 2021/22 audit plan, although was a little behind where they would like to be, and wanted to highlight to the Committee that audit work was taking slightly longer to agree scope of reviews, meetings and obtaining information. Tom Watson explained that monthly progress meetings were in place with Sally Stevenson and an escalation route to Lee Bond was available if required and they would keep a watching brief on it.

Simon Parkes noted that there were two requests for changes to the 2021/22 audit plan to move audits to Q4 i.e. Risk Management and Follow-up on Mental Health Act raised at the last meeting.

Lee Bond explained that he had met with Sally Stevenson, Tom Watson and Helen Kemp-Taylor and was aware of the pressure building in the second half of the year and was satisfied that it was not insurmountable to defer the two audits to Q4 as requested. He added however, that the plan had reached tipping point so if there were any further requests for deferring audits it could be a struggle to accommodate.

Gill Ponder raised a question on the Medical Staff Job Planning audit report. She stated that whilst aware that many other Trusts struggled with this same issue, asked if Internal Audit could highlight any exemplar Trusts on how they managed the process. She acknowledged that NLAG were not unique with their job planning problems but felt that the organisation should look to do something different. Tom Watson advised as part of agreeing the report recommendations the operational leads had asked a similar question. He had therefore contacted colleagues to ask what practices where in place around their client base, but had been advised that they had similar situations so Tom Watson was going to extend the request to a wider network including a national network if necessary and would share with the Trust. Helen Kemp-Taylor commented that a few years ago they could have provided details of an exemplar Trust but added that there had been an erosion in that area since the last time the processes had been reviewed and would be surprised if there were any shining lights, but confirmed they would certainly reach out to other IA networks.

Rob Pickersgill made an observation on item 12.9 - Salary overpayments and comments in the IA report in that the key to good control was good planning and asked if there was a link to the Workforce Committee if that would give any scope for improvement in job planning. He also highlighted the Health and Care Bill which included observations around the need for an independent National Workforce Planning System so vested interests would be marginalised.

Simon Parkes noted that the Medical Staff Job Planning report was still in draft form and therefore did not have the detail behind it and Tom Watson confirmed that it would be circulated once finalised and then brought to the next ARG Committee as usual practice.

Simon Parkes stated that it would be helpful if there were any exemplars to learn from so suggested more time would be spent at the next meeting to understand the recommendations and the impact on the Trust.

Lee Bond commented that it was a difficult one, as the process was not standardised across all organisations but he was curious to see what the report had to say.

There were no further comments on the report. Agreement was given to defer the two audits to Q4 as requested, acknowledging the risk that any further deferral requests could not be accommodated.

7.2 Internal Audit Recommendations Follow-up – Status Report

Tom Watson Advised that significant progress had been made since the last meeting with several historic, outstanding recommendations being closed which helped with an improved position. However, there were several outstanding recommendations beyond their target date, some more than twelve months. Out of the nine, eight of those were in the People Directorate and a meeting had been arranged with Christine Brereton to move those forward. Tom Watson confirmed that if there were ongoing problems they would be escalated to Lee Bond.

Simon Parkes noted the positive update on the progress being made, adding it would be good to keep the pressure on and get the remaining outstanding recommendations cleared as it was important but also acknowledged the good work to bring under control. He said he would be interested to see the progress being made following the meeting with Christine Brereton.

10.00am Tom Watson left the meeting to attend another Audit Committee.

7.3 Insight Technical Updates Report

Helen Kemp-Taylor advised that there was nothing specific to highlight to the Committee as the report was self-explanatory and asked if the Committee members found it useful.

Gill Ponder agreed that she found it useful as significant amounts of information were provided but this highlighted specific areas which may not have been seen through other channels. Michael Whitworth concurred.

Simon Parkes agreed it was useful and was an important way of keeping abreast on technical matters and was important when reviewing financial statements etc.

The report was noted.

Item 8 10/21 **Counter Fraud**

8.1 LCFS Progress Report

Simon Parkes commented that there were some really interesting points in the report.

Nicki Foley thanked the Committee for the support on the Fraud Awareness Video as part of the Trust's induction programme as it would be beneficial to get the message across to the staff as they commenced with the Trust.

Gill Ponder thanked Nicki Foley on the very good clear paper as always, but found particularly worrying the staff fraud awareness survey results, particularly when reading the narrative of some of the comments made. Noting references to culture, bullying, managers not listening and different rules for some and not others which she found all deeply worrying. Gill Ponder asked what action was being taken in response to the survey and asked what Executive colleagues were doing with that information to move it forward.

Nicki Foley explained that several fraud surveys had been undertaken over the years and the comments received were anonymous, so staff felt free to comment. She confirmed that she had shared the comments with Liz Houchin, the Freedom to Speak Up Guardian (FTSUG) who had also shared with Peter Reading, CEO. Nicki Foley added that the comments received highlighted areas where fraud awareness could be better. Staff were reporting allegations to their line mangers rather than direct to the LCFS and that could prevent potential fraud from being progressed. She added that as the comments were anonymous it was not possible to direct awareness to an individual, so she tried to target areas through general awareness promotion.

Michael Whitworth commented that he was drawn to the comments in the survey.

Simon Parkes agreed that the comments did not make comfortable reading, and assurance was relatively limited. However, he added that he did not want to overplay this as most respondents said they would report fraud, however it was acknowledged that the comments had been passed to the FTSUG. He also expressed concern at the apparent trend of working elsewhere whilst off sick which pointed to the earlier conversation of raising awareness.

Nicki Foley stated that nationally one of the biggest frauds was working whilst off sick and was difficult to put controls in place to prevent it, other than the return to work interviews where the conversation could take place as to whether the staff member had secondary employment and declared themselves unfit for work. The organisation takes part in the National Fraud Initiative every two years where data is compared with other organisations that take part; this also included creditor payments and payroll matches but reiterated that working whilst off sick was a difficult one to manage.

Nicki Foley also highlighted Fraud Awareness Month (FAM) where awareness would be raised and explained that this year she would be sharing a stand with the Humberside Police Economic Crime Unit which would normally attract more attention. The stands would be taking place in the restaurant areas which would involve leaflets being handed out and speaking to people as they pass through. Nicki Foley added the majority of people do wonder why anyone would think it acceptable to work elsewhere whilst off sick but there are others where you can see the realisation that it should not be done, which is why the induction video would be crucial to stress this particular area to staff.

Michael Whitworth asked Nicki Foley if there was any support that could be given, highlighting that the Workforce Committee undertake deep dives in culture and behaviour and linked closely with the FTSU Guardian, and suggested that the survey could have several themes that resonate with the Workforce Committee. Nicki Foley thanked Michael Whitworth for the offer as any additional help and assistance to raise awareness would be welcomed. She was happy to share the survey feedback if required and suggested having a conversation with Michael Whitworth outside of this Committee.

Action: Michael Whitworth / Nicki Foley

Robert Pickersgill queried the numbers of referrals which he thought were fewer than twenty, with the majority in the last four or five months and asked if Nicki Foley had any indication of the annualised rate of incidents or used any algorithms for suggesting the true level of fraud. Nicki Foley stated that they didn't know what they didn't know, and explained that during Covid referrals were minimal but were now starting to increase; on average there were a minimum of 15-16 referrals a year which had increased to around 20. Nicki Foley also advised that £1.5b was nationally lost to fraud every year. She explained that all information was contained within the LCFS's annual report, and Robert Pickersgill thanked her for pointing him in this direction.

Simon Parkes noted that most fraud goes undetected everywhere, so there would be much more that the organisation was not aware of, and it was therefore important to keep pushing on fraud awareness/education and that people felt able to speak up.

Following the discussion, the LCFS Progress Report was noted.

8.2 Local Counter Fraud, Bribery & Corruption Policy and Response Plan

Simon Parkes noted the above report which had been brought to the ARG Committee for approval. The content had only minor changes and the Committee were content to approve these.

Item 9 10/21 **Board Assurance Framework and Strategic Risk Register**

Helen Harris presented the report and highlighted that since the last meeting an update had been made on Strategic Objective 3 which had subsequently been reported to the Finance & Performance Committee and Trust Board. The ARG Committee would receive the Q2 report at its next meeting.

Lee Bond asked if Helen Harris was content that the Divisions were owning and maintaining the risk registers appropriately as the Committee needed to be assured that mechanisms were in place. He acknowledged that the BAF document is discussed in detail by the Trust Board but added that if looking from an external perspective would be asking about the risk register part of the document. Helen Harris agreed, adding that there was a gap with the risk register and intended working with Dr Kate Wood, Medical Director, to address this given the significant risks coming through from Divisions. An external review on the risk register had been undertaken by NHSE/I and further work would be undertaken by the Trust over the next year to reduce the gap further and see improvements.

Simon Parkes stated that if there were gaps then they needed to be addressed and commented that whilst risk reporting was important, he would also like to understand all the sources of assurance, so would welcome the opportunity to speak outside of the meeting with Helen Harris. He also suggested speaking with Lee Bond on how to further strengthen the links in the risk reporting framework. Whilst he did not want to overlap with other sub-Committees he wanted to understand, from ARG Committee

perspective, and get a better understanding and come back to the Committee for further discussion on how everything fitted together to ensure there were no gaps. Lee Bond responded by supporting a separate conversation about it if risk registers were not operating as quickly as they should.

Simon Parkes also noted that the timings on the Committee's annual workplan were out of sync with Board reporting of the BAF, which meant it was scheduled to come to the Committee after Trust Board. It was agreed that Helen Harris and Sally Stevenson would review and amend as required.

Post Meeting Note: *Two ARG Committee meeting dates were adjusted to resolve the timing issue of the BAF to the ARG Committee as follows: The scheduled January 2022 meeting would now move to February 2022 and the scheduled October 2022 meeting would move to November 2022. Updated meeting invitations were duly actioned.*

Item 10 10/21 **Losses and Compensations Report**

Lee Bond highlighted specifically the unrecoverable overseas debts, with one of the lines within the report being £95k and queried whether this was one item; Sally Stevenson confirmed this related to a collection of debts and pre-October 2017 overseas visitor debts before the introduction of up-front charging. All opportunities for recovery had been exhausted and the debts were therefore being written off. Lee Bond advised the Committee that there was a provision for bad debts on the Balance Sheet.

Gill Ponder noted the frequency by which the Trust seemed to lose patients' dentures and wondered if there was a process that staff had to follow, as it would be distressing for the patient and presumably could take time to get the dentures replaced. It was acknowledged that it was right that the Trust pay for replacements but not for the distress that it had caused in the meantime by patients not having them.

Gill Ponder also noted the loss of the £650 necklace which she wondered if it had or should have been investigated as a non-accident.

Lee Bond stated that the loss of dentures was common and agreed with Gill Ponder that the frequency of losses does need consideration and would pick up with Ellie Monkhouse, Chief Nurse, to determine what procedures are in place.

Action: Lee Bond

Lee Bond stated that personal effects was a problem for staff and whilst patients were advised not to bring valuables with them, most of the patients came in through the emergency routes and therefore had cash and valuables with them. Policies were in place and wards were supposed to remove the valuables for safe-keeping and the patient sign that they had been removed. Lee Bond explained the difficulty with the value claimed for some items and that becomes difficult for the Finance team requesting receipts, valuations, photographs etc. to prove the cost of lost items.

Sally Stevenson explained that from an assurance perspective jewellery items did not feature that often on the Losses and Compensation report, and added that staff were advised on the use of terminology to describe the jewellery e.g. yellow rather than gold and white stones rather than diamonds.

Simon Parkes thanked Lee Bond for picking up the issue of dentures with the Chief Nurse as this related to the dignity of the patient which was an important factor.

Following the discussion, the report was noted.

Item 11 10/21 **Management Reports for Assurance – Items for Approval**

11.1 Waiver Procedure – Proposed Minor Revisions

The waiver procedure had only minor revisions made, which Lee Bond pointed out were for a belt and braces approach to the procedure, and there were no comments made; the revised procedure was agreed.

Item 12 10/21 **Management Reports for Assurance**

12.1 Annual Review of Trust's Freedom to Speak Up Arrangements

Simon Parkes noted that Lee Bond was to present the report on behalf of Liz Houchin, the Freedom to Speak-Up Guardian.

Lee Bond stated that the ARG Committee's perspective was to ensure that there was a policy in place, as it is a national requirement to have a FTSUG, to consider whether we have an appropriate response and is it operating effectively. He noted that in other organisations there were more avenues to raise concerns and whilst there was only the one at NLAG he was relatively comfortable with the process.

Michael Whitworth endorsed Lee Bond's view there was an established process. This was reported at the Workforce Committee and as the Staff Wellbeing Guardian he had regular meetings with Liz Houchin and she also discussed FTSUG matters with Peter Reading and Linda Jackson so the indications were that it was well embedded and working well.

Simon Parkes commented that other Committees also looked at this but the ARG Committee need the assurance that the process was working. He noted that there were 143 current cases which could indicate that it was working but then if compared with the recent fraud survey where the indications were that people were reluctant to raise things, so questioned what was not coming up through the system and where were the gaps. Simon Parkes stated the he was confident it was handled well when people do speak up but was not sure if there were gaps.

Lee Bond agreed and acknowledged there was always some nervousness for people to speak-up and put their head above the parapet, and should maybe question if there were sufficient avenues available for staff to raise concerns to ensure that there was at least one they felt safe using. The process was relatively new to the NHS and as it progressed should start to see the volumes and information that could be produced both at regional and national level. Over time the number of cases would increase and would provide a greater assurance that it was working effectively for an organisation of this size. There was a need to triangulate the number of cases with the staff survey.

Michael Whitworth advised that in terms of staff engagement feedback the organisation benchmarked relatively poor against its peers, although that was against other struggling Trusts that needed to improve so there was an issue in terms of baseline, but there were some positives. He highlighted that through freedom to speak-up, he had seen that people were reporting incidents but not necessarily through the right mechanisms. There was confidence that Liz Houchin was working on getting people to refer through appropriate avenues, acknowledging that issues raised through any avenue was a good thing and the freedom to speak-up guardian was gathering

momentum but it was now about how to improve the level of engagement and the confidence for people to refer.

Simon Parkes agreed that momentum was gathering but looking for assurance needed to cross refer to other sources of information and therefore could not be sure that people felt confident to speak up. There is a need to correlate with other sources of information such as the staff survey and the fraud survey outcome, which suggested that there was still a problem about speaking up, although acknowledging that there will always be people reluctant to speak up, and comms would help with that so need to keep pushing on ensuring that the systems worked and people felt confident.

Lee Bond commented that there was a system in place but whether everyone was aware of it was difficult to say. Whether staff felt comfortable using the system was more difficult to answer but was not the job of ARG Committee to answer.

Simon Parkes stated that the report was provided to give assurance that the process was effective which it was for those using the system. The issue as to whether the system was effective in that everyone who should report an issue was coming forward, then not sure that it did that and maybe where the gap might be. In terms of follow up need to keep looking at how the system was working and need to ensure it was correlated with other sources of information to get the confidence that people were speaking up.

12.2 Clinical Audit Annual Workplan 2020/21 Update

Angie Legge joined the meeting to present this item and introduced Hayli Garrod, Head of Quality Assurance. Simon Parkes welcomed them both to the meeting.

Hayli Garrod explained that there was a small change to the numbers in the paper where audits had been progressed since the paper had been submitted, and everything was more or less on track for the time of year. There had been a slight delay with a small number of projects from the preceding audit programme due to Covid when the team were asked to support the patient helpline. Those projects were now getting back on track and tracked through the clinical governance routes.

Simon Parkes was conscious that there was some overlap with the Quality & Safety Committee and Hayli Garrod confirmed that they have oversight of quarterly reports and escalation process through PRIMs.

Lee Bond noted there had been 92 audits, some mandatory and others local, and asked how the organisation benefitted and learned from those audits. Clinical Audit is a tool used to improve and asked where that learning took place how the ARG Committee could get assurance.

Hayli Garrod stated that it was the most difficult part, the process worked well, and it was the end outputs where it was a struggle to get improvement. By way of example she explained that documentation audits were carried out each year and requested by Divisions resulting in similar themes. The results were discussed at clinical audit meetings with the relevant parties in attendance but sometimes it was a struggle to get that learning taken forward. Hayli Garrod also highlighted the pain audits in the Children Division, where learning had come out of that and significantly improved things and was now better than the national average in screening children for pain in ED.

Lee Bond asked if there was an annual report that highlighted what had been learned, noting the CQC focus on documentation and if not improving, despite having the tools available, then was a concern. Hayli Garrod advised that Paediatrics were currently trialling WebV documentation and had significantly improved their results. The nursing pathway had been amended to make more user friendly so clinically a lot of acceptance; electronic records would improve this.

Angie Legge advised that if there was no progress on the actions it would be escalated to QGG quarterly and also PRIMs and look for improvement in the audit going forward; where limited assurance had been given then this had to be included within the risk register. The focus was on the national audits so once they were all working they could focus on the others. Documentation was a worry which was why a learning event was undertaken recently.

Simon Parkes stated that this formed part of the quality accounts and the job of ARG Committee was to consider the rigour of the process which was difficult to do without having a good sense of how recommendations were dealt with and asked how the Committee could gain that assurance.

Angie Legge explained that the quality accounts looked at participation levels and the organisation had a good process to ensure participation in the national audits, it also included examples of improvement and identify any potential issues. Angie Legge advised that information could be produced for the Committee on the actions completed but explained that improvements did not always follow if the issue was around changing behaviours around the use of particular documentation and could be a difficult area to get people to change. She suggested that the measure to watch was the level of improvement with the re-audits which were not currently reported to the Committee but could be provided.

Rob Pickersgill stated that he was trying to understand the drivers for the activity noting that there were CQUINs initiative and tariff driven work and asked what priority each of the drivers took.

Angie Leggie explained that the prioritisation was articulated in the paper noting the CQUINs and national audits were “must dos” although CQUINs were currently suspended. The organisation was monitored on participation and considered by the CQC. The audits relating to quality were a priority and the Divisions also suggest areas where they felt would be of benefit, although noting the limited central resource and Divisions needed to provide the resource to do the audit work.

Simon Parkes explained that it was the job of the ARG Committee to provide assurance to the Trust Board on the rigour of the process and suggested that, on the face of it, there was a gap in not being able to see the outcome and whether implemented and it was therefore difficult to get the assurance on the adequacy of the arrangements. He said he would welcome the opportunity to follow-up with Angie Legge and Hayli Garrod outside of the meeting and report back to the next meeting on any gaps and how they might be closed.

Action: Simon Parkes / Angie Legge / Hayli Garrod

12.3 Risk Management Strategy Development Plan

Angie Legge presented the report and explained there was a five-year risk strategy with quarterly updates on the progress. NHS England undertook a piece of work with the organisation from which there were recommendations made. Good progress was being made and Ulysses, a new incident reporting and risk register system, was being implemented that week. It would enable greater ownership as it enabled individual actions to be broken down and followed through. Angie Legge explained that more work was being undertaken on roles and responsibilities and good progress was being made, although noting it can take time to change behaviours. There was an issue with equipment requirements being marked as a red risks every time, and Angie Legge was now on the Equipment Group so there would be more rigorous challenge and able to keep appropriate scoring to make the risk register more efficient.

Simon Parkes noted the assurance on training had moved to TMB and it appeared that not many people had been trained and was curious how that would be progressed and developed.

Angie Legge explained the assurance on training would be taken to the confirm and challenge meeting in November that reports into TMB, however it had also been added into the Strategy. The training had been delayed due to Covid and was now running monthly but with operational pressures and isolation it was proving difficult. The training would be recorded and available for others to watch later at a more convenient time.

Risk Clinics had also been undertaken with each Division to discuss the process in detail and give examples of any gaps. This had been quite successful, and Angie Legge's team had offered to replicate through the individual Divisions' groups.

Simon Parkes the issue of mandatory training and fully understood the difficulties but stated that having a properly functioning risk mechanism is important, and therefore it was necessary to strike the right balance.

Lee Bond asked if a particular sub-set of people were identified as requiring the risk training or if everybody was expected to complete it. Angie Legge confirmed that it was open to everybody which was why the risk clinics were implemented so they could be more focussed. Lee Bond likened it to finance budget holder training as it was not something that everyone needed, but instead have a more targeted approach to have a framework of those managers who could provide the infrastructure. Angie Legge explained the CQC had an expectation of awareness of risk and understanding which was why it was open to all.

Simon Parkes stated that it should have the distinction of those that need to be trained and those who ideally needed to be aware, recognising the pressures that staff were under. There needs to be clarity on who needs to be trained, as risk management is a huge part of how we keep everything safe.

11.03am Following the discussion, Simon Parkes thanked Angie Legge and Hayli Garrod and they left the meeting.

12.4 Quarterly Document Control Report

Helen Harris had advised that no changes had been made to the report which was for information.

Gill Ponder noted that progress had been made but there were still issues with overdue documents and noted at least one document overdue since 2016 (page 4). Helen Harris explained that she did meet with all Divisions and Corporate areas to review their overdue documents and proposed meeting with Executive Director colleagues to discuss the longer standing overdue documents to try and encourage getting them updated or removed from the list.

Simon Parkes noted the two from 2016 i.e. Managing Substance Misuse both Policy and Procedure which dated back to January 2016 so almost six years overdue. Simon Parkes stated that given there were several overdue documents in the same Directorate he would pick up with the Executive Director concerned, as it was not a trivial matter and points to how solid controls are.

Action: Simon Parkes

12.5 IG Steering Group Highlight Report

Sue Meakin stated that it was a very busy time of year for IG.

Simon Parkes noted item 9.7.6 on the action plan stated that 5% of devices had the firewall enabled and expected it to reach 40%-50% by 24 September and asked if that target had been achieved. Sue Meakin confirmed that the target had been achieved and had extended the timescale to capture as many as possible before it was submitted to NHS Digital, and to advise that it could then be taken off the improvement plan.

Sue Meakin advised there was an updated plan and highlighted specifically the actions that had changed:

- 7.21 had been extended to the end of November to get a tabletop exercise set up which had been arranged for 22 November 2021.
- 7.24 action by end of December and was reliant on the tabletop exercise taking place.
- IT security meeting now up and running.
- 9.6.10 not extended but had confirmation that £250k bid had been accepted, and now discussions taking place on how best to utilise that money
- 9.7.6 updated to end of month.
- 10.2.1 This could be removed as no longer a requirement for Tier 1 category organisations within the Data Protection Toolkit. Other mechanisms were in place i.e. frameworks for procurement, digital solutions delivery group where due diligence on procurement was undertaken.

Lee Bond commented that it was pleasing to note progress and noted that 87% of staff had completed their mandatory training and asked if the 95% requirement would be achieved. Sue Meakin stated that she hoped so, and explained that submission was due in June 2022 so as last year, the team were focussing on targeting those staff either coming out of compliance or particularly those showing red as out of compliance; which was also notified to their line managers.

11.15am Simon Parkes thanked Sue Meakin for the helpful updates, and she left the meeting.

12.6 Waiving of Standing Orders

Ivan Pannell attended the meeting and highlighted that there were 33 waivers in this quarter, which was not untypical.

Simon Parkes was concerned about one waiver i.e. Trent Cliff which had two direct awards totalling £450k and noting the declarations of interests made in paper 12.10, queried whether the conflicts were appropriately managed.

Lee Bond explained it was clear from the outset that any Consultant who had any financial investment or interest had to make that declaration of interest. The two areas of award were for the rent of the accommodation which was effectively buying the rooms for clinical and diagnostic use which Trust staff would be using because of the impact of Covid and infection control measures. Secondly, outsourcing the full service which could be undertaken by a Trust surgeon, not in our time, paying the equivalent to national tariff less 15%, which was overheads. A vast number of outside contracts pay tariff less % so from a VFM perspective would not be paying more than carrying out the work internally; this was simply due to capacity constraints. Interests had been disclosed appropriately. There could be a risk of surgeons "slow timing" and not doing work inside the organisation but there has been no indication that theatre fill rates were reduced due to poor behaviour because of this by a conflicted member of staff.

Lee Bond advised that it would be a short-term arrangement until recovery plans were complete and aiming to get to 42ww by the end of the financial year which if achieved would be the best in the region. Making use of this facility for now with full disclosure.

Helen Harris confirmed that the Chief Executive had asked if the necessary declarations of interest had been made. She asked for documentary evidence and made checks with Procurement that no Consultant was involved in the process of awarding the contract. Helen Harris confirmed that a complete double check had been done before sign off.

Simon Parkes stated that it was reassuring that internal processes could be seen working effectively with declarations made and the checks and balances to ensure that the arrangement did not create additional conflicts or additional risks.

Ivan Pannell explained that the arrangement was time limited and was also capped as linked to procurement regulations in terms of value. A full open tender was already underway for additional services in that area which gave every provider, able to meet the specification, the opportunity to bid and had the potential to take the organisation through to 2022/23.

12.7 Invoices without Purchase Orders (POs) Report

Ivan Pannell highlighted previous discussions on improving performance by setting clear targets. Ivan Pannell explained that a new finance system would soon be implemented which would result in a culture change for the organisation as it moved to end user requisitioning and full e-Procurement, it was hoped that this would automatically drive improvements. It would also be an opportunity to re-emphasise the need for POs as an extensive training programme would be undertaken as part of digitising the process.

Lee Bond noted the major areas where PO non-compliance was high was in capital and pharmacy. Pharmacy was difficult given the number of drugs that were purchased. He highlighted the system in IT at Hull who use a credit card for Amazon purchases and Lee Bond suggested that this gave them better VFM for IT purchases sometimes. In some cases, the departments sourcing the items understood the values better than Procurement so Pharmacy was not a concern, but capital could be an area for improvement.

Lee Bond also referred to the overdue audit report of which there was one recommendation for finance in terms of PO/Non PO statistics and divisional reporting. Given the impending new finance system and assurance from the Head of Procurement at the meeting he considered whether he would rather Ivan Pannell focussed on the implementation of the new system then spend time on the audit recommendation work as this was not a priority for Ivan. Lee Bond asked for views on this.

Gill Ponder stated that she could understand and agreed it seemed eminently sensible, in that there was little point spending time on something that could ultimately improve with the implementation of the new system. Gill Ponder added that the governance decision should be duly documented for audit trail purposes.

Rob Pickersgill referred to Lee Bond's comment on the use of credit cards but commented that no supporting documentation would be available. Lee Bond explained that whilst that was the case there was a system of auditing annually around the usage of credit cards.

Rob Pickersgill also referred to the staff and managers being intimately familiar with their particular areas and better placed on the value of certain products but there was also the risk that they would use the nearest or easiest supplier and not necessarily get VFM. Lee Bond advised that there were other mechanisms such as the budget system that would flag any anomalies.

Simon Parkes agreed that it was right to focus n implementing the new system, acknowledging that once implemented it should start to address some of the non-compliance issues. He was unclear however given that the report remains static why it would need to keep being presented to the Committee and would rather get assurance on the new system rather than keep monitoring the current system. Lee Bond proposed that a report be brought back after a year of implementation of the system; and confirmed that would include KPIs, which was agreed.

It was duly agreed therefore to close off the overdue audit recommendation, and that it was no longer necessary to routinely submit the Invoices without PO's Report to the Committee.

12.8 Contract Progress Report

Ivan Pannell advised that some progress had been made over the last quarter but the work on the elective recovery, capital programme and day to day operational procurement in terms of keeping the hospital stocked with critical items, had impacted on that progress.

Ivan Pannell explained the links with HUTH colleagues, and within the wider ICS footprint, on major contracting activities to determine if collaboration would be possible. but some differences in contract expiry dates were problematic and needed to be worked around where possible. There were some encouraging conversations on-going however.

Simon Parkes acknowledged the challenges for the Procurement team and the need to prioritise accordingly but noted that some of the contracts were four years over their expiry data i.e. Amvale was significantly overdue.

Ivan Pannell explained the delays with this had been due to a change of requirements and additional activity to create a bigger tender and linking with HUTH to determine if possible, to do as a joint tender. The contract covers Estates & Facilities as well as

clinical colleagues and were currently in the process of sense checking activity information provided by Amvale that was outside of those contracts to ensure everything was included within the specification.

Lee Bond also acknowledged the degree of complexity and constant changes to the specification not necessarily due to Estates & Facilities but the interaction of clinical services and patient transport and specimen transportation elements. That said the contract was significantly overdue and whether that involved the possibility of collaboration with a joint award, the tender needed to be finalised and contract awarded. Lee Bond also noted from a finance perspective that Amvale were holding prices from the start of the contract so was relatively satisfied that the current contract was still giving VFM but was not a substitute for a full tender.

Ivan Pannell agreed that this was high on the list and progress would be seen in the next 12 months.

11.40am Ivan Pannell was thanked for attending and he left the meeting.

12.9 Salary Overpayment Report

Sally Stevenson highlighted the decrease in overpayments in the last quarter. She highlighted one change since the circulation of the report which related to the first item of high value overpayments (page 3) and advised that a further payment had been made by cheque and a plan was in place to recover the remainder of the overpayment.

Simon Parkes was uncertain how anyone could not know that they had been overpaid by £22k and given the money had been received it should be paid back in one lump sum. Sally Stevenson explained that the question was always asked how it could have been missed but the person in question said they did not check their payslip or their bank account so was not aware of the overpayment. She advised that half of the money had now been received and arrangements were being made to repay the remainder. Lee Bond also stated that the recipient of the overpayment had asked if some of it could be written off but they were informed that it needed to be repaid in full.

Simon Parkes acknowledged that there were some very complicated salary arrangements with bank contracts etc. but would be interested in how this organisation benchmarks against other Trusts in terms of value and regularity of overpayments. He appreciated that things sometimes go wrong and suggested this could also come back to the earlier fraud awareness discussion. Sally Stevenson explained that the overpayment letter does specify, particular to leavers, if overpayment was not repaid the matter would be referred to the LCFS to determine if any particular offences had been committed which did seem to help.

Lee Bond suggested that Sally Stevenson could work with Hull on benchmarking information which would give a reasonable source of assurance for both Audit Committees. Sally Stevenson highlighted however that the Trust's overpayment data had recently been supplied to Internal Audit colleagues to benchmark across their clients, and the report on this was awaited.

Action: Sally Stevenson

Gill Ponder questioned the education of managers on their responsibilities in advising the Payroll team in a timely manner, of any changes / leavers etc.

Sally Stevenson explained there was a formal policy on overpayments so everyone should be clear on how overpayments were dealt with and included within that was a non-compliance process for managers who repeatedly failed to submit timely/accurate

information on pay changes. Sally Stevenson explained that overpayments were monitored on a 12-month rolling basis and letters were sent to those managers who re-offend, so there was a compliance process in place that worked by provoking useful discussions with managers.

Rob Pickersgill asked if there were similar problems with agency controls and Lee Bond explained the issue would be around the number of hours worked as ward sisters were required to sign-off shifts worked and the rates were pre-agreed; he was unsure of locum doctors which could be an area to look at in more detail at some point.

Simon Parkes acknowledged the robust handling of salary overpayments and added that employees needed reminding that there was an obligation on them to avoid being overpaid and asked if there were any trends. Sally Stevenson explained that the main issue was late termination forms which then involved a recovery process from people who had left the Trust. Managers were regularly reminded about the need for timely paperwork, etc through the Hub, the Wednesday weekly news posts etc. and also asked the Finance Divisional Finance Managers to remind managers at their regular finance meetings.

Following the detailed discussion, the report was noted.

12.10 Hospitality and Sponsorship Declarations

Helen Harris presented the report and explained that there were still two systems in place i.e. manual and electronic. The new electronic system required some tweaking in terms of data quality issues with reports, but it was identifying some gaps and Helen Harris was working with Dr Kate Wood on those areas. Dr Kate Wood was also raising awareness through MAC/HCC and JNCC meetings. Helen Harris also explained that the process was to be included in the audit plan for 2022/23 as an area to be audited to see how well it was working.

Lee Bond noted that the declarations of interest were looking more robust, but the register of hospitality and gifts looked less so. He referred to the paper (page 2) and the apparent absence of doctors declaring hospitality and gifts and highlighted the ABPI report of hospitality/sponsorship provided to all organisations. He noted that the Company Secretary at Hull checked through the ABPI report each year and and suggested that NLAG should do the same.

Michael Whitworth advised that the hospitality provided within the pharmacy and medical devices industry was classed as educational support and may not be just hospitality e.g. 4 days conference abroad was educational and part of continued professional development and investing in staff. He suggested that the lack of declarations could be due to the definitions of hospitality and gifts not being clear.

Gill Ponder acknowledged the offer from pharmaceutical industry of places at conferences and asked whose time that was and whether locums were brought in for cover as may not have been approved by managers in advance as a benefit for their development in relation to NLAG. Gill Ponder also felt there would be merit in a comms exercise, targeted at doctors, to identify the areas that this covered and ensure that declarations were made including any offers made and declined.

Sally Stevenson noted that the reports had looked much different pre-Covid as conferences and training events were now often undertaken virtually due to Covid restrictions. Comms had been done in the past but agreed a reminder session/comms would be useful. Lee Bond agreed that they were looking at a particular point in time which may not be typical and suggested keeping a watching brief.

Simon Parkes confirmed that a reminder communication would be helpful and include declarations of any rejections made.

Action: Helen Harris

Simon Parkes referred to the register of interest and expected to see more clinicians that had undertaken private practice. Helen Harris explained she had performed a cross checking exercise with the St Hugh's website and identified gaps in declarations She was also working with Dr Kate Wood on that issue and would then link in with the CEO if necessary to ensure a stronger approach.

Sally Stevenson noted that consultants should be declaring private practice on their job plans which would be another source for cross-checking if necessary. Simon Parkes agreed this would be a good place to start but completion of the forms was required, and it was maybe something that should be escalated to Peter Reading to pick up with Director colleagues to issue a reminder. There were significant gaps which did not give the assurance that it was complete.

Item 13 10/21 **Action Logs and Highlight Reports from other sub-committees.**

Actions Logs and Highlight reports were provided from the following sub-committees:

13.1 – Finance & Performance Committee
13.2 – Quality & Safety Committee
13.3 – Workforce Committee
13.4 – Health Tree Foundation Committee

There were no questions and the reports were noted.

13.5 – RATS Committee – None received
13.6 – Ethics Committee – No meeting had taken place

Item 14 10/21 **Private Agenda Items**

There were no private items for discussion.

Item 15 10/21 **Any Other Business**

Michael Whitworth reflected on the discussions held, particularly on the contract database and was pleased to hear the work that was going on in the background and the reasons for the delays with this particular contract. He said it had been good insight and was quite assured with the level of discussions throughout the organisation rather than just hearing at the Committee that it was an outstanding contract.

15.1 Schedule of Meetings Dates 2022

Gill Ponder queried the date of the meeting in January 2022. It was agreed that the dates would be checked and recirculated to the Committee.

Action: Sally Stevenson / Anne Sprason

15.2 Any Other Urgent Business

There was no other urgent business raised.

12.08pm *At this point the Internal and External Audit representatives left the meeting to allow for a private discussion on the next item.*

Richard Winter, Helen Harris and Nicki Foley also left the meeting.

15.3 Internal Audit Contract – Tender Process

Internal Audit contract

Lee Bond explained that the current Internal Audit contract was due to expire on 1 June 2022 and a tendering exercise would commence immediately after Christmas, as outlined in the paper. He highlighted that Audit Yorkshire were keen to retain the contract particularly as there were changes with the creation of the ICS as CCGs came to an end. It was noted that Helen Kemp-Taylor was retiring, and York Foundation Trust had recruited a replacement.

Once bids had been received an evaluation panel would be convened.

It was agreed that the evaluation panel would consist of the following:

- Simon Parkes
- Michael Whitworth or Gill Ponder – depending on availability
- Lee Bond
- Sally Stevenson
- Helen Harris

Item 16 10/21 **Matters for Escalation to the Trust Board**

There were no issues to escalate to the Trust Board currently. Helen Harris suggested seeing how the declarations of interest work progressed and if no further uptake then could escalate to the Trust Board later, which was agreed.

Item 17 10/21 **Matters to Highlight to other Trust Board Assurance Committees**

Simon Parkes referred to earlier discussions and the need to map the assurance across the different sub-committees, which he noted was a piece of work that he would be undertaking. There were no specific issues to highlight to other Trust Board sub-committees.

Item 18 10/21 **Review of ARG Committee Workplan**

The workplan was reviewed. Simon Parkes noted the discussions held on the need to report progress on some items and these needed reflecting within the workplan.

Action: Sally Stevenson

Item 19 10/21 **Review of the Meeting.**

Simon Parkes noted this had been his first meeting as Chair of the ARG Committee and asked the Committee to provide any feedback either now or outside of the meeting if preferred.

Sally Stevenson informed the Committee that the technical difficulties with MS Teams connectivity that morning had been encountered across the Trust and wider local patch and were not unique to this meeting.

Gill Ponder stated it was unfortunate that Richard Winter from NHSE/I was in attendance given the number of technical difficulties as this was not typical of the meeting. She noted that it was a packed agenda and thought the meeting went well with time for good debate which had been useful.

Michael Whitworth agreed with the comments that there was good pace, the agenda balance was right, and the papers provided were good. Michael Whitworth also referred to the discussion on declarations of interest and liked the approach taken by Simon Parkes as this could be a sensitive issue that consultants see it as being checked up on rather than in a supportive and constructive way.

Lee Bond referred to the length of the agenda and whilst there were several items that needed to be regularly presented to the Committee e.g. Internal Audit, External Audit, and Counter Fraud, he noted the number of papers included within section 12 "Management Reports for Assurance". He suggested that if these items continued to be brought to the Committee with only five minutes on each, then the front sheet should be clear as to why they were on the agenda and what was expected of the Committee, which should help with timing.

Simon Parkes agreed that he was sometimes unsure of the reason why a paper was brought to the Committee whether that was because they were always brought or because they were required and what was trying to be achieved. Simon Parkes was still trying to understand the levels of assurance across the different sub-committees and did not want to duplicate discussions if not necessary. He agreed that some good discussions had been held and was grateful for contributions.

Michael Whitworth agreed that it was a lengthy agenda with some reports not suitable for this Committee but were more detailed in terms of the Quality & Assurance Committee. Simon Parkes stated that he would pick up through the agenda setting process but was clear that the ARG Committee was an assurance committee to be assured on the processes being taken.

Item 20 10/21 **Date and Time of the next full meeting**

Since the meeting a further change to the meeting dates had been made to ensure the timings of the BAF were aligned. The next meeting therefore is scheduled for:

Thursday, 24 February 2022 at 9.30am-12.30pm via Microsoft Teams.

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	5 April 2022
Director Lead	Simon Parkes – Chair of Audit, Risk and Governance Committee
Contact Officer/Author	Lee Bond – Chief Financial Officer
Title of the Report	**Results of ARG Committee Annual Self-Assessment Exercise 2022**
Purpose of the Report and Executive Summary (to include recommendations)	The annual self-assessment exercise has been conducted by the Audit, Risk and Governance Committee. The updated draft self-assessment document for 2022 was reviewed by the following: 1. Simon Parkes– NED / ARGC Chair 2. Michael Whitworth – NED / ARGC Deputy Chair 3. Gill Ponder – NED 4. Lee Bond – Chief Financial Officer 5. Helen Harris – Director of Corporate Governance 6. Sally Stevenson – Assistant Director of Finance – Compliance and Counter Fraud 7. Tom Watson – Internal Audit Manager, Audit Yorkshire The results of the 2022 self-assessment exercise are recorded on the attached checklist. At its meeting on the 24th February 2022, the Committee also discussed the need for continuous improvement in developing the work of the Committee throughout the coming financial year. The Chair of the Committee also considered that a key area was to have an up to date assurance map of the different sub-committees where assurance took place. This would assist in being clear on the level of assurance required for the Board. **The Trust Board is asked to note the results of the self-assessment exercise performed by the Audit, Risk and Governance Committee in February 2022.**
Background Information and/or Supporting Document(s) (if applicable)	ARG Committee agenda papers from 24th February 2022.
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: ARG Committee
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable

Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	Approval ☐ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

Northern Lincolnshire and Goole NHS Foundation Trust

Audit, Risk and Governance Committee

Self-Assessment Review of Committee Processes - HFMA NHS Audit Committee Handbook, 2018

24th February 2022

Area/ Question	Yes	No	Comments/Action
Composition, establishment and duties			
Does the audit committee have written terms of reference and have they been approved by the governing body?	√		Latest version freely available on the Trust intranet. Last approved by the Trust Board in February 2021. Updated version being submitted to April 2022 for ratification, following review at February 2022 ARG Committee.
Are the terms of reference reviewed annually?	√		Part of the Committee's annual work plan. Last reviewed and updated by the Committee in February 2022. New narrative added in relating to attendance at meetings and decision making. Being submitted to April 2022 Trust Board for ratification.
Has the committee formally considered how it integrates with other committees that are reviewing risk?	√		The Committee's ToR specifically refers to how it integrates with other Trust Board Assurance sub-committees. This is achieved by reviewing their work, specifically in terms of the management of risks, through the routine receipt of action logs and highlight reports at each meeting of the Committee, and identifying any issues that the Committee feel further assurance is required on. Additionally, there is formal ARG Committee member representation on each of the other Board assurance sub-committees.
Are committee members independent of the management team?	√		The Committee's membership comprises 3 Non-Executive Directors.
Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?	√		Minutes and highlight reports submitted to Trust Board. Chair of ARG Committee presents highlight report at TB (as do all other sub-committee Chairs).
Does the committee prepare an annual report on its work and performance for the governing body?	√		Annual report submitted to the Trust Board and CoG for information.

Area/ Question	Yes	No	Comments/Action
Has the committee established a plan of matters to be dealt with across the year?	√		Formal work plan first adopted in 2012, reviewed annually thereafter and any ad-hoc changes made as necessary in between. Rolling twelve month work plan adopted in July 2020. Latest annual review conducted at February 2022 ARG Committee meeting.
Are committee papers distributed in sufficient time for members to give them due consideration?	√		In line with ToR – 5 working days before each meeting.
Has the committee been quorate for each meeting this year?	√		Five meetings during 20/21 and all were quorate. Five routine meetings during 21/22, plus an extraordinary meeting, and all were quorate.
Internal control and risk management			
Has the committee reviewed the effectiveness of the organisation's assurance framework?	√		Through internal audit annual review. The Committee also routinely reviews the BAF and Strategic Risk Register report at each meeting.
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?	√		Through minutes from other sub-committees. As from April 2017 the Committee has received a quarterly report on the BAF and Strategic Risk Register for oversight and scrutiny purposes.
Has the committee reviewed the accuracy of the draft annual governance statement?	√		ARG Committee minutes will evidence this.
Has the committee reviewed key data against the data quality dimensions?	√		***New question in 2018*** - The Trust's Data Quality Strategy was refreshed and submitted to the July 2019 meeting of the ARG Committee for review/comment. External audit review performance indicators as directed by NHSI as part of their year-end audit work, and report the results accordingly to the Committee. The Committee also receives reports from Internal Audit on the outcome of reviews of targeted KPI's as part of the IA annual plan.

Area/ Question	Yes	No	Comments/Action
Annual report and accounts and disclosure statements			
Does the committee receive and review a draft of the organisation's annual report and accounts?	√		Annual Accounts.
Does the committee specifically review: • The going concern assessment • Changes in accounting policies • Changes in accounting practice due to changes in accounting standards • Changes in estimation techniques • Significant judgements made in preparing the accounts • Significant adjustments resulting from the audit • Explanations for any significant variances?	√		Facilitated as necessary through reports from Finance / External Auditor and discussion at Committee meetings.
Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?	√		Prior to submission to NHSE/I.
Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?	√		Robust discussions involving annual accounts. Letter of Representation includes explanations for areas of non-adjustment.
Internal audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?	√		Formal Internal Audit Charter and Internal Audit Working Protocol with Internal Audit Provider (currently Audit Yorkshire).
Does the committee review and approve the internal audit plan, and any changes to the plan?	√		Annual and strategic plans are approved prior to the beginning of each financial year. Changes are documented and approved through IA progress reports to each ARG Committee meeting as necessary.
Is the committee confident that the audit plan is derived from a clear risk assessment process?	√		Plan derived from Internal Audit's individual discussions with Trust Board members, followed by discussion of draft plan at an Executive Team meeting and then submission to the ARG Committee for review and approval.

Area/ Question	Yes	No	Comments/Action
Does the committee receive periodic progress reports from the head of internal audit?	√		At each meeting.
Does the committee effectively monitor the implementation of management actions arising from internal audit reports?	√		At each meeting.
Does the head of internal audit have a right of access to the committee and its chair at any time?	√		Specifically referred to in ToR.
Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?	√		Could be raised at the annual private meeting between the auditors and the Committee (June – Audited Accounts meeting), or by calling an ad-hoc private meeting at any time or during Committee meetings if such an issue arose.
Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*?	√		Audit Yorkshire's work is undertaken in accordance with their detailed Internal Audit Quality Assurance Manual which ensures a consistent approach and compliance with all relevant regulatory standards. In addition they use an Internal Audit Quality Assessment Framework biennially and an external review every five years to objectively assess the quality of our service. Audit Yorkshire agreed with their Board to perform a self-assessment in 2019/20 to confirm compliance for the organisation, with an external review planned for 2020. This external review was duly undertaken by CIPFA in February 2020 with the following outcome: *'It is our opinion that Audit Yorkshire's self-assessment is accurate and, as such, we conclude that Audit Yorkshire FULLY CONFORMS to the requirements of the Public Sector Internal Audit Standards.'*
Does the committee receive and review the head of internal audit's annual opinion?	√		ARG Committee minutes will evidence this.

Area/ Question	Yes	No	Comments/Action
External audit			
Do the external auditors present their audit plan to the committee for agreement and approval?	√		ARG Committee minutes will evidence this. Received at the February 2022 meeting.
Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?	√		ARG Committee minutes will evidence this.
Does the committee review the external auditor's value for money conclusion?	√		ARG Committee minutes will evidence this.
Does the committee review the external auditor's opinion on the quality account when necessary? **[Note: this question is not relevant for CCGs]**	√		ARG Committee minutes will evidence this.
Does the committee hold periodic private discussions with the external auditors?	√		Once a year (June – Audited Accounts meeting) or at any other meeting if requested in advance by the auditors.
Does the committee assess the performance of external audit?	√		On-going assessment by exception. However, a more formalised approach adopted in July 2020 with a paper to the Committee providing a formal annual evaluation of performance by the External Auditor. Performed again in July 2021.
Does the committee require assurance from external audit about its policies for ensuring independence?	√		Formal confirmation in audit strategy/fee documentation.
Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?	√		Policy for Engagement of External Auditors on Non-Audit Work devised and approved in February 2015 and subject to annual review thereafter. Revised in January 2019 to reflect new NAO guidance on this area and reviewed again in January 2020. Latest review at February 2022 meeting. Details of non-audit work included in the annual ISA260 report from the External Auditor. Value of non-audit work is also identified separately in the annual accounts.

Area/ Question	Yes	No	Comments/Action
Clinical audit [Note: this section is only relevant for providers]			
If the committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?	√		The Quality & Safety (Q&S) Committee are responsible for monitoring the delivery of clinical audit activity. Q&S Committee minutes received by the ARG Committee. The clinical audit annual plan for 2021/22 was received by the ARG Committee in July 2021 for information.
If the committee is responsible for monitoring clinical audit has it: • Reviewed an annual clinical audit plan? • Received regular progress reports? • Monitored the implementation of management actions? • Received a report over the quality assurance processes covered by clinical audit activity?	N/A	N/A	Part of the formal terms of reference for the Q&S Committee.
Counter fraud			
Does the committee review and approve the counter fraud work plans, and any changes to the plans?	√		Plan agreed with Chief Financial Officer and received by the ARG Committee for review.
Is the committee satisfied that the work plan is derived an appropriate risk assessment and that coverage is adequate?	√		Counter fraud work plan informed by register of fraud risks, internal audit, NFI, NHS Counter Fraud Authority (NHS CFA) intelligence reports, etc. Work plan areas based on national provider standards established by the NHS CFA.
Does the audit committee receive periodic reports about counter fraud activity?	√		Standing agenda item for written counter fraud progress reports from the LCFS at each ARGC meeting.
Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?	√		ARG Committee minutes will evidence this where appropriate.
Do those working on counter fraud activity have a right of direct access to the committee and its chair?	√		Contained within ToR in relation to the LCFS.

Area/ Question	Yes	No	Comments/Action
Does the committee receive and review an annual report on counter fraud activity?	√		This has always been the case in relation to counter fraud work since 2000.
Does the committee receive and discuss reports arising from quality inspections by NHSCFA?	√		ARG Committee minutes will evidence this where appropriate.

NLG(22)058

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Neil Gammon, Independent Chair of HTF Committee	
Contact Officer/Author	Lee Bond, Chief Financial Officer	
Title of the Report	**Health Tree Foundation Trustees' Committee Minutes of meeting held on 4 November 2021**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Health Tree Foundation Trustees' Committee held on 4 November 2021 and approved at its meeting on 3 March 2022	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: HTF Committee
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **4 November 2021 – Via Teams Meeting**

Present:	Neil Gammon	Independent Chair of HTF
	Mike Proctor	Non-Executive Director
	Gill Ponder	Non-Executive Director
	Maneesh Singh	Non-Executive Director
	Peter Reading	Chief Executive
	Lee Bond	Chief Financial Officer
	Dr Kate Wood	Medical Director
	Paul Marchant	Chief Financial Accountant
	Victoria Winterton	Head of Smile Health
	Clare Woodard	HTF Charity Manager
	Mel Sharp	Deputy Chief Nurse (Rep Ellie Monkhouse)
	Claire Low	Deputy Director of People (Rep Christine Brereton)
In attendance:	Simon Leonard	Communications Assistant (Rep Adrian Beddow)
	Maria Wingham	Transformation Manager (End of Life Care)
	Anne Sprason	Finance Admin Manager (For the Minutes)

Item 1 11/21 **Apologies for Absence**

Apologies for absence were received from: Ellie Monkhouse (Mel Sharp deputising); Christine Brereton (Claire Low representing); Adrian Beddow (Simon Leonard representing).

Item 2 11/21 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declarations of Interests". None were raised.

Item 3 11/21 **Minutes of meeting held on 16 September 2021**

Neil Gammon noted that the minutes previously circulated had omitted Maneesh Singh from the attendees. This has been rectified and updated minutes uploaded to the sharepoint site prior to the meeting.

The minutes of the meeting held on 16 September 2021 were reviewed for accuracy and completion of actions and following review were agreed as an accurate record.

Minutes of Extraordinary meeting held on 5 October 2021

The minutes from the extraordinary meeting were reviewed and agreed as an accurate record.

At this point the Chair explained that an item under AOB would be discussed in Private and asked Victoria Winterton and Clare Woodard to leave the meeting for this to take place.

Item 10 11/21 **Any Other Business – PRIVATE ITEM**

Neil Gammon referred to the meeting in September 2021 when the expiry of the current Smile contract was discussed. It was explained at the time that when the current contract expires at 31st March 2022, it will have been in place for 7 years, including two extensions. The view at the meeting was to undertake a retendering exercise subject to approval from Trust Board.

Concern was expressed around the timescales and it was understood from the Head of Procurement that this could take 3-6 months. An informal request had been received from Smile to extend the contract for 3 months. This would give a period of stability to the Smile team but also avoid any delays with the retendering exercise requiring a month-by-month extension, which would not be fair on either the organisation or the Smile personnel. It was also noted that it would be the responsibility of the employer (Smile) to give statutory notice to employees if they were not awarded a new contract.

Paul Marchant advised that he had spoken with Ivan Pannell as Head of Procurement, who had explained that the contract tendering process could be undertaken in 3 months but it would require the documents and specification out in December so the 30 day notice could be given. This would be an open tender exercise due to the cumulative cost.

Claire Low commented that should Smile not be successful in winning the contract the staff may be eligible for TUPE, which Smile would also have to consider.

Peter Reading assumed that TUPE would apply and he noted that after 7 years the retendering exercise was the right approach, but sufficient time should be allowed to do that. He noted that Covid was one of the factors that could cause delays but if the contract needed to be extended then a waiver could be signed by himself and Lee Bond to extend and would not need a further meeting to agree. Lee Bond also noted that if Smile did not tender for the contract, they would still have to provide the service until the end of the current contract period; they would then assume responsibility for those members of staff and no TUPE would apply.

Neil Gammon asked Trustees if they wanted to proceed now or wait until after the Trust Board meeting on 7 December before commencing the process.

Peter Reading suggested a short paper should be provided to the Trust Board to recommend the decision made at this meeting, which Neil Gammon confirmed was done and would just require slight amendments depending on the decision made today.

Gill Ponder agreed that it was absolutely the right decision to go out tender but if the commencement of the process runs too much into Christmas there could be a problem in receiving quality submissions. She added that tenders invariably take longer than anticipated so suggested consideration should be given to an extension to the contract to allow time to run a thorough tendering process.

Neil Gammon confirmed therefore, that everyone was in agreement that the decision to retender was the correct one and highlighted that at the next HTF meeting on 13th January the Committee would review the process. The recommendation would be taken to the Trust Board in December and the tendering exercise set to commence in January 2022.

Peter Reading agreed with Gill Ponder's comment in not rushing the process over the Christmas period.

Neil Gammon asked the Trustees if they agreed to an extension for three months as discussed. He could see no evidence on the Smile teams' performance as to why the extension could not be agreed. All agreed to recommend to the Trust to extend the contract for three months to 30th June 2022 whilst the retendering exercise took place.

1.33pm Victoria Winterton and Clare Woodard were invited back to the meeting and Neil Gammon informed them of the decision made.

Item 5 Review of Action Log

The action log was reviewed as follows:

7 (08 03 21) – Office space for HTF. The HTF team were now able to move back into the office at the entrance to the hospital at DPOW. **Action** Closed.

7 (08 03 21) – Dedicated Estates Support for HTF. The new Sparkle Project Officer had now commenced and was reviewing the Sparkle requests; these could now be taken forward. **Action** Closed.

7 (13 05 21) – Future Strategic Funding plan – Clare Woodard confirmed that she had now been invited to the Business Planning Strategy Group to ensure HTF were seen as a prominent funding partner. **Action** closed.

6.1 (16 09 21) – Fusion Biopsy Machine – Following the agreement at the last meeting Victoria Winterton and Clare Woodard had been asked to speak to Cleethorpes Cancer Support Group to explain that whilst the equipment would be located at another site it would certainly benefit Grimsby patients. The donation was given to help support patients of NLAG and therefore the request fulfilled the donation criteria. **Action** closed.

6.3 (16 09 21) – Future Strategic Planning – Clare Woodard had met with the Business Case Review Group to promote future charity spend. **Action** closed.

6.4 (16 09 21) – Dates of meetings 2022. These were included with the papers. **Action** closed.

(16 09 21) – Any Other Business – Request for funding for the flu campaign. Considered at the extraordinary meeting held on 5 October 2021 and agreed £10k to be provided from HTF. **Action** closed.

12 (16 09 21) – Private discussion at the commencement of the meeting. **Action** closed.

12 (16 09 21) – Contractual Agreements – Christine Brereton had taken the action to determine if TUPE applied to current HTF staff if the contract was lost by Smile. Discussed under private item at the commencement of the meeting. **Action** closed.

Following review, the action log was noted.

The next item was taken out of sequence

Item 6 11/21 **Items for Discussion / Approval**

6.2 Trustee Development Opportunity "Making the Best of the Board" Survey

Clare Woodard presented the paper and highlighted that following the agreement at the last meeting the survey was circulated to the Committee members and she thanked everyone for their returns. The responses were set out within the document and Clare Woodard highlighted that there were a couple of areas where strengths and skills could be developed and stated it would be useful to arrange for a half day workshop in the New Year to explore those areas in more detail.

Clare Woodard confirmed that she would approach the same external facilitator who had supported the training event she attended.

The Committee agreed this would be a good opportunity and Gill Ponder commented that the survey results made interesting reading and she would welcome further work in the areas highlighted. She said it could be easy to think that it was not needed but felt it would be helpful for all Trustees to refresh and fill in skill gaps.

It was agreed therefore that Clare Woodard should take this forward and arrange a half-day workshop in the New Year noting time constraints on diaries.

Action: Clare Woodard

Mike Proctor joined the meeting.

The next item returned to the order of the agenda as Maria Wingham joined the meeting.

6.1 Wish Ref 284/21 – Funding request for Band 7 End of Life Nurse to support the roll out of the Bluebell project

Maria Wingham presented the request and was asked to highlight any additional information for the Committee.

Maria Wingham gave a brief background explaining that the Community and Therapies Division have lead responsibility for rolling out the outputs from the End of Life Programme across the Trust. This involves four key projects that focus on specific areas relating to End of Life that each link back to the Ambitions for Palliative and End of Life (EOL) Care. There were currently two EOL nurses supporting delivery of those projects. Nurses will work with each of the wards to roll out new tools and develop training packages to support both patients and staff. The sooner the tool was rolled out across the wards the earlier an equitable service for all EOL patients could be delivered.

Under current resources it would take until June to roll out the programme across all wards but if funding was agreed for an additional nurse this would be completed by March 2022.

Neil Gammon noted the other Band 7 post that HTF were currently supporting and added that if this wish were successful there would be a need to consider which fund zone it would come from. Clare Woodard also highlighted that additional sundries, such as tote bags, were already being supported by the charity.

Mike Proctor asked if any other funding streams had been sought e.g. MacMillan or Marie Curie. He also noted that once the post was in place it was difficult to remove it, so he advised caution that this route does not provide a future cost pressure that adversely impacts consideration of other priorities.

Maria Wingham was not aware of any other funding being sought as this was a short-term post required to embed changes, and whilst the team may require further increase in the future this would be managed through budget planning.

Lee Bond was happy to support given that it was a 12-month contract.

Kate Wood noted the excellent success through the time limited ReSpect post that HTF also support as this was about change and offered commitment to the EOL agenda she fully supported the request.

Mel Sharp also agreed that any additional resource into the EOL agenda was fully supported.

Gill Ponder commented that as it was over and above what the Trust would have provided, it was definitely for patients' benefit and represented appropriate use of charitable funds. She also fully supported the request.

Peter Reading agreed with the comments made and was fully supportive.

Maneesh Singh was supportive and asked about the recruitment process. Maria Wingham advised that there was an individual who had previously covered for sickness absence and would likely be interested in the post.

Neil Gammon commented that whilst he always had some nervousness when charitable funds were used to fund posts he agreed this was enhancement and a clear patient benefit.

Victoria Winterton queried that if the post was being funded for 12 months and it was anticipated that the work would be concluded by March 2022, what would be involved for the remaining time. Marie Wingham explained that the time would be used to evaluate the success of the project and ensure that the changes were fully embedded. Victoria Winterton asked that if the work finished earlier than the 12 months then the identified monies could be used for other things by the HTF.

Following the detailed discussions, it was agreed there was unanimous support for the wish. Maria Wingham was thanked for attending and she left the meeting.

Item 7 11/21 **Updates from Health Tree Foundation**

7.1 HTF Update Report

Clare Woodard presented the report and advised that it was "full steam ahead" for Christmas events including craft fairs and staff events, and they were also trying to work around the A&E fund raising to put on a festive theme. There were special graphics going out and hopefully that would bring in more support for the A & E appeals.

The team were working on applying for grant funding where possible and Clare Woodard highlighted to the Committee that it could be clearly seen from the charity champions' reports that everyone was enthusiastic and trying to get as much funding as possible during a really difficult time.

Clare Woodard drew attention to the grant funding applications (page 6), which outlined the current position. It was noted there were some applications had been declined and those submissions would be reviewed by the HTF Team to see if there were any lessons that could be learned.

Kate Wood commented that it was a comprehensive report as usual and referred to the success of the ReSpect role (pages 1-2), noting that Rachel Hewison had been appointed for two years, from August 20. Kate Wood explained that she had spoken with Rachel who had informed her that she had been offered work from NHSE/I which Kate did not think fitted in with the arrangements when the original funding from HTF had been agreed. Kate Wood suggested therefore that the discussion should have been held with the HTF.

The role had been really successful and Kate Wood noted the update in the report, which stated that since June 2021 the old DNACPR forms should not have been used yet those completed in the community were still coming in. Kate Wood felt therefore that if there was still more work to be done then this should be undertaken before moving to other places. It was agreed that whilst not wanting to prevent career progression the role was being funded by HTF for NLAG patients. Neil Gammon asked how one of NLAG's members of staff could move without NLAG having a say, noting that she was funded for 2 years for the benefit of NLAG patients. Clare Woodard advised that Rachel Hewison was line managed by the community and therapy team.

Mike Proctor agreed that if the charity funded a post and then the postholder moves to work for another organisation, the funding should come back to the charity to decide what should happen to that work.

Gill Ponder was in agreement and asked how this had happened and how the Trustees could ensure that it did not happen in other roles that had been supported. She added that it felt like a process gap and in this case a fait accompli, so Trustees would need to ensure that the funding was recovered as it would be failure of duty if funding was not returned to the charity.

Neil Gammon asked if this was a "done deal" and already happening or if Rachel was advising Kate Wood of an offer. It was agreed that Kate Wood, Neil Gammon and Clare Woodard have further discussions outside of the meeting.

Action: Neil Gammon / Kate Wood / Clare Woodard

Victoria Winterton commented that this was always an issue in that posts were funded and the charity team were not able to track and it may be useful to have a nominated liaison person for the charity each time such funding was provided.

Clare Woodard suggested in the case of the earlier agreement for the EOL Band 7 post that Maria Wingham should act as the conduit and provide a 6 month feedback to the Committee. This was agreed.

Action: Clare Woodard

Paul Marchant noted that the monies for the HTF funded posts were paid out on a monthly basis and therefore if not undertaking the role then payment would not be made, rather than paying up front and having to reclaim the money.

Neil Gammon noted that the status of the annual report was currently with the SMILE graphic design team and he proposed sending a hard copy to the Charity's Patron, Sir Reginald Sheffield, with a note highlighting areas of interest. He went on to explain that unfortunately due to Covid restrictions it had not been possible to invite Sir Reginald on site and would keep in contact that way.

The number of wishes outlined on the first page of the KPIs was reviewed and noted the increase each year. This year, however, was lower than previous years and it did not look like 500 wishes would be achieved. Clare Woodard advised that staff were understandably very busy and it did take time to complete the wishes appropriately but the team were trying to encourage more wishes to be requested.

Victoria Winterton commented that it was not necessarily a bad thing, and there were still the Christmas wishes to come in, but it could be that working smarter with the resources in place. It was noted that the proposal to give out blankets to patients as their Christmas gift was receiving good feedback.

Neil Gammon asked how that would work in the Community setting and Clare Woodard explained that the idea was about patients leaving hospital, but she could contact the Community Teams to see what help could be given. Neil Gammon asked Clare Woodard to contact the community and therapy teams to see if there was something similar to the blankets that could be provided.

Action: Clare Woodard

Gill Ponder noted that when reading the HTF Charity Manager updates there was so much going on that left her feeling, as a Trustee, that she should know more but did not see that much publicity. She acknowledged that there were smaller items in the comms that did reach her but felt as a Trustee there may be occasions when they would wish to donate a prize and actively support some of the things of particular interest.

Clare Woodard explained that posters were put in local shops and a lot of the fund-raising awareness was publicised through social media. Clare Woodard suggested she could put a short note to Trustees together to include the variety and number of activities that were already underway or planned over the forthcoming months. Gill Ponder agreed it was a good idea but wondered if other Trustees felt the same.

Claire Low highlighted the Equality and Diversity calendar that could join together with HTF to provide the information to Trustees. Neil Gammon stated that there was some scope to provide an update, noting that the E & D dates were more set in stone, but suggested that Claire Low and Clare Woodard discuss outside of the meeting, and if Gill had any particular suggestions to let Clare Woodard know.

Action: Clare Woodard / Gill Ponder / Clare Low

Item 8 11/21 **Sparkle Programme**

8.1 Sparkle Update

Clare Woodard was pleased to report that since the new Sparkle Officer had joined the Trust, she had made an immediate difference with a number of "quick wins" already commenced. Neil Gammon asked that the Trustees' thanks go to Lauren for the good start, and asked if this would mean more wishes would be completed which Clare Woodard confirmed.

Item 9 11/21 **Finance**

9.1 Finance Report September 2021

Paul Marchant presented the report and highlighted the key points, including:

- Income for the first 6 months of the year was £253k, which was £176k behind plan.
- The annual income plan of £850k had been revised and reduced by £112k to £738k, which reflected anticipated fund raising, donations and legacies for the remainder of the year. This would be reviewed again in December 2021
- Expenditure for the first 6 months was £389k which was £299k underspent against the plan of £688k. The annual expenditure forecast of £1,260k had been revised and reduced by £34k to £1,226k to reflect forecast expenditure for the remainder of the year. This would also be reviewed in December 2021.
- An operational support grant of £62k had been received from NHS Charities Together for the development and delivery of the Stage 2 grants for the Humber Coast and Vale ICS. The £62k had been ring fenced.
- Fund balances after commitments were £1,231k.

Neil Gammon referred to the £62k and was not sure that it should be included under income, and whilst the money was ring fenced he wanted to ensure that the appropriate financial governance mechanisms were in place to record grant spend and explain clearly the use of the grant to Trustees and auditors.

Neil Gammon also referred to the financial KPIs (page 5) and noted that in the current year fund raising costs were significantly higher and asked why. Paul Marchant explained that expenditure on charitable activities was less than plan which that meant fund raising costs represented a higher proportion of total expenditure. Moreover, when the whole year period was complete, it was likely that the fund raising costs would fall in line with the norm. A shortened period always has the potential to distort the results.

Following the discussions, the finance report was noted

Item 10 11/21 **Any Other Business**

There was no other business raised.

Item 11 11/21 **Matters for Escalation to the Trust Board**

It was agreed that the following items would be included within the Highlight Report to the Trust Board:

- The decision to extend the Smile contract for 3 months
- The decision to fund an EOL Nurse for 12 months

Mike Proctor suggested that the highlight report should also allude to the discussion around the ReSpect post already funded and that if the postholder moved from that post it must be in consultation with the charity going forward. This was agreed and Neil Gammon also noted that a link person would ensure that HTF were kept informed of any changes and provide periodic progress reports to the Committee.

Item 12 11/21 **Date and Time of the next meeting**

It was noted that this had been the last Trustees meeting of the year and Clare Woodard thanked everyone for their support over the last 12 months.

The next meeting would take place as follows

Thursday, 13 January 2022 – 1.00pm-3.30pm – via Teams Meeting

The dates for 2022 had been included for information. The meeting invitations would be sent out following the meeting.

Action: Anne Sprason

Attendance Record:

Name	May 2021	July 2021	Sept 2021	Nov 2021	Jan 2022	March 2022
Neil Gammon	✓	✓	✓	✓		
Peter Reading	✓	✓	✓	✓		
Terry Moran	-					
Linda Jackson	✓	Apols	-	Apols		
Gill Ponder	✓	✓	Apols	✓		
Mike Proctor	Apols	Apols	-	✓		
Maneesh Singh			✓	✓		
Lee Bond	✓	Apols (Rep)	Apols	✓		
Jug Johal	✓	✓	✓	Apols (Rep)		
Kate Wood	✓	✓	✓	✓		
Ellie Monkhouse	✓	Apols (Rep)	Apols (Rep)	Apols (Rep)		
Christine Brereton	✓	-	✓	Apols (Rep)		
Paul Marchant	✓	✓	✓	✓		
Andy Barber	Apols	-	Apols	-		
Victoria Winterton	✓	✓	✓	✓		
Clare Woodard	✓	✓	✓	✓		
Adrian Beddow	✓	Apols (Rep)	✓	Apols (Rep)		
Ian Reekie (Governor)	Apols (Rep)	Apols	Apols	-		
Total	**13**	**8**	**9**	**10**		

NLG(22) 059

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5/4/2022	
Director Lead	Adrian Beddow, Associate Director of Communications	
Contact Officer/Author	Charlie Grinhaff, Communications Manager	
Title of the Report	**Communications Round up – April 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights some of the key projects the Communications team are working on as well as providing updates on media and social media activity. It covers the period 15 January 2022 to 18 March 2022 and also includes a brief summary of the financial year	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Pandemic Response ✓ Quality and Safety ✓ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

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Communications Team update

April 2022

Kindness • Courage • Respect

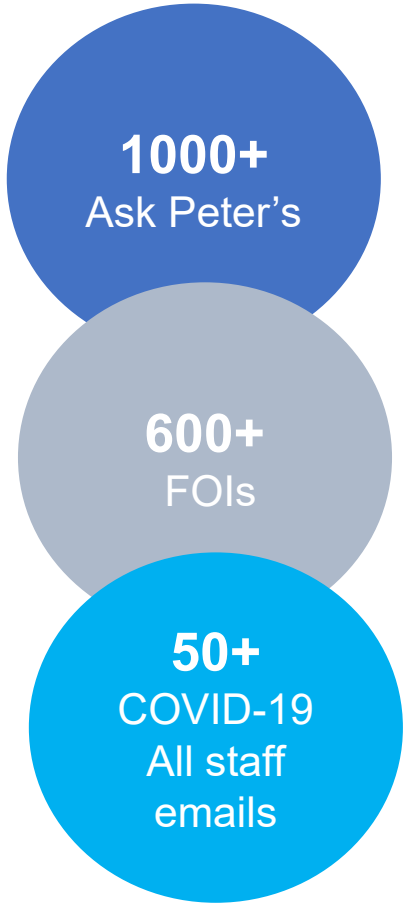
End of year overview

During 2021/22
The team has supported the **pandemic response** by keeping staff and key stakeholders informed and up-to-date.
We have:

- Sent more than 50 COVID-19 updates to staff and key stakeholders
- Responded to 62 COVID-19 related media enquiries (out of 317 received in total)
- Played a key part in VCOD, with 3,821 staff sharing their vaccination status or intentions with us following our hard copy and digital comms (we've also continued to support the wider vaccination campaign, including second doses and boosters)
- We've kept staff and patients up-to-date with changing guidance and visiting arrangements.

During this time we have also:

- Responded to 1,333 Ask Peters from staff
- Dealt with 682 FOI responses
- Issued 69 proactive news releases
- Written 34 reactive media statements
- Launched a brand new Trust patient facing website bringing it up-to-date with accessibility requirements
- Celebrated staff achievements on our corporate social media pages with more than 300 Thumbs up Fridays and 180 Thank You Tuesday's shared. We've also continued to support divisions to promote their work and key campaigns
- Our Building Our Future campaign has had a combined reach of more than 800,000 since it began.



April update 2022 – covering 15 Jan to 18 March

Key campaigns in this period

QI strategy launch - We worked closely with the Quality Improvement (QI) team in February to launch the Trust's first QI Strategy. We engaged with staff using different approaches via Ellie's Monday Message via email, Hub and staff Facebook group posts, a hot topic, screensaver and face-to-face conversations with staff. Feedback generated during the launch will contribute to future plans by the QI team. The launch-week kicked off promotion for the Trust's first QI Conference, which we are supporting by preparing materials for the day and attending to promote both externally via social media and internally.

International Women's Day - As well as promoting our first ever International Women's Day event, we also used it as an opportunity to do some employer brand work in line with the People strategy, highlighting NLaG as a great place to come and work.
We interviewed and created articles on just 11 of the inspirational women at NLaG and shared them on our corporate social media, website and internal channels. Many of them had started out as volunteers or apprentices but, with the support of the organisation, have risen through the ranks to take on senior and specialist roles. The reaction was extremely positive. Collectively, we reached an audience of 43,430 – over 1,000 of which liked or loved the posts, shared them on or left a positive comment for our amazing ladies.

Supporting the Trust's priorities

Workforce and leadership
Communications are prepared for the publication of the national Staff Survey on 30 March, as well as the launch of the third wave of the People Pulse survey on 1 April. Involved with the work around the culture transformation programme and the new induction for staff.
Green agenda
We continue to promote Green initiatives across the Trust such as recycling. We are also encouraging staff to become Net Zero Heroes. We are supporting the Sustainability team to get volunteers for a wildflower meadow project at DPoW.

Other Projects

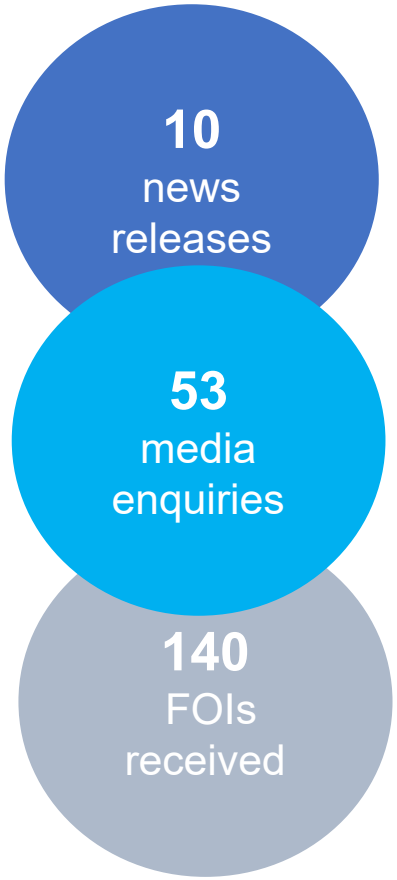
Annual report
Work has started to prepare the Trust's Annual Report 2021/22 following the publication of the guidance at the beginning of March 2022.
Trust learning group
The team are supporting the Trust Learning Group in promoting key themes identified from complaints and incidents.
Digital communications
The team have promoted the re-introduction of SMS reminders and continue to support the digital letters rollout.

Improving reputation through external communications

Media coverage
There were 114 stories about the Trust in the media during this period. 84% of media coverage was positive or neutral in tone. Coronavirus continues to be the top theme on media coverage, with 49 stories on this.
The most covered news release issued was on visiting restrictions easing.
National media coverage of note: The Trust featured in the Health Estate Journal about new lighting at Goole and there was a negative patient experience story from maternity services in the Daily Mail and The Sun.
The Chief Nurse division has generated the most news releases this year and Family Services division have had the most positive coverage.

Media enquiries
53 media enquiries were handled in this time, 92% were dealt with within the requested timescale.
The top theme for media enquiries was ‘other’, followed by coronavirus and performance. 2 came in on the back of proactive news releases. The main reason journalists got in touch was to put in an information request. 4 statements were issued in this period

Freedom of Information requests (FOIs)
Complex FOIs are continuing to require more time than in the past to pull together an appropriate response which meets the statutory requirements. There was 140 submitted in this period – of these 101 are closed, 35 are still in progress and 4 are awaiting a response from the requester.



Improving reputation through external communications

Health Tree Foundation (HTF)

We launched a new campaign to encourage staff and patients/public to submit a wish to the charity.
We supported the charity photography competition for pictures to be put up in our hospitals. We put out a press release and have been regularly promoting this on social media. The story has featured in the media. We also featured a story on our social media channels about an ultrasound machine funded by HTF for Scunthorpe hospital. We have supported with the Covid recognition services, where plaques and trees funded by HTF were unveiled at the three hospitals.

Website

Key stats:
76,806 visits and 226,726 page views
71% of visitors were new users
97% of users were in the UK
Safari was the top browser used to access the site
72% of users accessed the site via a mobile or tablet.
Most visited page: Grimsby hospital home page
The top three news releases were a community equipment appeal, changes to visiting and International Women's Day

Improving reputation through external communications

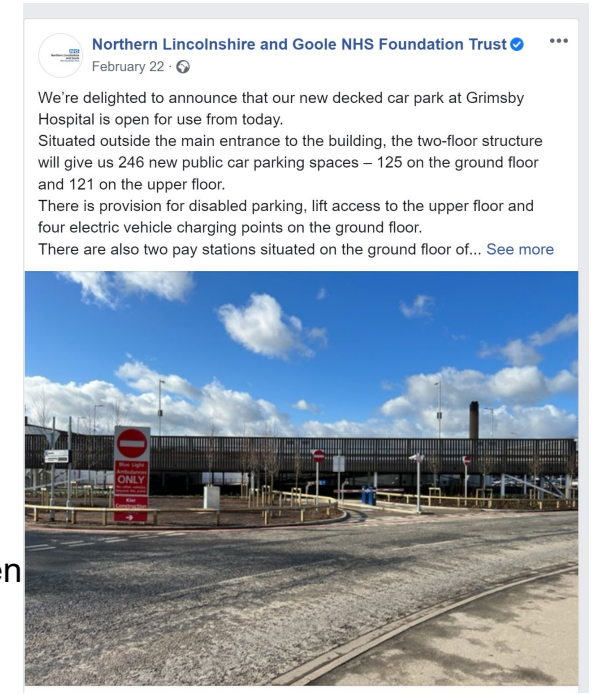
Social media
Followers update:
12,638 on the Trust's Facebook page
5,050 followers on Twitter
We are rated 4.6 out of 5 stars on reviews on Facebook

The top Tweet and top Facebook post in this period were both on the opening of the new decked car park at Grimsby.

Thumbs up Friday and #ThankYouTuesday

We have posted around 30 Thumbs Up Fridays and 35 #Thank You Tuesdays in this period.
Since the 'Thank you' system launched in January staff have sent more than 450 thank you's to date -200 of which have been copied to our team to share.

Top Facebook post
18,947 reach



Top Tweet
1,106 impressions

Our decked car park is now open at **#Grimsby** Hospital, providing 246 spaces for patients and visitors - just turn right when you come in from Scartho Road.
Now the new facility is up and running, the nursery car park has reverted back to staff and nursery parking only.
Thanks pic.twitter.com/dtUdk22V5C

Improving staff morale and engagement

Staff closed Facebook group stats
3,094 active members
908 posts
5,515 comments
14,243 reactions
The most popular post was a tribute to a former staff member

Ask Peter .
369 Ask Peter's were received in this period (up 105 from last year's 264)
Hot topics included: VAT on lease cars, retire and return, staff COVID-19 vaccines, staff morale and behaviour, as well as free staff car parking. In this period we have redacted five questions and removed one.

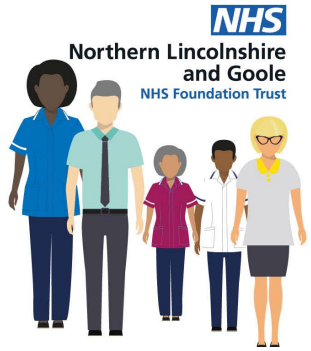
Senior Leadership Briefing
100 senior leaders attended the March SLC briefing. Updates included cyber security, CQC, HAS, Quality Improvement and leadership strategy.

Improving staff morale and engagement

Keeping staff informed

Wednesday Weekly News

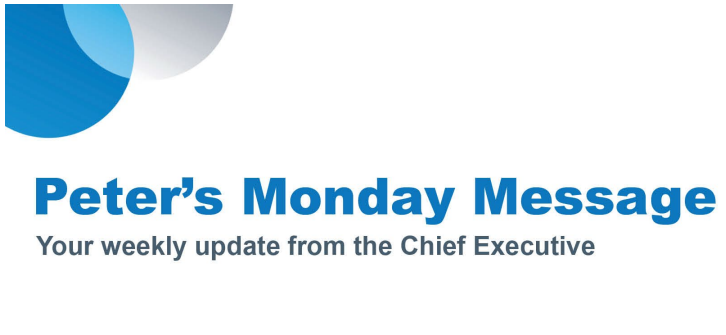
We are unable to track how many people read this all-staff email, but we are able to access link clicks. The top story for link clicks was the Annual leave buy back scheme which had more than 700.



Monday Message

Topics have included:

- Message from new Trust Chair
- Covid anniversary
- HTF update
- QI update
- International Womens Day
- Update following the Trust Board meeting.



Promotion of awareness weeks and months: In this period we have helped highlight NHS Overseas Workers Day, International Women's Day, National Apprenticeship Week, Global Recycling Day, World TB Day, Cervical Cancer Prevention Week, International Thank You Day, World Aspergillosis Day, Random Acts of Kindness Day and Endometriosis Action Month.

Communications relating to service and capital investment

Building Our Future update

We have:
Shared 39 external social media posts
Responded to 18 direct questions from the public
Had 5,652 visitors to the website pages giving updates on our capital works (Including the latest parking information).

Internally, over the same period we:
Had 314 visitors to our internal Hub pages
Shared 31 staff Facebook posts
Sent out 11 all staff emails
Answered 11 Ask Peter queries
Provided six direct staff briefings

877,222
Combined campaign reach so far

The combined reach of the campaign to date is well in excess of 877,222. This figure does not include those who have viewed articles on the Hub or read all staff emails, as this data is not available to us.

When taking into account the circulation/ viewing and listening figures of the media outlets who have shared our content, this takes our potential reach to over 12,037,835

NLG(22)060

Name of the Meeting	**Trust Board – Public**
Date of the Meeting	Tuesday 5th April 2022
Director Lead	Ivan McConnell, Director of Strategic Development
Contact Officer/Author	Kerry Carroll, Deputy Director of Strategic Development
Title of the Report	**Clinical Strategy Reporting Framework**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this report is to provide a high level reporting status of the progress made against the Clinical Strategy 2021-25 for year end 2021/22; to highlight plans where complete, on track or overdue against the following Trust 6 priorities detailed in the strategic framework: • Integrated Urgent & Emergency Care • Transformed outpatient services • Worked in partnership with Primary Care Networks • Reconfigured specialties to one site where appropriate • Restructured cancer services • Created a sustainable hospital at Goole The reporting framework also aligns to the each of the Division's 5 year strategies providing a status of the divisional objectives against each of the Trust 6 priorities (detailed in appendix 1).
Background Information and/or Supporting Document(s) (if applicable)	Clinical Strategy 2021-25 Strategic Framework 2019-24
Prior Approval Process	☐ TMB ☐ PRIMs ✓ Divisional SMT ✓ Other: TMB
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ☐ Workforce and Leadership ✓ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ✓ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	

Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

NHS
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Clinical Strategy Reporting Framework
End of Year Report (2021/22)

Strategic Framework 2019-24 and Clinical Strategy 2021-25

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

The Clinical Strategy sets out our ambitious commitments to ensure the people who rely on our services receive high quality and accessible care and treatment. For our Trust to achieve this, the way services are currently delivered will need to change. Proposals have been designed with the needs of patients central to our thinking. This must be set within the context in which we operate. We will continue to focus our efforts on ensuring that we improve the efficiency, effectiveness and safety of our services.

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

The **six Trust Priorities** will be evolving through transformation over next few years, reflected in the Clinical Strategy and Clinical Divisional plans

Our Clinical Divisions are at the heart of delivering front line services to our patients to achieve our six Trust Priorities and each Division has a 4 year strategy articulating the visions, challenges, aims and objectives which are built from the Trust Strategic Framework and priorities aligning to quality priorities.

Trust Priorities (2024) Plans and Timescales

The timescales and the improvements that will be achieved through delivering our Clinical Strategy, set within the context of our six trust priorities are summarised below. The Clinical Strategy reporting framework will be updated quarterly;

Priorities	Timescales		
	2021-2022	**2022-2023**	**2023-2025**
Integrated Urgent and Emergency Care (U&EC)	• Implement an Urgent Care Hub • Increase access to SDEC and Ambulatory Care • Reduce the length of stay in hospital • Implement Talk before you Walk, Frailty model and Community Response Team	• A new dedicated Acute Assessment Unit and Emergency Department at both DPoW and SGH • Implement Humber Acute Services Review models of care	Continue to work in partnership to improve performance levels
Transformed Outpatient Services	• Expand the use of non face-to-face appointments • Reduce the back log of follow up appointments • Reduced waiting times and progressed recovery from COVID • Increased digital technology to manage pathways	• Developed digital devices and systems to support patient record sharing • Implemented joint pathways with Primary care • Patient initiated follow ups and pt apps	• Increased virtual and community clinics • Reduced 30% of face-to-face appointments • Eliminated overdue follow ups
Worked in Partnerships with PCNs	Implement Cardiology clinics within the community	Develop shared training, recruitment and retention approaches	Formation of teams within each location, sharing skills across the system
Reconfigured Specialities to one site where appropriate	• Deliver the HASR Interim Clinical Plan • HASR Core service change: • Completed pre-consultation engagement • Submission of pre-consultation business case	Implement Humber Acute Services Review models of care	Continue to work in partnership across the Humber to improve the delivery of patient care
Restructured Cancer Services	• Explore and develop new models of care to ensure faster diagnosis and treatments • Implement additional CT and MRI scanners in DPoW	• Implement 2nd MRI scanner in SGH • Alignment of histopathology service to support faster diagnosis • Implement all stratified pathways	Full deployment of digital pathology and digital outsourcing
Created a Sustainable Hospital at Goole	Ensure full utilisation of our theatres and clinics to meet demand	Reshape the workforce working in different ways to effectively use specialist skills of staff	Continue to work in partnership with local and regional partners

Clinical Strategy Reporting Framework (high level)

Key: On Track | Complete | Overdue

Priorities	Q3 position					
	Objectives (for 2021/22 timescales)	Target Date	Q1 Apr - Jun	Q2 July – Sept	Q3 Oct – Dec	Q4 Jan – Mar
Integrated Urgent and Emergency Care (U&EC)	Implement an Urgent Care Hub	2021-22				
	Increase access to Same Day Emergency Care and Ambulatory Care- **Continuous**	2021-22				
	Reduce the length of stay in hospital	2021-22				*Carry over*
	Implement Talk before you Walk, Frailty model and Community Response Team	2021-22				*Carry over*
Transformed Outpatient Services	Expand the use of non face-to-face appointments- **Continuous**	2021-22				
	Reduce the back log of follow up appointments (reducing but not on target)	2021-22				*Carry over*
	Reduced waiting times and progressed recovery from COVID (reducing but not on target)	2021-22				*Carry over*
	Increased digital technology to manage patient pathways	2021-22				*Carry over*
Worked in Partnerships with PCNs	Work with the PCN's as an enabler to the elective and non elective pathways	2021-22				*Carry over*
	Implement Cardiology clinics within the community	2021-22				
Reconfigured Specialities to one site where appropriate	Deliver the HASR Interim Clinical Plan	2021-22				*Carry over*
	HASR Core service change: completed pre-consultation engagement	2021-22				
	HASR Core service change: submission of pre-consultation business case	2021-22				
Restructured Cancer Services	Explore and develop new models of care to ensure faster diagnosis and treatments	2021-22				*Carry over*
	Implement additional CT and MRI scanners in DPoW	2021-22				
Created a Sustainable Hospital at Goole	Ensure full utilisation of our theatres and clinics to meet demand	2021-22				*Carry over*

Summary – key messages

- The Clinical Strategy 2021-25 is aligned to the Trust's strategic framework 5 year priorities set in 2019 which are:
  - *Integrated Urgent and Emergency Care*
  - *Transformed Outpatient Services*
  - *Worked in partnerships with Primary Care Networks*
  - *Reconfigured specialities on to one site where appropriate*
  - *Restructured cancer services*
  - *Created a sustainable hospital at Goole*

- The Clinical Strategy narrates 16 objectives for 2021/22 – as at year end
  - 7 complete
  - 9 on track – noting further continuation to be carried over into 2022/23

- The Divisional Strategies combined narrates 93 objectives for 2021/22:
  - 36 as complete
  - 46 as on track
  - 11 as overdue

- COVID-19 had an impact on some of the divisions and their planned timescales therefore, making some objectives overdue.

- Strategic framework (Trust priorities currently referenced) to be reviewed by **July** 2022

Appendix

- **Slides 7-12:**
  - **Divisional status on achievement of objectives aligned to each of the Trust priorities**

2021/22 Divisional status against Trust priorities Reporting Framework - (high level)

TRUST PRIORITIES	COMBINED DIVISIONAL STATUS				
	Overall Objectives Scope 2019-24	Objectives 2021-22	On track	Complete	Overdue *
Integrated Urgent and Emergency Care (U&EC)	**28**	**19**	9	10	0
Transformed Outpatient Services	**31**	**21**	9	12	0
Worked in Partnerships with PCNs	**12**	**9**	7	2	0
Reconfigured Specialities to one site where appropriate	**16**	**12**	8	2	**2**
Restructured Cancer Services	**25**	**24**	7	9	**8**
Created a Sustainable Hospital at Goole	**11**	**8**	6	1	**1**

* NB: Impact of Covid-19, ICS and Humber wide delays in programmes, lead to certain divisional objectives being reported as 'overdue', although this is outside the control of the divisions. Actions have been put in place to either bring these back on track or completion.

Surgery & Critical Care Clinical Strategy Reporting Framework (high level)

Priorities	Overall 21/22 Year position				
	Aims	Objectives Scope 2021-22	On track	Complete	Overdue
Integrated Urgent and Emergency Care (U&EC)	Increase urgent and emergency pathways up to and beyond 2024 to enable senior decision making to be made earlier	4	1	3	0
Transformed Outpatient Services	To reduce visits to hospital appointments in by about a third	3	0	3	0
Worked in Partnerships with PCNs	To work in collaboration to improve patient pathways and outcomes	3	2	1	0
Reconfigured Specialities to one site where appropriate	To ensure all services are assessed to be sustainable and to provide optimal care for the population in the right place and the right time	4	1	1	2
Restructured Cancer Services	To ensure patients get access to diagnostics quickly and, where cancer is identified, treatment can start as soon as possible.	5	1	4	0
Created a Sustainable Hospital at Goole	To support the increase in providing elective and day case procedures	1	1	0	0

Medicine Clinical Strategy Reporting Framework (high level)

Priorities	Overall 21/22 Year position				
	Aims	Objectives Scope 2021-22	On track	Complete	Overdue
Integrated Urgent and Emergency Care (U&EC)	We want to create an urgent and emergency care service to improve the patient experience, reduce their length of stay and avoid admission where appropriate. *This means patients are not seen or treated in the A&E department (as they have been for many years) but in other, more appropriate services*	2	2	0	0
Transformed Outpatient Services	To reduce visits to hospital appointments	4	4	0	0
Worked in Partnerships with PCNs	To alter the place of care – being delivered in community settings as a hybrid service with Primary Care	3	2	1	0
Reconfigured Specialities to one site where appropriate	To provide optimal care for the population in the right place and at the right time	4	4	0	0
Restructured Cancer Services	To ensure patients get access to diagnostics quickly and, where cancer is identified, treatment can start as soon as possible	3	1	0	2
Created a Sustainable Hospital at Goole	To support safe sustainable services in Goole	2	1	1	0

Family Services Clinical Strategy Reporting Framework (high level)

Priorities	Overall 21/22 Year position				
	Aims	Objectives Scope 2021-22	On track	Complete	Overdue
Integrated Urgent and Emergency Care (U&EC)	Ensure that there is safe, timely and accessible emergency care services for Paediatrics, Gynaecology and Obstetrics	**3**	1	2	0
Transformed Outpatient Services	Building on the Covid-19 recovery plan, to reduce visits to hospital appointments in Family Services by about a third	**1**	0	1	0
Worked in Partnerships with PCNs	Work with the PCN's as an enabler to the elective and non elective pathways	**1**	1	0	0
Reconfigured Specialities to one site where appropriate	To ensure services are sustainable	**2**	1	1	0
Restructured Cancer Services	To ensure patients get access to diagnostics quickly and, where cancer is identified, treatment can start as soon as possible.	**5**	0	2	3
Created a Sustainable Hospital at Goole	To support the increases in planned care services	**2**	1	0	1

Clinical Support Services Clinical Strategy Reporting Framework (high level)

Priorities	Overall 21/22 Year position				
	Aim	Objectives Scope 2021-22	On track	Complete	Overdue
Integrated Urgent and Emergency Care (U&EC)	To support the improvements in patient flow	**3**	1	2	0
Transformed Outpatient Services	To move to a single integrated care system for outpatients through the outpatient transformation programme and reduce face to face appointments	**6**	4	2	0
Worked in Partnerships with PCNs	To support the integration of clinical support services within the PCN developments	**1**	1	0	0
Reconfigured Specialities to one site where appropriate	To support the Trust's Clinical Strategy with service reconfiguration	**1**	1	0	0
Restructured Cancer Services	To improve patient experience and the effectiveness of cancer pathways	**10**	4	3	3
Created a Sustainable Hospital at Goole	To support sustainability	**1**	1	0	0

Community & Therapies Clinical Strategy Reporting Framework (high level)

Priorities	Overall 21/22 Year position				
	Aim	Objectives Scope 2021-22	On track	Complete	Overdue
Integrated Urgent and Emergency Care (U&EC)	To expand and provide 7-day working services	**7**	4	3	0
	To develop and implement Community based frail elderly services				
	To improve Integrated Community Response Team (CRT) in North Lincolnshire				
Transformed Outpatient Services	To implement Advice & Guidance opportunities within community	**7**	1	6	0
	To strengthen Shared Care plans and sharing of information				
	To develop digital solutions				
Worked in Partnerships with PCNs	To work with PCN development to a new model of care for community services in North Lincolnshire ***(action reported as complete in Q2, during Q3, action updated to include ongoing continuous work to maximise impact and effectiveness of MDTs and therefore, status reverted to Amber (NB: requires partnership working)***	**1**	1	0	0
Reconfigured Specialities to one site where appropriate	Streamline clinical pathways to ensure consistency, improve patient experience and maximise efficiency	**1**	1	0	0
Restructured Cancer Services	Improved End of Life Care across Northern Lincolnshire and achievement of 'good' CQC rating	**1**	1	0	0
Created a Sustainable Hospital at Goole	To support potential developments of rehabilitation services	**2**	2	0	0

NLG(22)068

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 April 2022	
Director Lead	Lee Bond, Chief Financial Officer	
Contact Officer/Author	Brian Shipley, Deputy Director of Finance Matt Clements, Assistant Director of Finance, Financial Management	
Title of the Report	**Finance Report M11**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights the reported financial position of Month 11 of the 21/22 reporting period.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ✓ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Contained within the report.	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
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: 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: 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.
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.
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1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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.
4.	**To work more collaboratively**
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.
5.	**To provide good leadership**
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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Finance Report Month 11

February – 2021/22

Executive Summary Month 11 2021/22

Northern Lincolnshire and Goole NHS Foundation Trust

The Trust reported a £0.53m surplus for the month of February, which was £0.43m better than plan. The year-to-date position is now a £0.53m surplus, which is £0.42m better than plan.

Income was £2.06m worse than plan in month.

- TIF income was £0.58m above plan, representing a share of non-recurrent ICS income available to support the activity and capacity pressures across the system. ERF income was £0.05m above plan (see paragraph below). Covid outside envelope income was £0.02m below plan due to lower testing costs. Other income was £0.58m above plan due to additional income across several areas including QSM funding support, Path links, Pharmacy Recharges and accommodation income. Donated income, excluded from NHSE&I financial targets, was £3.80m below plan due to continued delays in the Salix Energy scheme.
- Elective Recovery Funding (ERF) – the Trust achieved £0.30m ERF income in month, £0.05m above February's plan. ERF income achievement is subject to volatility and subsequent validation as it is dependent on the overall ICS position.

Pay was £1.88m overspent in month.

- Medical staff was £0.96m overspent primarily due to Flowers cost estimates, Anaesthetic Middle Grade rota delays, additional staff over WTE budget in Orthopaedics, ENT, Urology, Gynaecology and Paediatrics, additional waiting list expenditure in Cellular Pathology, and an estimate for unfunded Middle Grade pay reforms.
- Nursing was £0.81m overspent in month. There were underspends due to Midwifery vacancies, but these were offset by use of escalation and surge beds, transfer team costs, increased staff absence and implementation of Chief Nurse safety recommendations.
- Other Pay variances include unidentified CIP in Family Services and Surgery, and £0.05m Flowers costs, for which the Trust has not been reimbursed (£0.36m year-to-date).

Non Pay was £1.11m underspent in month. This was mostly due to independent sector outsourcing underspends and a CNST rebate, partly offset by some internal ERF and Pathology overspends.

Post EBITDA items were £0.21m underspent in month, primarily on depreciation due to capital programme delays.

COVID-19 Specific Expenditure

- The Trust has incurred £11.96m year-to-date expenditure as a direct consequence of the pandemic, marginally within its covid expenditure funding of £12.72m (£13.37m total covid funding less £0.65m funding for loss of car parking income and loss of other income).

Income & Expenditure to 28th February 2022

Income & Expenditure	Annual Plan to 31st March 2022 £'000	Current Month Plan £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
Clinical Income	349,593	29,629	30,106	477	319,943	324,616	4,673
ERF Income	11,266	251	299	48	11,016	4,834	(6,182)
TIF	5,905	984	1,567	583	4,920	7,837	2,917
Block Top Up	60,160	5,042	5,118	76	55,118	56,019	901
Covid Inside Envelope Block	13,019	1,023	1,022	(1)	11,996	11,990	(6)
Covid Outside the Envelope	1,839	146	124	(22)	1,693	1,376	(317)
Other Income	37,081	2,954	3,533	579	34,107	35,499	1,392
Donated Income	57,684	4,585	785	(3,800)	53,677	8,550	(45,127)
Total Operating Income	**536,547**	**44,614**	**42,555**	**(2,058)**	**492,470**	**450,721**	**(41,749)**
Clinical Pay	(255,013)	(20,942)	(22,627)	(1,685)	(233,350)	(239,932)	(6,582)
Other Pay	(66,075)	(5,914)	(6,109)	(195)	(60,875)	(64,171)	(3,296)
Total Pay	**(321,088)**	**(26,856)**	**(28,735)**	**(1,879)**	**(294,225)**	**(304,103)**	**(9,878)**
Clinical Non Pay	(70,449)	(5,762)	(6,127)	(365)	(64,619)	(63,735)	884
Other Non Pay	(72,928)	(6,564)	(5,093)	1,471	(66,297)	(59,974)	6,322
Total Non Pay	**(143,377)**	**(12,326)**	**(11,220)**	**1,106**	**(130,916)**	**(123,709)**	**7,207**
Operating Expenditure	**(464,465)**	**(39,182)**	**(39,955)**	**(773)**	**(425,141)**	**(427,813)**	**(2,671)**
EBITDA	**72,081**	**5,431**	**2,600**	**(2,831)**	**67,329**	**22,908**	**(44,421)**
Depreciation	(12,538)	(1,213)	(972)	240	(11,310)	(10,181)	1,129
Interest Expenses & Other Costs	(182)	(14)	14	29	(168)	(254)	(87)
Dividend	(5,192)	(334)	(391)	(57)	(4,745)	(4,240)	505
Total Post EBITDA Items	**(17,911)**	**(1,561)**	**(1,349)**	**212**	**(16,222)**	**(14,675)**	**1,547**
Remove Capital Donated I&E Impact	(54,182)	(3,771)	(718)	3,053	(51,000)	(7,850)	43,150
Remove net loss on disposal of DHSC donated equipment	0	0	0	0	0	145	145

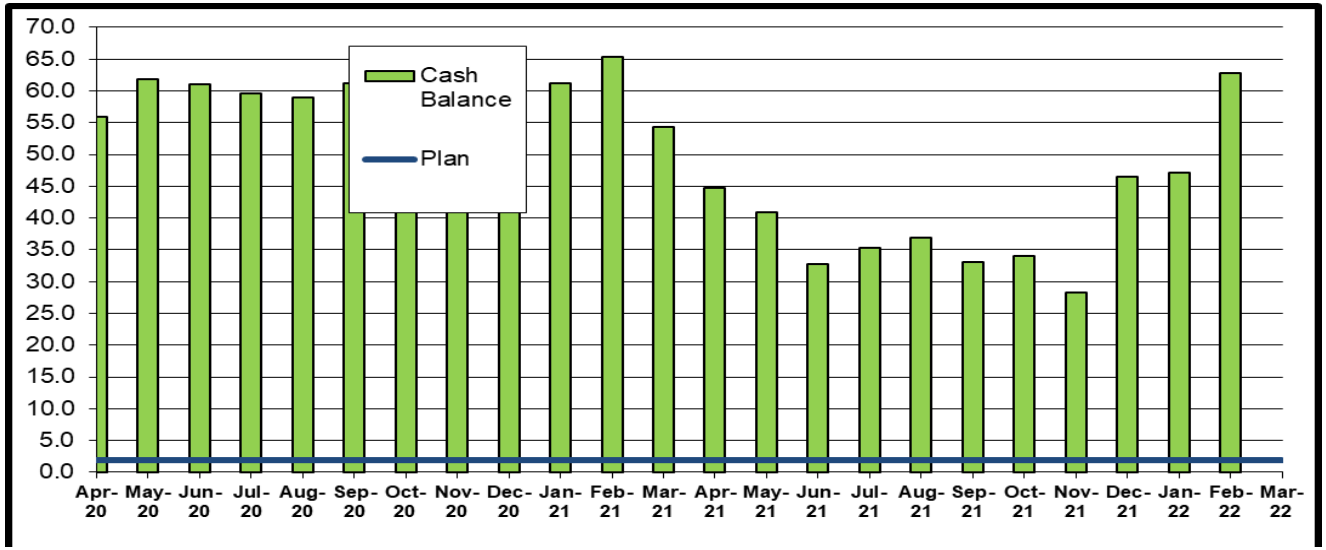
COVID-19 Expenditure

Expenditure Category	Year-to-date 21-22		
	Pay (£k)	Non-pay (£k)	Total (£k)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	2,801	0	2,801
Existing workforce additional shifts to meet increased demand	5,034	0	5,034
Backfill for higher sickness absence	1,938	0	1,938
Total Testing - In Envelope	423	79	502
PPE associated costs	0	7	7
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0	2	2
Remote management of patients	6	0	6
Segregation of patient pathways	0	43	43
Decontamination	0	241	241
Additional PTS costs	0	7	7
After care and support costs (community, mental health, primary care)	0	35	35
Remote working for non-patient activities	0	0	0
Outside Envelope COVID-19 - Vaccination Programme - Provider/ Hospital hubs	161	1	162
Outside Envelope COVID-19 - Deployment of final year student nurses	141	0	141
Outside Envelope COVID-19 - International quarantine costs	0	6	6
Outside Envelope COVID-19 virus testing - rt-PCR virus testing	36	39	75
Outside Envelope COVID-19 virus testing - Rapid / point of care testing - locally procured reagents costs	0	835	835
Outside Envelope COVID-19 virus testing - Rapid / point of care testing (for DHSC provided Samba2, DNA Nudge, Primer Design, LumiraDx and Abbott ID NOW)	69	0	69
Outside Envelope NIHR SIREN testing - antibody testing only	19	0	19
Outside Envelope Antibody Assays	0	36	36
Total Trust Operating Expenditure (including COVID-19 expenditure and all other operating expenditure)	304,103	123,709	427,812

Cash

The cash balance at 28th February was £62.79m, an in-month increase of £15.64m. The increase is cash relates to the draw down of PDC.

	£m	£m
Cash Balance as at 28th February		**62.79**
Commitments:		
Income received in advance	5.12	
Capital creditors	5.36	
Capital loan repayments	0.39	
February PAYE/NI/Pension	11.52	
Public Dividend Capital payment	2.72	
Annual leave income	4.49	
Capital PDC received	4.11	
To support other creditors due	27.18	
		(60.89)
NHSi minimum balance		**1.90**



Balance Sheet as at 28th February 2022

	Last Month	This Month
	£mil	£mil
Total Fixed Assets	216.63	219.02
Stocks & WIP	3.63	3.46
Debtors	15.14	13.37
Prepayments	6.25	4.40
Cash	47.15	62.79
Total Current Assets	72.17	84.02
Creditors : Revenue	40.24	42.80
Creditors : Capital	6.33	5.36
Accruals	15.07	22.63
Deferred Income	5.92	5.12
Finance Lease Obligations	0.00	0.00
Loans < 1 year	1.37	1.39
Provisions	2.77	3.12
Total Current Liabilities	71.70	80.43
Net Current Assets/(Liabilities)	0.46	3.60
Debtors Due > 1 Year	0.89	0.89
Creditors Due > 1 Year	0.00	0.00
Loans > 1 Year	8.21	8.21
Finance Lease Obligations > 1 Year	0.02	0.02
Provisions - Non Current	5.38	5.38
TOTAL ASSETS/(LIABILITIES)	204.36	209.90
TOTAL CAPITAL & RESERVES	204.36	209.90

- Stock has reduced again this month, mainly in Pharmacy.
- Debtors have reduced in month; the Trust has now received the additional TIF funding £3.5m and Salix funding of £1.1m.
- The reduction in prepayments relates to rates and CNST paid over 10 months.
- The Trust cash balance has increased to £62.8m. The Trust has now received £25.6m of PDC for capital schemes.
- Revenue creditors and accruals have increased in month, this relates to accruals, the Trust is waiting for invoices or purchase orders to be goods received. Following the outsourcing of accounts payable the BPPC figures for the Trust stands at 100% for both non- NHS and NHS invoices. This is for the number of invoices paid and the value paid in the month. The increase relates to the invoice date as the date transferred to the accounts payable system. We will continue to monitor the BPPC and are communicating to staff the importance of authorising invoices.

Northern Lincolnshire and Goole NHS Foundation Trust

Name of the Meeting	Trust Board in Public
Date of the Meeting	5th April 2022
Director Lead	Christine Brereton, Director of People
Contact Officer/Author	Karl Portz, Equality, Diversity & Inclusion Lead
Title of the Report	Modern Slavery Statement
Purpose of the Report and Executive Summary (to include recommendations)	The approval of the Anti-Slavery statement is a legal requirement for Northern Lincolnshire and Goole NHS Foundation Trust and must be annually reviewed and published on the Trust's website. Recommendation The Board of Directors are asked to consider and approve the enclosed statement and to continue to support the requirements of the legislation. The CEO and Chair are asked for their signatures to support the approval so that it can be uploaded to the Trust's website.
Background	The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the Act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is obliged to comply with the Act.
Prior Approval Process	☐ TMB ☐ PRIMs ✓ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Component of the Equality, Diversity & Inclusion remit for the Trust that must be renewed annually

Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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MODERN SLAVERY ACT 2015 – STATUTORY STATEMENT

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

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

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

A person commits an offence if:

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

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

Modern Slavery and Human Trafficking Act 2015 Actions Required

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.
The aim of this statement is to demonstrate that the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.
Where possible all members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility lead for overall compliance.
This statement will be published externally on the Trust's internet site and internal on the Hub.

Northern Lincolnshire and Goole NHS FT

Northern Lincolnshire and Goole NHS Foundation Trust provides services across North Lincolnshire, North East Lincolnshire, East Riding of Yorkshire and West and East Lindsey. The Trust's total turnover for 2020/2021 was £477,698,000 (Annual Report). The Trust employs 6,965 permanent and fixed term contract staff.

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

The Trust policies, procedures, governance, and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. We also conform to the NHS employment check standards within our workforce recruitment and selection practices, including through our managed

service provider contract arrangements. This strategic approach incorporates analysis of the Trust's supply chains and its partners to assess risk exposure and management on modern slavery.

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

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

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

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2022.

Chair Person Signature

CEO Signature

Equality Act (2010)

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

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

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

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

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