NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 1 February 2022, via MS Teams
Time – 9.00 am – 11.30 am

For the purpose of transacting the business set out below

		Note / Approve	Time	Ref
1.	**Patients' Story and Reflection** Jo Loughborough, Senior Nurse – Patient Experience	Note	09:00 hrs	Verbal
2.	**Business Items**			
2.1	**Chair's Opening Remarks** Linda Jackson, Vice Chair	Note	09:15 hrs	Verbal
2.2	**Apologies for Absence** Linda Jackson, Vice Chair	Note		Verbal
2.3	**Declarations of Interest** Linda Jackson, Vice Chair	Note		Verbal
2.3.1	**Fit & Proper Persons Annual Declaration** Helen Harris, Director of Corporate Governance	Approve		NLG(22)001 Attached
2.4	**To approve the minutes of the previous Public meeting held on Tuesday, 7 December 2021** Linda Jackson, Vice Chair	Approve		NLG(22)002 Attached
2.5	**Urgent Matters Arising** Linda Jackson, Vice Chair	Note		Verbal
2.6	**Trust Board Action Log - Public** Linda Jackson, Vice Chair	Note		NLG(22)003 Attached
2.7	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note		NLG(22)004 Attached
2.8	**Integrated Performance Report (IPR)**	Note		NLG(22)005 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Executive Report – Quality & Safety** Dr Kate Wood, Medical Director & Ellie Monkhouse, Chief Nurse	Note	09:30 hrs	NLG(22)006 Attached
3.2	**Quality & Safety Committee Highlight Report and Board Challenge** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	Note	09:40 hrs	NLG(22)007 Attached
3.3	**Delivering Midwifery Continuity of Carer at Full Scale** Nicky Foster, Deputy Head of Midwifery	Note	09:45 hrs	NLG(22)008 Attached

3.4	**Executive Report – Operational Performance** Shaun Stacey, Chief Operating Officer	Note	09:50 hrs	NLG(22)010 Attached
3.5	**Executive Report – Digital** Shauna McMahon, Chief Information Officer	Note	10:30 hrs	NLG(22)011 Attached
3.6	**Finance & Performance Committee Highlight Report and Board Challenge – Performance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	10:40 hrs	NLG(22)012 Attached
4.	**Strategic Objective 2 – To Be a Good Employer & Strategic Objective 5 – To Provide Good Leadership**			
4.1	**Executive Report – Workforce & Leadership** Christine Brereton, Director of People	Note	10:45 hrs	NLG(22)013 Attached
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Executive Report – Finance** Lee Bond, Chief Financial Officer	Note	10:55 hrs	NLG(22)014 Attached
5.2	**Finance & Performance Committee Highlight Report & Board Challenge – Finance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:05 hrs	NLG(22)015 Attached
5.3	**Annual Accounts – Delegation of Authority** Lee Bond, Chief Financial Officer	Note	11:10 hrs	NLG(22)016 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Executive Report – Strategic & Transformation** Ivan McConnell, Director of Strategic Development	Note	11:15 hrs	NLG(22)017 Attached
7.	**Governance**			
	None			
8.	**Approval (Other)**			
	None		11.25 hrs	
9.	**Items for Information / To Note (please refer to Appendix A)** Linda Jackson, Vice Chair	Note		
10.	**Any Other Urgent Business** Linda Jackson, Vice Chair	Note		Verbal
11.	**Questions from the Public**	Note		Verbal
12.	**Date and Time of Next meeting** **Board Development** Tuesday, 1 March 2022, Time TBC **Public & Private Meeting** Tuesday, 5 April 2022, Time TBC	Note		Verbal

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

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

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

APPENDIX A

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

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

9.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
9.1	**Finance & Performance Committee Minutes** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(22)018 Attached
	Quality & Safety Committee	
9.2	**Quality & Safety Committee Minutes – November and December 2021** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(22)019 Attached
	Other	
9.3	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(22)020 Attached
9.4	**Documents Signed Under Seal** Helen Harris, Director of Corporate Governance	NLG(22)021 Attached
9.5	**Trust Board Development 2021/22 and 2022/23** Helen Harris, Director of Corporate Governance	NLG(22)025 Attached

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NLG(22)001

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1 February 2022	
Director Lead	Linda Jackson, Vice Chair	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	Fit and Proper Persons Test: Chair's Annual Declaration	
Purpose of the Report and Executive Summary (to include recommendations)	The Trust's Fit and Proper Persons Policy (Section 4.2.1) requires an annual declaration by the Trust Chair at a Board meeting held in public that all those covered by the scope of the policy continue to meet the requirements of the Fit and Proper Persons Test. An audit of the files has evidenced that it is clear that completion of the required checks and the recording of those checks are comprehensive and thorough. An annual review and updating of the Register of Directors' Interests (Appendix A) has also been completed, as per the requirements of the Fit and Proper Person's Policy. The Trust Board is asked to receive the content of this paper and record that the Fit and Proper Persons Test has been conducted for the period 1 February 2021 to 31 January 2022 and all Board members satisfy the requirement.	
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

Fit and Proper Persons Requirements: Chair's Annual Declaration

1. Purpose

1.1. The purpose of this paper is to provide annual assurance that all Board directors remain fit and proper for their roles.

2. Background

2.1. As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the introduction of regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test'.

2.2. The Trust's Fit and Proper Persons Policy specifies the scope of the staff who are included as: "Section 3. Individual Executive Directors, Non-Executive Directors, the Trust Secretary and the Associate Director of Communications are responsible for ensuring compliance with the Fit & Proper Persons Test and this policy and for declaring where they may no longer meet these requirements."

2.3. The Policy requires a full Fit and Proper Person Test to be completed on appointment. It also requires ongoing assurance as follows: "Section 4.2. The fitness of directors will be reviewed on an annual basis so that the Chair is assured that all directors remain fit and proper for their roles. An annual appraisal process will also be carried out. Relevant directors and employees will be required to complete and sign an annual self-declaration which will be retained on their personal file."

2.4. The Director of Corporate Governance is responsible for initiating audit or review of the compliance on behalf of the Trust Chair and for an annual assurance report to be submitted to the Board.

3. Fit and Proper Person: On Recruitment and Annual Assessment of Continued Compliance

3.1. All new appointments are subject to a full Fit and Proper Persons Test that includes:

- Determination and evidence of employment history and specific qualifications/requirements set out within the job description and person specification and contained within an application form and/or CV and tested during a competency based interview (evidence of the latter may be provided in an interview pack or itinerary (which may include details of a presentation or the actual presentation) and/or interview notes)1
- Receipt of references
- Identity checks e.g. passport/birth certificate/driving licence
- Qualification checks
- Professional body registration checks, if applicable
- Occupational health checks

- Right to work checks e.g. passport/birth certificate/EU Visa/Non-EU Tier 2 Visa
- Disclosure and Barring Service (DBS) checks
- Fit & Proper Person Checks (in addition to the above listed standard employment checks):
  - Insolvency and bankruptcy register checks
  - Disqualified directors' register checks
  - Disqualified charity trustee checks
  - Web based or reasonable search of the individual using key words such as 'NHS', 'Criminal', 'Fraud', 'Dismissed', 'Investigation', 'Disqualified'

3.2. The annual assurance check consists of the following:

- The completion of an annual self-declaration of ongoing compliance with the Fit & Proper Persons Test
- Annual review and updating of the Register of Directors' Interests. (The Trust Board will undertake a formal annual review of the register. This is supplemented by the requirement at every Board meeting for confirmation of any new declarations to the Directors' register of interests and declarations of interest in any of the agenda items)
- Declarations of gifts and hospitality
- Declarations of secondary/outside employment
- Annual re-checks of the Fit & Proper Persons and other appropriate checks undertaken on recruitment; specifically DBS, professional body registration checks, if applicable, insolvency and bankruptcy register checks, disqualified directors' register checks and disqualified charity trustee checks
- Annual appraisal and the agreement of objectives and, where required, the agreement of personal development plans and/or any managerial supervision
- The management of any performance management or disciplinary issues
- Monitoring of sickness absence
- Monitoring of mandatory training compliance and evidence of any continuing professional development
- An annual declaration by the Trust Chair at a Board meeting held in public that all those covered by the scope of this policy continue to meet the requirements of the Fit & Proper Persons Test
- Confirmation that Directors remain on the relevant professional register

4. Outcome of the Annual Fit and Proper Persons Checks

4.1. The completed declarations and the outcome of the searches have been saved on each personal file and will be refreshed in July (declarations) and August 2022 (searches and DBS), in line with the annual process.

4.2. Each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attention of the Director of People or the Trust Chair.

4.4 A full audit (100%) of files of the relevant individuals against the Trust's Fit & Proper Persons Policy was undertaken by the Personal Assistant to the Chief

Executive on 7 April, 27-28 May, 16 June, 6 July, 29 July, 29 September, 25 October, 23 November, 10 December 2021 and 14 January 2022. A sample test of five files was undertaken on 12 August 2021, by the Director of Corporate Governance and Personal Assistant to the Chief Executive; to review specifically the Fit and Proper Persons checks required on recruitment and those required on an ongoing basis, to ensure capture of the required information and assurances.

The audit and sample testing identified that completion of the required checks and the recording of those checks are comprehensive and thorough.

5. Recommendations

5.1 The Trust Board is asked to:

a) receive and record that the Fit and Proper Persons Test has been conducted for the period 1 February 2021 to 31 January 2022 and all Board members satisfy the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

b) receive and note the Directors Register of Interest (Appendix A).

Linda Jackson
Vice Chair
February 2022

REGISTER OF DIRECTORS' INTERESTS
Updated as at January 2022 (v2.1)

NAME & POSITION	INTERESTS	DATE
Linda Jackson, Acting Chair & Non-Executive Director	➢ Associate NED at Hull University Teaching Hospitals NHS Trust ➢ Both Sister and Sister-in-law works at DPoW (in Women's and Children division)	06.10.2021
Dr Peter Reading, Chief Executive	➢ Spouse of Dr Catherine Reading, Director, Catherine Reading Limited ➢ Company Secretary of spouses company, Catherine Reading Limited ➢ Co-Chair Disabled NHS Directors Network	31.01.2022
Lee Bond, Chief Financial Officer	➢ Chief Finance Officer and Deputy Chief Executive Officer at Hull University Teaching Hospitals ➢ Trustee of WISHH Charity ➢ Vice President, Healthcare Financial Management Association (HFMA)	01.12.2021
Ellie Monkhouse, Chief Nurse	➢ Husband is foot and ankle Consultant Orthopedic Surgeon at Leeds Teaching Hospitals ➢ Husband is a Yorkshire and Humber Regional Consultants and Specialists Committee Member	14.05.2021
Shaun Stacey, Chief Operating Officer	➢ None	06.10.2021
Dr Kate Wood, Medical Director	➢ Husband is Trust employee (Theatre Manager, DPoWH)	18.08.2021
Christine Brereton, Director of People (non-voting director)	➢ Partner is currently working in the Humber Coast and Vale as the Integrated Care System Finance Lead and working with the Trust's Chief Financial Officer	07.10.2021
Helen Harris, Director of Corporate Governance	➢ Member of Patient Participation Group, central Surgery, Barton-upon-Humber (NLCCG)	11.10.2021
Jug Johal, Director of Estates & Facilities (non-voting director)	➢ Chairman, Asian Sports Foundation	06.10.2021
Ivan McConnell, Director Of Strategic Development (non-voting director)	➢ None	11.10.2021
Shauna McMahon, Chief Information Officer	➢ I am on an Exam Writing group to add UK content to the Certified Health CIO credential.	08.10.2021
Stuart Hall, Associate Non-Executive Director	➢ Non –Executive/Vice Chair, Hull University Teaching Hospitals NHS Trust	06.10.2021

NAME & POSITION	INTERESTS	DATE
Fiona Osborne, Non-Executive Director	➢ Parish Councilor for Leverton Parish Council, Lincolnshire	10.09.2021
Simon Parkes, Non-Executive Director	➢ Director of Lincoln Science and Innovation Park (Unremunerated) ➢ Lay Cannon/ Chair of Finance Committee – Lincoln Cathedral ➢ Senior Independent Director, Lincolnshire Housing Partnership ➢ Deputy Vice Chancellor and CFO – University of Lincoln	31.01.2022
Gillian Ponder, Senior Independent Director, Interim Deputy Chair and Non-Executive Director	➢ Employed by Openreach Ltd in role responsible for large scale recruitment, supply chain and logistics	07.10.2021
Michael Proctor, Non-Executive Director	➢ Non-Executive Chair of Conclusio (Health Care Consultancy).	25.08.2021
Maneesh Singh, Associate Non-Executive Director	➢ Currently CEO of Biotechology company BioCross UK Ltd	28.10.2021
Michael Whitworth, Non-Executive Director	➢ Interim Chief Executive Officer of Barnet Federated GPs (part-time) ➢ Owner/Director of Michael Whitworth Consultancy Ltd	18.08.2021
Ade Beddow, Associate Director of Communications	➢ None	20.10.2021

REGISTER OF DIRECTORS' INTERESTS
Updated as at January 2022 (v1)

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

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

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
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
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 the guidance only applied to the mortuary's at SGH and DPOWH as the Goole District Hospital (GDH) site was not licenced premises as it was a temporary body store. New guidance had been received by the Human Tissue Authority (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 of work 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 has been 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 Care Quality Commission (CQC) 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 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 Jenny Hinchliffe 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 as particular times.

Linda Jackson clarified that the establishment review would go through the business planning process and would be referred back through the Finance & Performance Committee (F&PC) and Q&SC. 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.

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

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 Prevention, Preparedness and Resilience (EPPR) 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 agreed 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)003

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2021/2022

Kindness · Courage · Respect

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Public Meeting
2021/22

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
3.8	05/10/2021	Safeguarding - Changes to Deprivation of Liberty Safeguards authorisation		It was agreed a board development session would be held to look at Safeguarding changes.	Helen Harris	2022	The session has been added to the 2022/23 programme to be approved.		Programme of Development includes this session.	
4.1	05/10/2021	Executive Report - Workforce - Support in respect of Mandatory training to divisional teams		Support to be offered to the divisional teams in presenting current ratings for mandatory training in reports, specifically for the CQC.	Christine Brereton	Dec-21	Further update to be provided at the December 2021 meeting.		Minutes from the meeting held on 7 December 2021 item 2.6 provide an update	
5.5	05/10/2021	Business Planning / CIP Timetable H2		Trust Board to receive the H2 plan due to the requirement to exit financial special measures. Trust Board advised this would be available in November.	Lee Bond	Dec-21	Further update to be provided at the December 2021 meeting.		Minutes from the meeting held on 7 December 2021 item 5.1 provide an update	
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.			
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.			
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.			
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.			

Key:

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

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Public Meeting

2021/22

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
11	03/08/2021	Any Other Urgent Business - Sub-Committee Terms of Reference		Sub-Committees to follow the same process in respect of Terms of Reference.	Helen Harris	Oct-21	At the October 2021 meeting the Terms of Reference were submitted for approval. Approval was agreed with agreement they would again be shared at the November meeting. The Terms of Reference were shared and approved at the November 2021 meeting.		Board Papers	Papers are held on NLAG Hub

Key:

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

NLG(22)004

Name of the Meeting	**Trust Board - Public**	
Date of the Meeting	1st February 2022	
Director Lead	Peter Reading, Chief Executive	
Contact Officer/Author	Peter Reading, Chief Executive	
Title of the Report	**Chief Executive's Briefing**	
	To brief the Board on any major issues of interest which are not covered elsewhere on the agenda: • Development of Humber Coast and Vale Integrated Care System; • Key areas of Executive Team focus; • CQC inspection and Financial Special Measures.	
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.
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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

Chief Executive's Briefing

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

   The implementation of Integrated Care Systems across England has been postponed by three months to 1July 2022 (subject to legislation), but recruitment to key posts on the Humber Coast and Vale (HCV) Integrated Care Board and development of the architecture of the ICS continues. NLaG is represented at executive director level in the HCV Partnership Board, the Humber Partnership Board, two Collaboratives (Acute and Community) and three Place Partnership Boards (East Riding of Yorkshire, North Lincolnshire and North East Lincolnshire). The first two of these Place Partnerships and the Collaboration of Acute Providers have all held development sessions in recent weeks, as they shape their governance and priorities. NLaG signed the Partnership Agreement with the North East Lincolnshire Place Partnership in December 2021.

2. Key areas of ExecutiveTeam focus

   Key areas of focus in December and January were:

   - Pandemic response;
   - Urgent and emergency care, and patient flow;
   - Elective recovery;
   - Staffing (including managing high levels of absence due to Covid, and supporting staff wellbeing);
   - Planning for and implementing Vaccination as a Condition of Deployment (VCOD);
   - Continuation implementation of the Trust's extensive investment programme in estates, equipment and infrastructure, and digital.

Each of these areas is picked up in executive director reports later on this Board agenda.

3. CQC inspection and Financial Special Measures

   The CQC announced before Christmas that it was delaying hospital inspections until after the latest (Omicron) wave of the pandemic. No announcement has yet been made of when they will resume inspections, but this has delayed NLaG's inspection, which had been anticipated before Christmas.

   NLaG had been advised to expect that a decision would be made at national level in January 2022 whether to lift the Trust out of the Financial Special Measures (FSM) part of Level 4 of the Recovery Support Programme, but shortly before Christmas, NHS England advised the Trust that because the unusual financial and planning circumstances of the NHS in 2021-22 due to the pandemic, the financial and planning context would not allow NHS England to gauge properly whether or not NLaG was meeting all the conditions previously laid down for it to exit FSM, and consequently, it would remain in FSM for several months longer.

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	Tuesday 01 February 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 (December Data) Quality and Safety – IPR (November Data) Workforce – IPR (December 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.

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Access and Flow
Objective: To give great care
Planned Care Referral to treatment (RTT) has started to see a decreasing number of patients waiting and a decreasing number of RTT 52 week pathways. This decrease in the number of pathways is as a direct result of the continued elective activity throughout the pandemic. Significant progress has been made in creating additional capacity which includes both the use of Goole District Hospital and the Independent sector where the initial focus is on the treatment of urgent and cancer patients. Diagnostic services has seen an improvement in performance, a new outsourced non-obstetric ultrasound service went live in November 2021 and is planned to continue the improvement in performance. Cancer Cancer two week wait (2ww) standard continues to be achieved however 2ww Breast Symptomatic failed to meet the target for the 4th month in a row. There have been some pressures in achieving the 31 day first treatment but this was acheived within December. Urgent Care/Flow The Emergency Departments (ED) is facing pressure in moving patients through the system as well as challenges with the workforce in terms of number and skill mix across the Trust which has impacted upon delivery of the patient flow, Emergency Department waits and ambulance handover delay target. Ambulance handovers continues to be a challenge with a high number of pateints waiting over 60 mins. A new Urgent Care Service (UCS) model has gone live in SGH with a phased approach from 18th October 2021 to provide a streamlined patient pathway for accessing urgent and emergency care. The new pathway has two dedicated services, the UCS combining the traditional minors and UTC cohort of patients, and the ED with retains the majors and resus patients. All walk-in patients have an immediate initial assessment by a senior practitioner before booking into the most suitable service for their presentation. The UCS has shown a reduced wait and a reduction in unnecessary waits with patients streamed effectively to appropriate areas, a reduction in unnecessary triage and investigations, and an improved patient experience. Family Services are currently working with the Medicine Division to ensure that the relevant pathways for gynaecology and breast patients are in place. An equivalent UCS model has gone live in Grimsby on 18th January 2022. The Department has recently implemented a new East Midlands ambulance service (EMAS) direct streaming to same day emergency care (SDEC) service and hot clinics at both sites as well as Stroke Assessment on the SGH site. The trust is an early adopter in the region and went live with direct bookable arrival slots in ED at Grimsby for the single point of access (SPA) as part of the "NHS111 First" initiative programme to try and increase performance. In support of this, The Trust's Single Point of Access (SPA) within Community Services is also working with EMAS to enable the transfer of Category 3 and 5 calls from EMAS into the SPA which will reduce both pressures within EMAS and also the number of unnecessary conveyances to hospital. Work is also underway to progress implementation of the Urgent Community Response 2 Hour Pathway, with implementation by 31 March 2022 on track. All wards now have senior consultant presence at board rounds before 10am to aid discharge and are able to report if and when a patient no longer meets the criteria to reside in an acute hospital bed, by completing webV. Our LOS in non elective remains below the national figure. Outpatients Attend Anywhere implemented within the trust at the start of COVID-19 for ease of virtual consultations. The Outpatients department are continuing to push PIFU for appropriate patients and continue with other programmes such as CHN. The Outpatient Follow Up Overdue Number continues above target with the non face to face attendance rate dropping as consultants reach the point of having to put hands on patients after multiple virtual contacts. COVID-19 The Trust is already being challenged by the increasing number of COVID-19 poisitve patients with a relatively even split between Scunthorpe Hospital (SGH) and Grimsby Hospital (DPoW). The staff absences (particularly medics and nursing due to sickness and self-isolation) yet again has created a serious challenge which is being managed by the teams as proactively as possible.

Quality and Safety
Objective: To give great care
Mortality: The Hospital Standardised Mortality Ratio (HSMR) is within the as expected threshold and remains under 100. The official SHMI for the Trust has reduced significantly since July 2019 and whilst it continues to be above the national average (100) it remains within the 'as expected' range with a score of 108.98. For the second month DPOW have a 'higher than expected' SHMI rate whilst SGH remains within the 'as expected' bracket. The out of hospital SHMI shows significant disparity of 34 points (DPOW: 48 / SGH: 20) and whilst improvement has been observed, greater progress is seen in the North Lincolnshire out of hospital indicator over the last 5 months with a 'step change' observed. Work is underway in collaboration with NHSEI and the CCGs to investigate the site disparity and identify key learning or themes attributing to inappropriate hospital admissions, VTE Risk Assessments: Compliance continues below the 95% target. However it has been identified that the denominator to calculate compliance has been incorrect due to a number of clinical areas being inaccurately included. This has been escalated through the EPMA and Information teams, the inclusion criteria has been reviewed and is in the process of being amended. This intervention is expected to be reflected in next months' figures, anticipating improvement to approximately 90% (based on manual calculations). The risk previously identified surrounding completing risk assessment for stranded patients in ED has now been resolved. Sepsis: Audit results continue to identify a failure to meet the required standards regarding SEPSIS SIX screening and commencing the pathway within the recommended timescales. The WEB V dashboard is up and running to provide ward based SEPSIS compliance rates, this allows the Sepsis Nurse Specialist and Clinical Nurse Educators to provide intensive support to wards continually failing to meet the standards. The deteriorating patient policy has been refreshed to mirror current NICE guidance to guide appropriate escalation. The Deteriorating Patients and Sepsis Group have oversight and review all reported incidents relating to the deteriorating patient and sepsis. Weighing and prescribing: Clinical Audit results continue to demonstrate limited assurance against the standards. This represents a greater risk to patients close to 50kg who are being prescribed paracetamol whose weight is being estimated. Where risk is identified, individual case note reviews are being undertaken for all patients identified as being close to 50kg with feedback on prescribing practice in cases that may represent risk. To raise awareness of the necessity in documenting an actual weight an aide memoire/alert has been added to EPMA.

Workforce
Objective: To give great care
Trustwide Vacancies Recruitment activity has increased significantly across the business as usual activity and various projects , sourcing candidates locally, nationally, and internationally. This is taking the form of regular advertising and sourcing through the Talent Acquisition Team. Registered Nurse Vacancies NQN recruitment has resulted in 61 starts October 2021 to December 2021, with a further 8 due to start in March. International nurse recruitment is overseen by a project group led by the Chief Nurses Office. Regular recruitment activity is underway sourcing candidates from overseas via the internal Talent Acquisition Team. Candidates have started in December, with further scheduled for January and February, and interviews ongoing. A funding bid to support further recruitment has been successful, with £360,000 awarded to support starting? 120 nurses from overseas by December 2022. Medical Vacancies A pipeline of 30 doctors due to start in the next 3 months has been established, with 13 of those confirmed to start in January. A further 8 doctors are in the pipeline with expected longer term starts. Recruitment activity is ongoing to recruit to vacant medical posts. Unregistered Nurse Vacancies A project group led by the Chief Nurse's Office oversees the unregistered nursing workstream. The current pool of HCAs is 12.91 WTE starting in January and a further 5.57 WTE for February. Further applications have been received to be interviewed, with a rolling advert in place for further applications. A bid has been submitted for further funding to support recruitment and enhanced induction of this staff group. Turnover The latest turnover data point (10.95%) 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%. Deep dive of leavers data in Januaray 2022 to identify hotspot areas with focused interventions. Sickness Continued close monitoring of sickness levels with increased operational reporting - volume, trends & themes. Targeted preventative intervention in known high pressure areas. Greater levels of health and wellbeing resource via PEO??. 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. PADR The non medical PADR compliance position currently stands at 83% this is below the Trust target of 85% . Medical Staff PADR compliance currently stands at 78% as of December 2021 this below the Trust target of 85% The combined appraisal complaince currently stands at 82% as of December 2021. Mandatory Training The Core Mandatory Training position currently stands at 93%. This continues to be above the Trust target of 90%., Performance has exceeded the target since Feb The Role Specific Mandatory Training position currently stands at 80% (December 2021). This is continues to be in line with the Trust target of 80%

Access and Flow
Objective: To give great care

Areas of improvement

- Steady decrease in the total inpatient waiting list size
- Cancer – request to test in 14 days, although performance has improved in recent months it is still falling short of the target.
- Ongoing decrease in the number of emergency department attendees
- Improvement in the percentage of patients discharged on the same day as admission (excluding daycases) which is now registering as consistently passing target.
- Improvement in inpatient non elective average length of stay

Areas of concern

- An increase in the percentage of COVID staff absences (weekly)

Areas with ongoing poor performance

- Number of incomplete RTT pathways
- Emergency department waiting times
- Ambulance handover delays –number 60+ minutes
- Decision to admit – number of 12 hour waits
- Number of medical ward outliers (sum of all ward admissions and transfers)
- % inpatient discharges before 12:00 (golden discharges)
- Bed occupancy rate (G&A)
- Outpatient overdue follow up (non RTT)
- Outpatient did not attend (DNA) rate
- % outpatient non face to face attendances
- % outpatient summary letters with GPs within 7 days

Quality and Safety
Objective: To give great care

Areas of improvement

- Reduction of Falls on inpatient wards.

Areas of concern

- Out of hospital SHMI
- Emergency Caesarean Section Rate
- Percentage of Patients Re-admitted within 30 days
- VTE Risk Assessment Rate
- Care hours per patient day

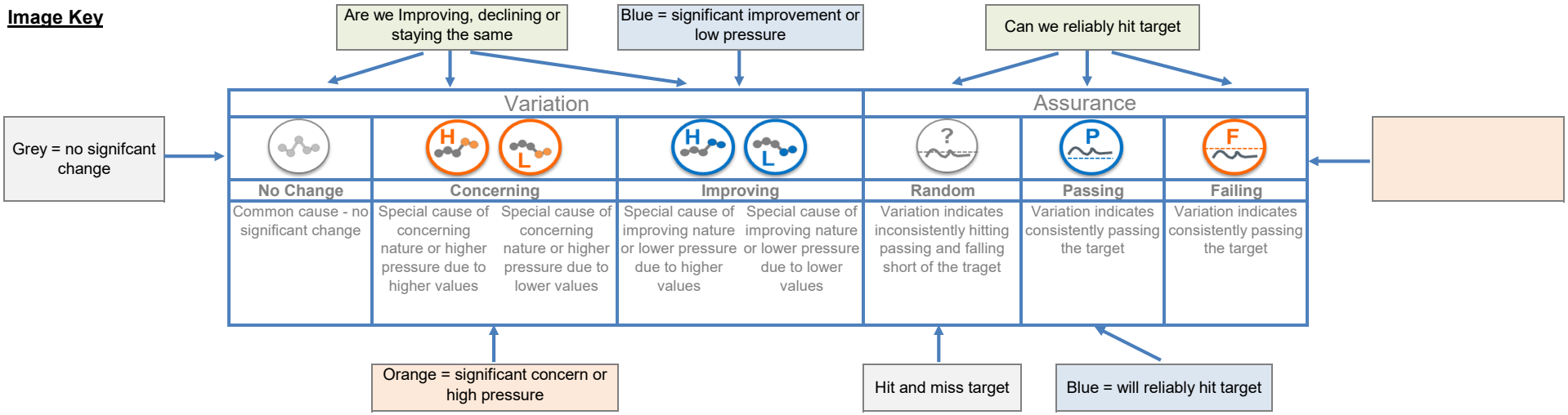
Areas with ongoing poor performance

It is suggested that the board discuss these areas and agree actions to be taken to improve performance

- Care hours per patient day
- VTE Risk Assessment rate
- Emergency Caesarean Section Rate

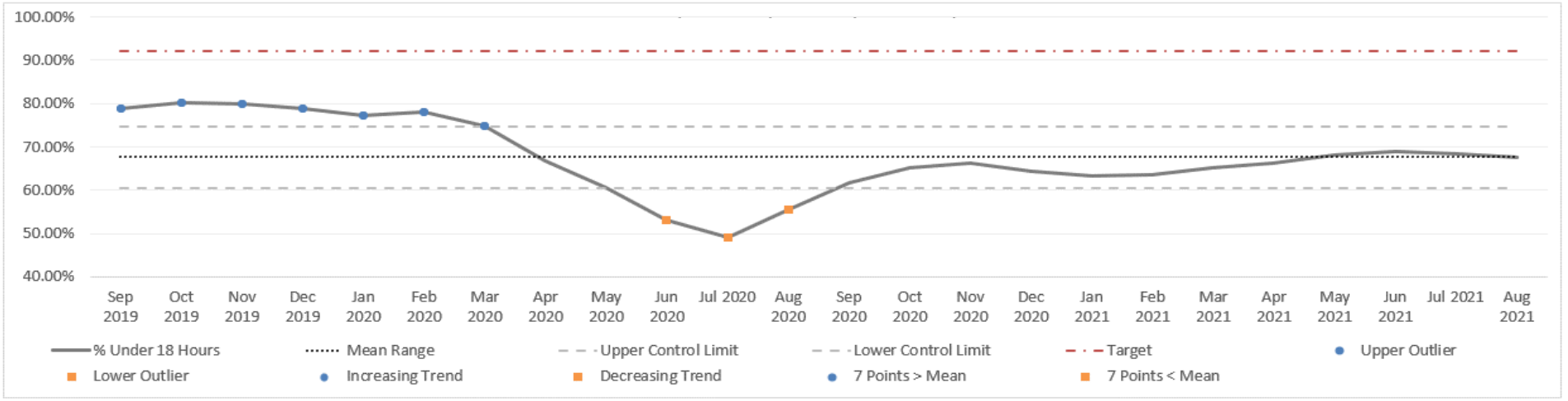
Workforce
Objective: To give great care
Areas of improvement • Registered nursing vacancy rate. • Combined AfC and medical staff PADR. • Core mandatory training compliance rate. **Areas of concern** • Turnover rate • Unregistered nursing vacancy rate. **Areas with ongoing poor performance** It is suggested that the board discuss these areas and agree actions to be taken to improve performance • Trustwide vacancy rate. • PADR Rate • Medical Staff PADR Rate

Image Key



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

SPC Key - example SPC chart

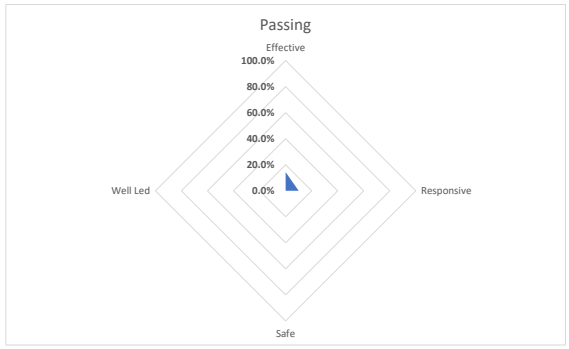


Orange Squares = significant concern or high pressure / change required to hit target

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

Consistently Passing

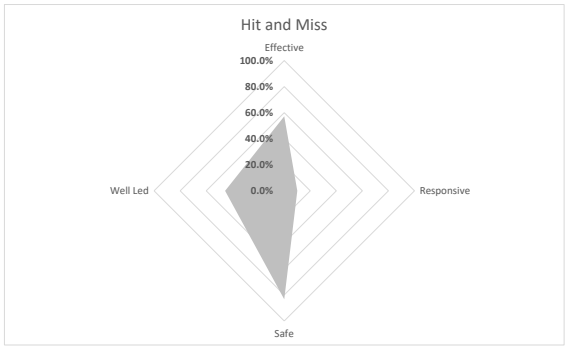
Total: 2



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

Hit and Miss

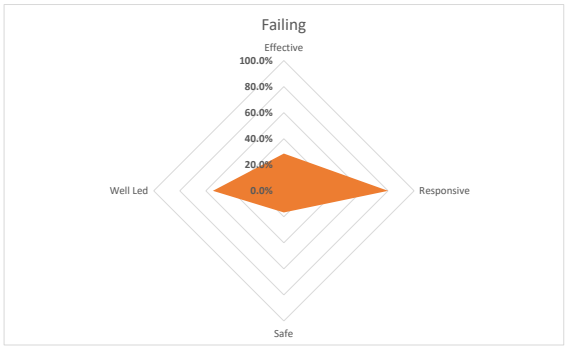
Total: 15



% 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
Inpatient Elective Averge Length Of Stay
Inpatient Non Elective Averge Length Of Stay
Medical Vacancy Rate*
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
Registered Nurse Vacancy Rate*
Role Specific Mandatory Training Compliance Rate
Turnover 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 - 62 Day GP Referral*
Combined AfC and Medical Staff PADR Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)
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*
Sickness
Trustwide Vacancy Rate*
Unregistered Nurse Vacancy Rate*
Venous Thromboembolism (VTE) Risk Assessment Rate

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

Scorecard - Access and Flow

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

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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Planned	% Under 18 Weeks Incomplete RTT Pathways*	Dec 2021	67.3%	92.0%	Action Required	H	F
	Number of Incomplete RTT pathways 52 weeks*	Dec 2021	384	0	Action Required		F
	Total Inpatient Waiting List Size	Dec 2021	10,190	11,563		L	P
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Dec 2021	31.0%	1.0%	Action Required	L	F
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Dec 2021	62.2%	85.0%	Action Required		F
	Cancer Waiting Times - 104+ Days Backlog*	Dec 2021	34	0		n/a	n/a
	Cancer - Patients With Confirmed Diagnosis Transferred By Day 38*	Dec 2021	28.6%	75.0%	Action Required		F
	Cancer - Request To Test In 14 Days*	Dec 2021	86.7%	100.0%	Action Required	H	F
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Dec 2021	59.0%	95.0%	Action Required	L	F
	Number Of Emergency Department Attendances	Dec 2021	11,061	No target		L	No target
	Ambulance Handover Delays - Number 60+ Minutes	Dec 2021	600	0	Action Required	H	F
	Decision to Admit - Number of 12 Hour Waits	Dec 2021	165	0	Action Required	H	?
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Dec 2021	35.4%	92.0%			P
	Patients with an Extended Stay of 21+ Days (Month End Snapshot)	Dec 2021	53	No target			No target
	Inpatient Elective Average Length Of Stay	Dec 2021	2.2	2.4			?
	Inpatient Non Elective Average Length Of Stay	Dec 2021	3.9	4.1		L	?
	Number of Ward Medical Outliers (Sum of all Ward Admissions and Transfers)	Dec 2021	2,741	No target	Action Required	H	No target
	% Discharge Letters Completed Within 24 Hours of Discharge	Dec 2021	87.0%	85.0%			?
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Dec 2021	16.4%	30.0%	Action Required		F
	Bed Occupancy Rate (G&A)	Dec 2021	86.2%	92.0%			?
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Dec 2021	30,120	9,000	Action Required		F
	Outpatient Did Not Attend (DNA) Rate	Dec 2021	10.6%	No target	Action Required	H	No target
	% Outpatient Non Face To Face Attendances	Dec 2021	30.4%	No target	Action Required	L	No target
COVID	Number of COVID patients in ICU beds (Weekly)	Dec 2021	4	No target			No target
	Number of COVID patients in other beds (Weekly)	Dec 2021	31	No target			No target
	% COVID staff absences (Weekly)	Dec 2021	41.4%	No target	Action Required	H	No target

Scorecard - Quality and Safety

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

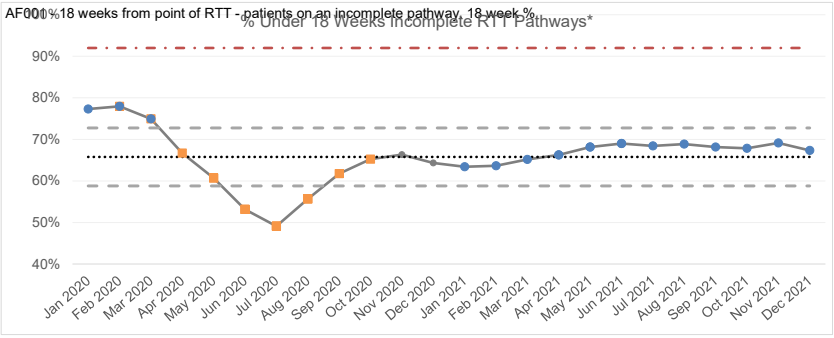
Infection Control	Number of MRSA Infections	Nov 2021	0	0			
	Number of E Coli Infections	Nov 2021	3	9			
	Number of Trust Attributed C-Difficile Infections	Nov 2021	1	3			
	Number of MSSA Infections	Nov 2021	4	0			
	Number of Gram Negative Infections	Nov 2021	6	12			
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Oct 2021	102.8	As expected			As expected
	Summary Hospital level Mortality Indicator (SHMI)	Jul 2021	109.0	109.0			As expected
Safe Care	Patient Safety Alerts actioned by specified deadlines	Nov 2021	100%	100%	**Action Required**		n/a
	Number of Serious Incidents raised in month	Nov 2021	8	No target			n/a
	Occurrence of 'Never Events' (Number)	Nov 2021	0	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)	Nov 2021	5.0	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate per 1000 bed days)	Nov 2021	4.1	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Nov 2021	75.7%	95.0%	**Action Required**		
	Care Hours Per Patient Day (CHPPD)	Nov 2021	8.1	No target	**Action Required**		n/a
	Mixed Sex Accommodation Breaches	Nov 2021	0	0		n/a	n/a
Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Nov 2021	8.0	No target			n/a
	Friends and Family Test (FFT)						
	Percentage of Positive Inpatient Scores	Oct 2021	92.9%	No target		n/a	n/a
	Percentage of Positive A&E Scores	Oct 2021	58.7%	No target		n/a	n/a
	Percentage of Positive Community Scores	Aug 2021	90.9%	No target		n/a	n/a
	Number of Positive Maternity Antenatal Scores	Oct 2021	0 out of 2	No target		n/a	n/a
	Number of Positive Maternity Birth Scores	Oct 2021	86 out of 86	No target		n/a	n/a
	Number of Positive Maternity Post-Natal Scores	Oct 2021	2 out of 2	No target		n/a	n/a
	Number of Positive Maternity Ward Scores	Oct 2021	80 out of 92	No target		n/a	n/a

Scorecard - Workforce

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

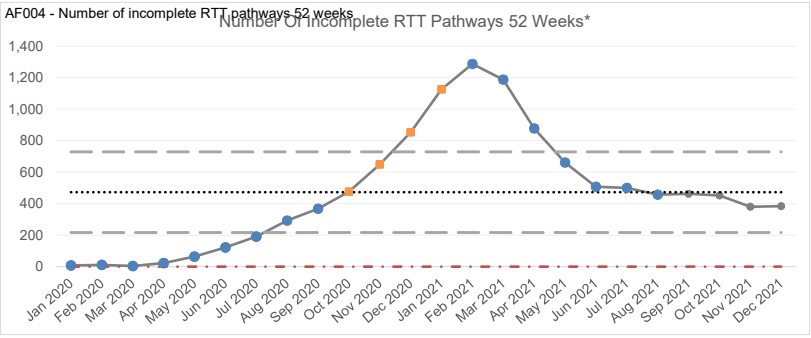
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate*	Dec 2021	10.8%	2.0%	Action Required		F
	Registered Nurse Vacancy Rate*	Dec 2021	7.1%	8.0%	Action Required	L	?
	Medical Vacancy Rate*	Dec 2021	13.8%	15.0%			?
	Trustwide Vacancy Rate*	Dec 2021	9.4%	7.0%	Action Required	H	F
Staffing Levels	Turnover Rate	Dec 2021	11.0%	9.4%	Action Required	H	?
	Sickness Rate	Nov 2021	6.2%	4.1%	Action Required		F
Staff Development	PADR Rate	Dec 2021	83.0%	85.0%	Action Required		F
	Medical Staff PADR Rate	Dec 2021	78.0%	85.0%	Action Required	L	F
	Combined AfC and Medical Staff PADR Rate	Dec 2021	82.0%	85.0%	Action Required	H	F
	Core Mandatory Training Compliance Rate	Dec 2021	93.0%	90.0%		H	?
	Role Specific Mandatory Training Compliance Rate	Dec 2021	80.0%	80.0%			?

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



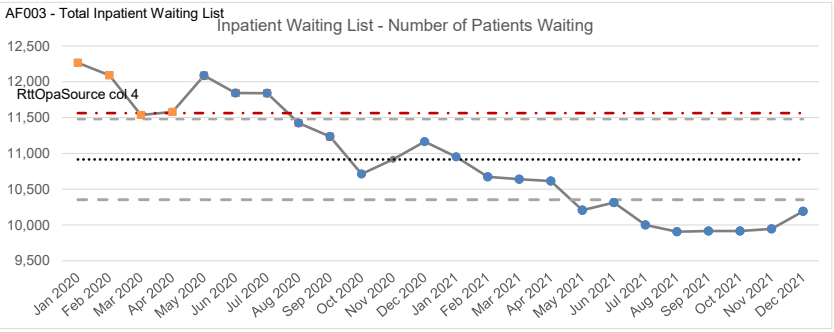
Dec 2021	Target	Variance	Assurance
67.3%	92.0%	Special cause of improving nature or lower pressure due to higher values	Variation indicates consistently falling short of the target

AF004 - Number of incomplete RTT pathways 52 weeks



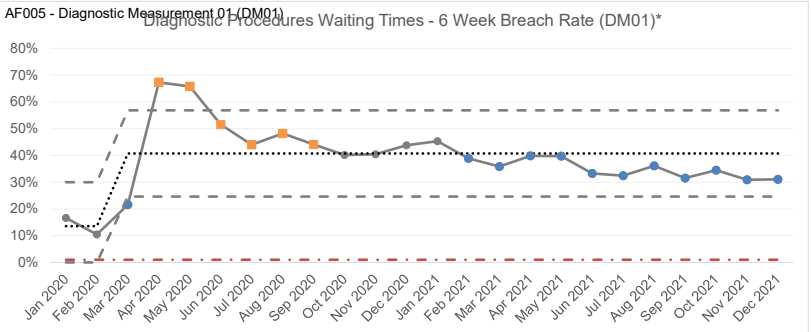
Dec 2021	Target	Variance	Assurance
384	0	Common cause - no significant change	Variation indicates consistently falling short of the target

AF003 - Total Inpatient Waiting List



Dec 2021	Target	Variance	Assurance
10,190	11,563	Special cause of improving nature or lower pressure due to lower values	Variation indicates consistently passing the target

AF005 - Diagnostic Measurement 01 (DM01)



Dec 2021	Target	Variance	Assurance
31.0%	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, however this is at a level lower than seen pre-pandemic. This process is showing special cause variation of an improving nature. However, it is not capable of meeting the target without process redesign.

Incomplete 52 weeks*: The number of 52 week waits has decreased over recent months and shows early signs of stabilising following the spike in waiters caused by the pandemic. The number of waiters is significantly higher than numbers seen pre-pandemic. 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. 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 last year. Latest performance is 31% compared to the target of 1%. Process redesign is required in order to meet the target.

Challenges:

• Medicine division performance has decreased slightly when compared to previous month. The division has 4/11 specialties above 92% threshold.
• 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.

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%.
• Anaesthetic pre-assessment
• Non-Obstetric Ultrasound is a low performing area.
• Consultant Radiologists: high vacancy rate

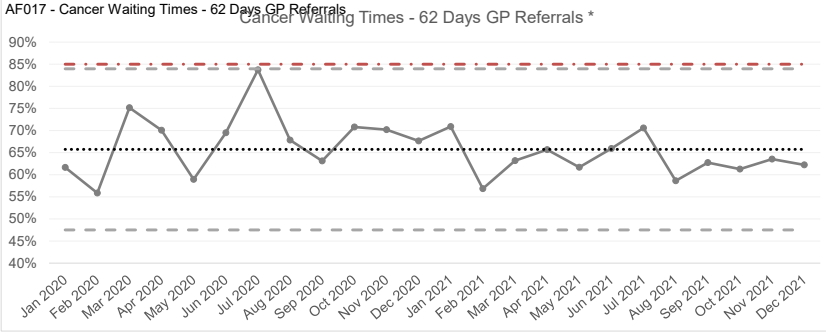
Actions:

• 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. Independant providers being utilised for ENT, Ophthalmology, Orthopaedics and General Surgery. December H2 delivery 97.6% achieved.
• External Providers sourced for Gastroenterology, Respiratory, Cardiology, Endocrinology and Rheumatology. Additional sessions being delivered by internal consultants also.
• Note review of all Anaesthetic pre-assessment patients- working well to reduce the wait for assessment of pts on waiting list.
• Band 3 pre-communication staff member to ensure the patients planned for surgery are contacted 10/7/5/3 days pre-op to reduce on the day cancelations has commenced early January and commenced the contact points
• Extra capacity has been sourced for Non Obstetric Ultrasound and the DM01 is expected to improved from November 2021 onwards.
• 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:

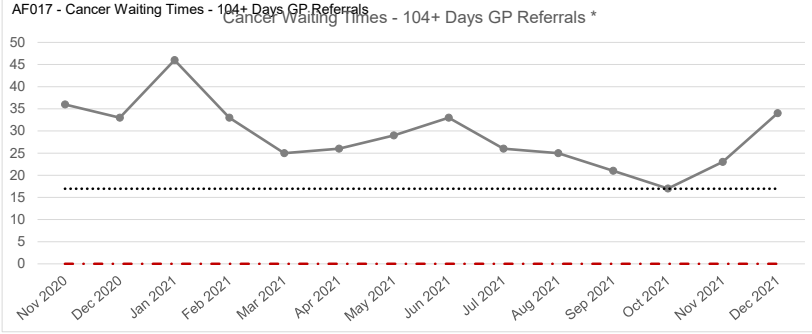
• Medicine and Surgical Division continue with recovery with additional sessions by NLaG clinicians. Working with various external providers to provide additional clinic capacity and reduce the time patients wait to receive treatment.
• Locum staff in place
• Weekly assurance that on the H2 planning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

AF017 - Cancer Waiting Times - 62 Days GP Referrals



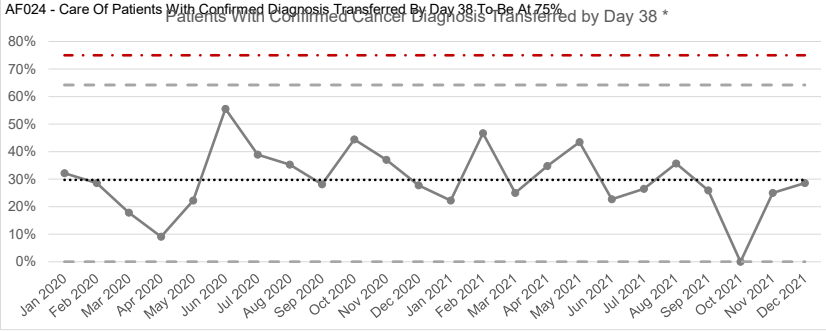
Dec 2021	Target	Variance	Assurance
62.2%	85.0%	Common cause - no significant change	Variation indicates consistently falling short of the target

AF017 - Cancer Waiting Times - 104+ Days GP Referrals



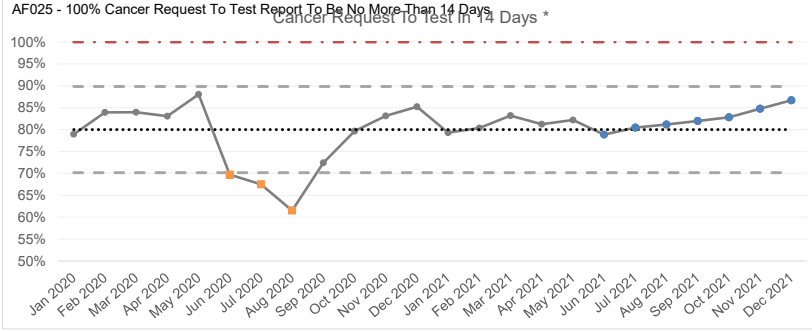
Dec 2021	Target	Variance	Assurance
34	0	There is currently insufficent data therefore variance is not relevant	There is currently insufficent data therefore assurance is not relevant

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



Dec 2021	Target	Variance	Assurance
28.6%	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



Dec 2021	Target	Variance	Assurance
86.7%	100.0%	Special cause of improving nature or lower pressure due to higher values	Variation indicates consistently falling short of the target

Data Analysis:
62 days GP referral*: Performance has remained stable since September 2019 (common cause variation). This target has not been achieved within the last 2 years. It will fail to meet the target without process redesign.
104+ days GP referrals*: The number of 104+ day waiters is now being calculated differently. The new calculation starts from November 2020. Therefore there is insuffcient data for an SPC chart and as such this indicator has reverted to a line chart. It will be converted to an SPC chart for the next iteration of this report.
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 redesign.
Request to test 14 days*: Performance has stabilised close to pre-pandemic levels following a period of poorer performance last summer and is showing special cause variation of an improving nature. The target of 100% has not been achieved within the last 2 years. It will continue to fail the target without process redesign.

Challenges:

• All tumour sites are affected by the increasing waiting times for oncology consultant appointments (62 day pathways)
• Colorectal is a challenge but the teams are working to improve referrals in to ensure the right pts receive the diagnostics required, we are reviewing the 28 day peroframce and RDC commencing at DPOW next week and SGH the week after.

Key Risks:

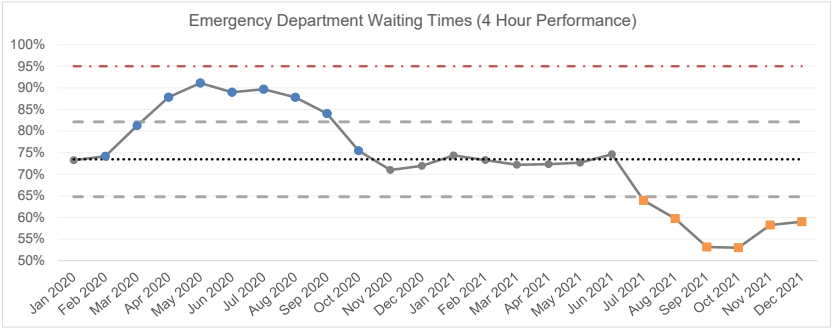
• There are a number of issues related to visiting consultant services (e.g urology, oncology), tertiary based staging scans (EUS, PET CT) which affect the ability to transfer (IPT) for treatment by Day 38 - as you are aware the oncology concerns when pts transfering to HUTH.

Actions:

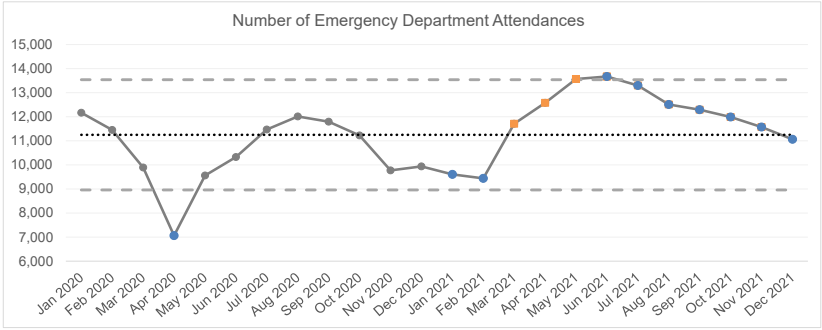
• 62 day performance is being reviewed and managed weekly- along with the 28 day performance. Colorectal RDC up and running and intention to have CN's contact with all 2 WW referals within 48 hours.
• The Cancer Transformation team has completed a pathway analysis on 100 patient pathways for Lung. Outputs 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 will be undertaken in Q4.

Mitigations:

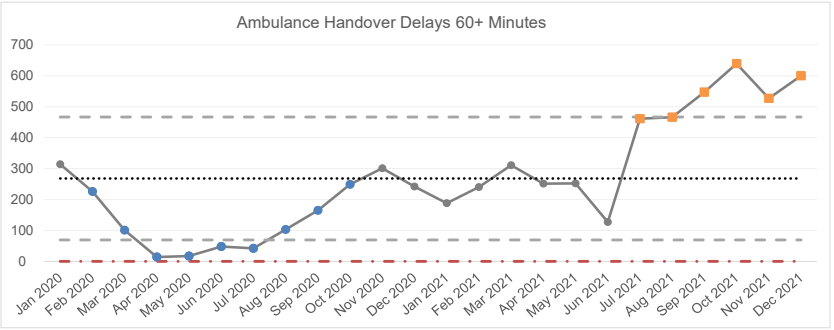
• The pathway analyser tool that has been developed within NLAG (using the IST tool) and the in depth analysis of pathways will enable teams to identify where improvements in NLAG can be achieved. Lung completed and fed back to clinical team - remedial actions being discussed.
• The joint transformation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



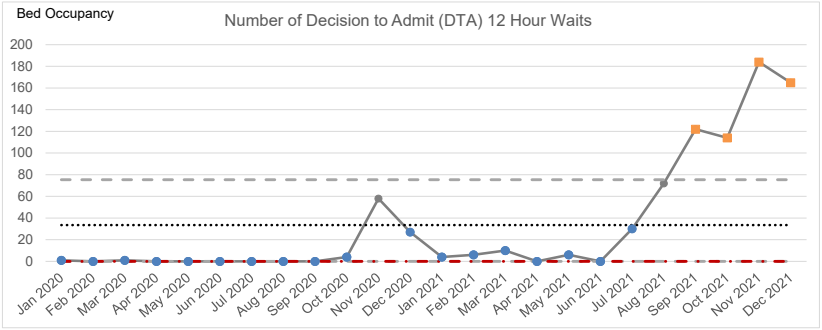
Dec 2021	Target	Variance	Assurance
59.0%	95.0%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates consistently falling short of the target



Dec 2021	Target	Variance	Assurance
11,061	No target	Special cause of improving nature or lower pressure due to lower values	There is no target therefore target assurance is not relevant



Dec 2021	Target	Variance	Assurance
600	0	Special cause of concerning nature or higher pressure due to higher values	Variation indicates consistently falling short of the target



Dec 2021	Target	Variance	Assurance
165	0	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

Emergency Dept 4 hour performance: Since the summer there has been a significant deterioration in performance, which has particularly deteriorated in the past 6 months. The target has not been achieved within the past 2 years and it will continue to fail to meet target without process redesign.
Emergency Dept Attendances: The past seven months have shown a steady decrease in the number of A&E attendances and as such the data is demonstrating an improving picture over the last 7 months.
Ambulance handover 60+ minutes: The indicator is showing deteriorating performance over the last 6 months. During Novermber there were 600 occassions when an ambulance handover was delayed for more than one hour. The target will not be met without process re-design.
DTA 12 hours: Over the past four months the indicator has consistently shown a deterioration. In December 165 patients waited 12 hours for a decision to admit. The target will not be met without process redesign.

Challenges:

- ED attendances continue to be higher than last year
- 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
- Exit block out of ED is resulting in stagnant patient flow and ED reaching beyond full capacity each day. This leads to no capacity to offload incoming ambulances and delays in wait to be seen times
- Implications of COVID19 (zoning segregation, PPE, awaiting swab results, staff sickness and isolation) creating challenges and delays for patient pathway through the ED
- Patients remaining in resus after stablisation for too long due to lack of prompt access to HDU/CC
- Delays in diagnostic imaging at times and in specialty in-reach not meeting the less than 30min attendance to review Emergency Care Standards
- Inappropriate attendances to ED due to lack of access to alternative, more appropriate services
- There is a risk of 12 hour breaches occurring due to a lack of bed availability and patient flow out of the Emergency Department
- Risk of harm to patients kept in ECC for more than 12 hours

Key Risks:

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

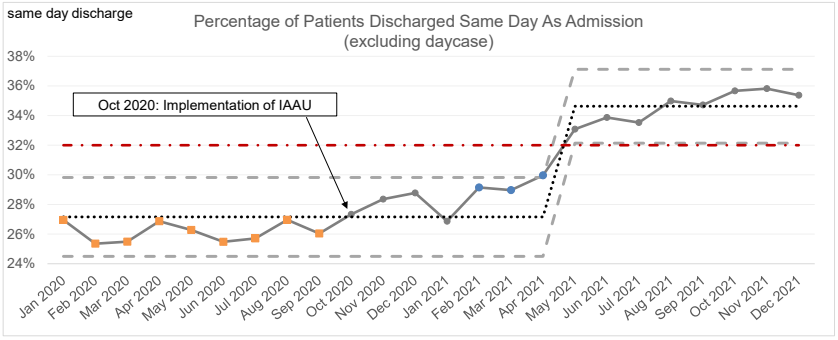
Actions:

- The Urgent Care Service (UCS) at SGH is providing improved patient experience and 99.4% performance during December 2021
- The UCS at DPOWH is now being implemented (training and staff engagement) with a go live scheduled for 18th January 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

Mitigations:

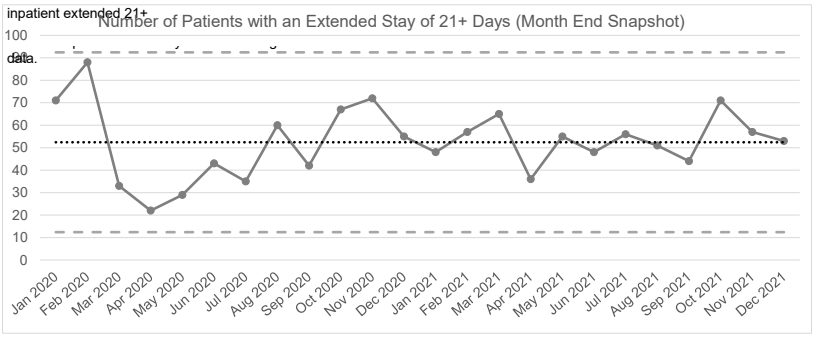
- Tier system of Medicine senior management in place for prompt escalation, resolution and support for ED
- Fast track paediatric process in place
- Senior clinician reviews taking place in ambulances when delays to offloading occur
- Increased staffing in ED
- 2 hourly board rounds with EPIC and Clinical 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

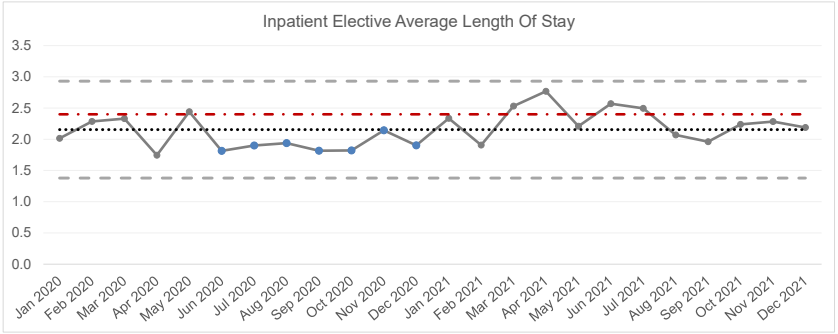


Dec 2021
35.4%
Target
32.0%
Variance
Common cause - no significant change
Assurance
Variation indicates consistently passing the target

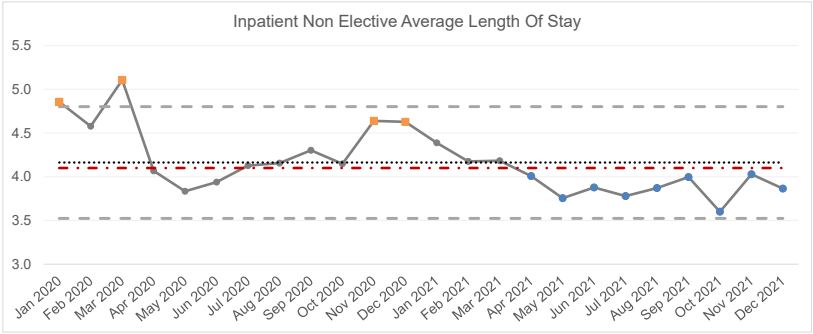
inpatient extended 21+ data.



Dec 2021
53
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Dec 2021
2.2
Target
2.4
Variance
Common cause - no significant change
Assurance
Variation indicates inconsistently hitting passing and falling short of the target



Dec 2021
3.9
Target
4.1
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:
Discharged same day as admission: Following implementation of the IAAU in October 2020 this indicator showed steady improvement with the process limits being recalculated from May 2021. Since that time the trend has shown no significant change and performance is consistently exceeding the target.
Extended stay 21+ days: The number of patients has remained stable for over a year. However there is wide variation in the data.
Elective length of stay: The elective average length of stay has been stable for the past several months. The target of 2.4 days has been achieved for the past five months. However, the target can be expected to achieve and fail at random.
Non elective length of stay: The non elective average length of stay been showing an improvement for the past 9 months. 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:

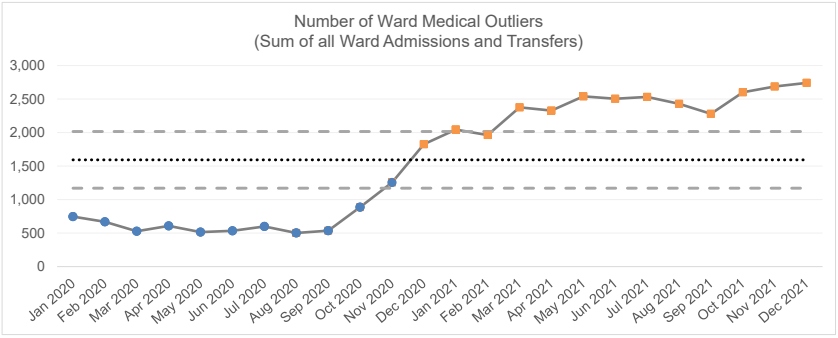
- Exit block due to social care constraints (staffing, interim bed availability, lack of packages of care availability)
- NLAG staffing constraints (staffing, sickness, vacancy, use of agency/bank staff)
- Covid and IPC requirements for social distancing
- Environment and ability to create (and staff)escalation 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 inconsistancy and delays in patient pathways
- Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission and long patient waits in ED
- High acuity levels and patients means more patients require further support on discharge
- Multiple Care home closures to new patients/repatriations due to COVID oubreaks

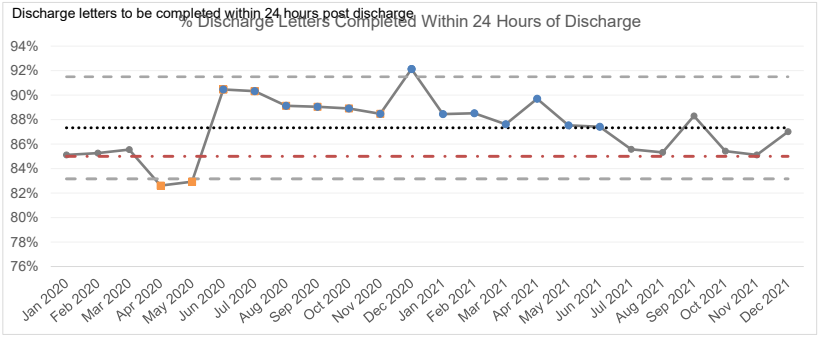
Actions:
- Daily board rounds on wards
- Discharge rounds at weekends
- LLOS reviews in place for medicine twice per week led by the senior tri
- Regular meetings with system partners to understand current delays/issues
- Discharge imporvement plan currently being developed which pulls together all areasof 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

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.

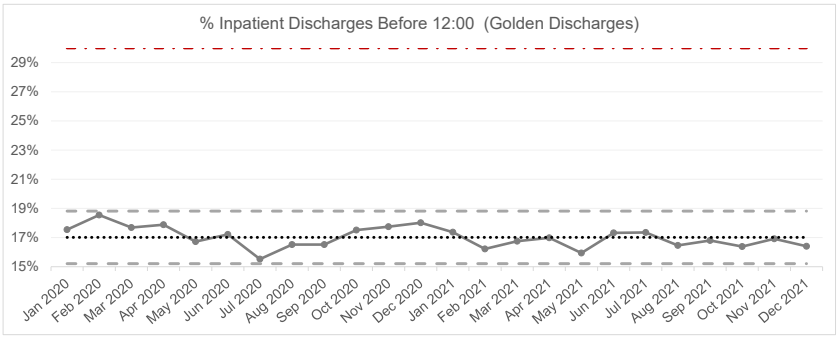


Dec 2021	Target	Variance	Assurance
2,741	No target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant

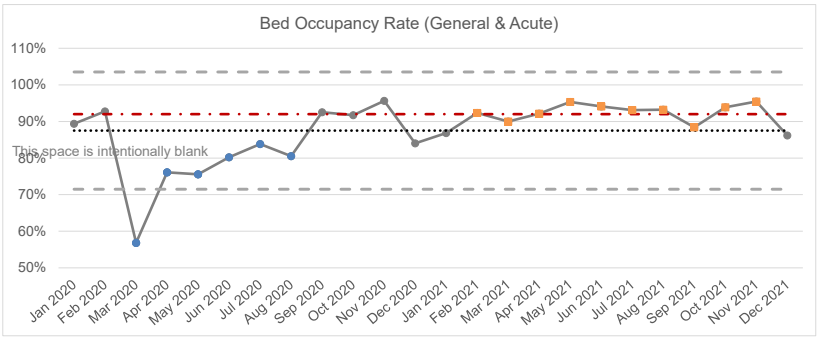
Discharge letters to be completed within 24 hours post discharge



Dec 2021	Target	Variance	Assurance
87.0%	85.0%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



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



Dec 2021	Target	Variance	Assurance
86.2%	92.0%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:
Ward medical outliers: For the past year there has been a significantly higher number of medical outliers. There has been a five-fold increase in numbers compared to September 2020. The business rules for deriving medical outliers are currently under review with a view to updating these.
Inpatient discharge letters: The target for the percentage of dicharge letters completed within 24 hours has been consistently achieved for the past 18 months and performance is currently stable.
Inpatient discharges before 12:00: Performance has remained stable for the past two years. Currently, the highest performance that can be expected without redesign is 19% against a target of 30%.
G&A Bed Occupancy: After a long period of poorer performance (since February 2021), performance in December moved into the expected range. The target lies between the process limits therefore 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:

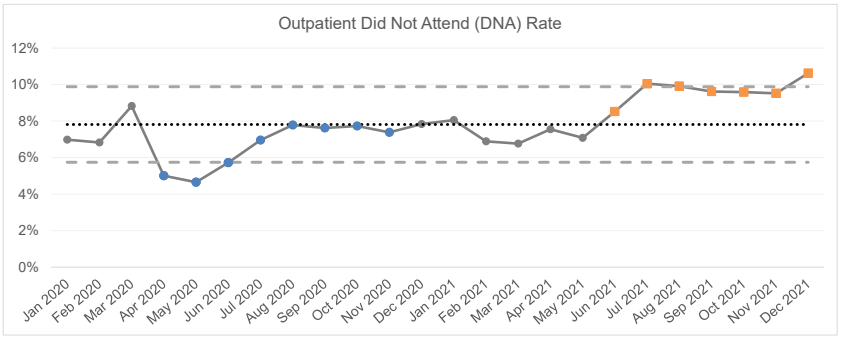
- Shortages in available workforce to meet service needs which results in inconsistancy and delays in patient pathways
- Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission and long patient waits in ED
- High acuity levels and patients means more patients require further support on discharge
- 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 and encouraging patients to discharge lounge to wait for medicaltion, letters & transport
- Discharge imporvement plan currently being developed which pulls together all areasof discharge including checklist, discharge lounge, board rounds & transport
- Continuous engagement with ward staff around the discharge pathway

Mitigations:

- Working through the IAAU model as part of implementation of the Urgent Care Service to ensure right patient, right bed
- Daily board rounds on wards - work to further develop these to ensure they are effective and timley
- Discharge rounds at weekends
- LLOS reviews in place for medicine twice per week led by the senior tri, next step is to ensure this is in place for surgery as LOS for surgery have increased
- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust
- Currently planning to implment the criteria to admit tool within ED
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire from 1 November 2021.



	Dec 2021 **30,120**	Dec 2021 **10.6%**	Dec 2021 **30.4%**
	Target **9,000**	Target **No target**	Target **No target**
	Variance: Common cause - no significant change	Variance: Special cause of concerning nature or higher pressure due to higher values	Variance: Special cause of concerning nature or higher pressure due to lower values
	Assurance: Variation indicates consistently falling short of the target	Assurance: There is no target, therefore target assurance is not relevant	Assurance: There is no target, therefore target assurance is not relevant

Data Analysis:
Outpatient Overdue follow up: For the past 18 months 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 redesign.
Outpatient DNA rate: DNA rates have been significantly higher for the past seven months and performance is in concern.
Non Face To Face Outpatient Attendances: For the past nine months there has been a run of poorer performance. This is due to the data recording lower than average rates based on the data since the introduction of the Attend Anywhere software and the implementatin of virtual clinics.

Challenges:

Key Risks:

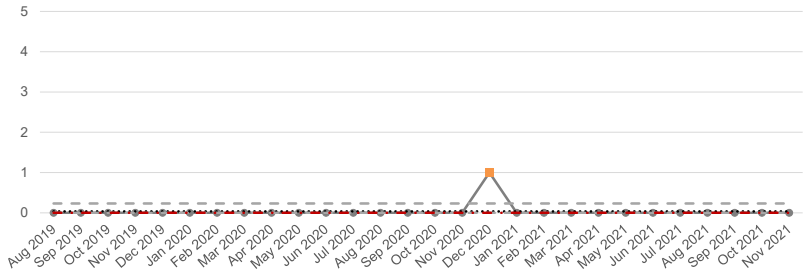
Actions:

- PIFU
- Targetted work with other specialties to increase the number of patients on a PIFU pathway in line with expected Trajectory
- CHN continues with cardiology seeing reduction in overall waiting list position.
- Further collaborative work with Primary Care Networks: Clinics being held by GPWSI in Rheumatology
- Heart Failure at home being trialled as part of PKB in Cardiology.
- Development of 2022/23 Business Plans including delivery of Outpatient Transformation actions required in Operational Planning Guidance
- Attend Anywhere software implemented at the start of COVID to alow for ease of virtual consultations

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

Northern Lincolnshire and Goole NHS Foundation Trust



Nov 2021
0

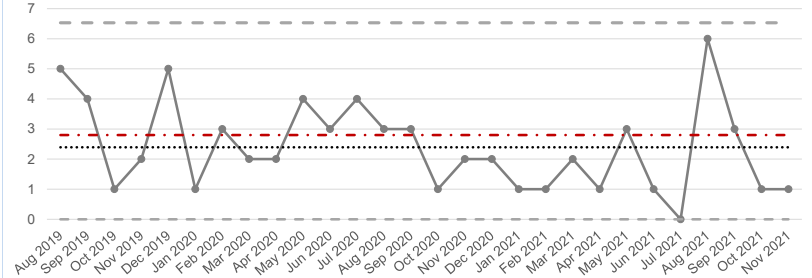
Target
0

Variance

Common cause - no significant change

Assurance

Variation indicates inconsistently hitting passing and failing the target



Nov 2021
1

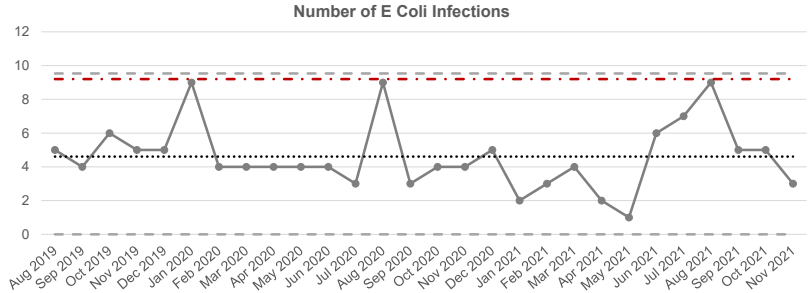
Target
2.8

Variance

Common cause - no significant change

Assurance

Variation indicates inconsistently hitting passing and failing the target



Nov 2021
3

Target
9.2

Variance

Common cause - no significant change

Assurance

Variation indicates inconsistently hitting passing and failing the target

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Data Analysis:

MRSA: No infections occurred in November. 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.
C Diff: 1 infection occurred in November. 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.
E Coli: 3 infections occurred in November. 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.

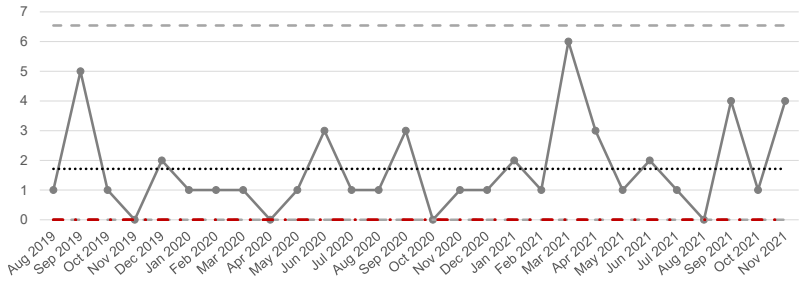
Commentary:

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



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

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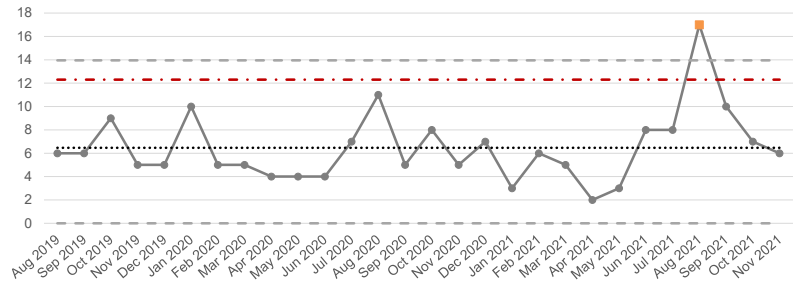
Number of Gram Negative Infections



Nov 2021	Target	Variance	Assurance
6	12	Common cause - no significant change	Variation indicates inconsistently hitting passing and failing the target

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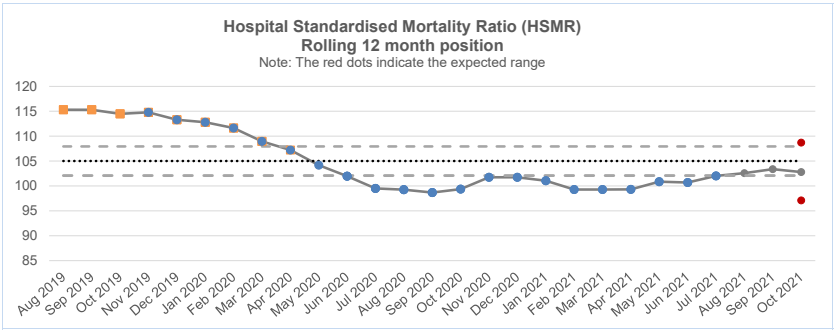
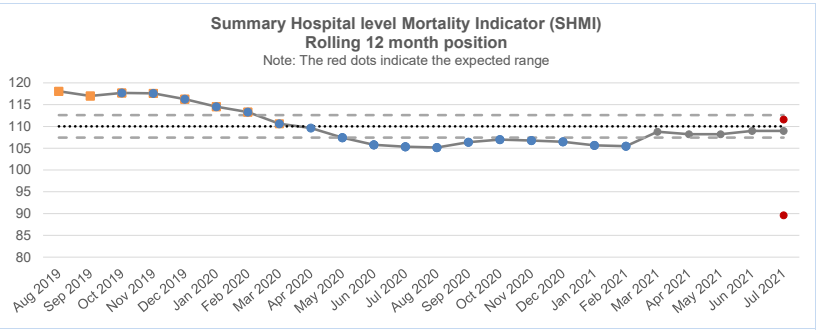
Data Analysis:
MSSA: 4 infections occurred in November. This indicator involves very small numbers and the nature of the data may lend itself to a different type of chart and this will be looked at.
Gram Neg: 6 infections occurred in November. This indicator involves very small numbers and the nature of the data may lend itself to a different type of chart and this will be looked at.

Commentary:



Oct 2021
102.8
Target
As expected
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Within 'Expected' range



Jul 2021
109.0
Target
As expected
Variance
Common cause - no significant change
Assurance
Within 'Expected' range

This space is intentionally blank

This space is intentionally blank

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.

October's HSMR continues to demonstrate improvement, remaining stable and within the expected range.

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

SHMI

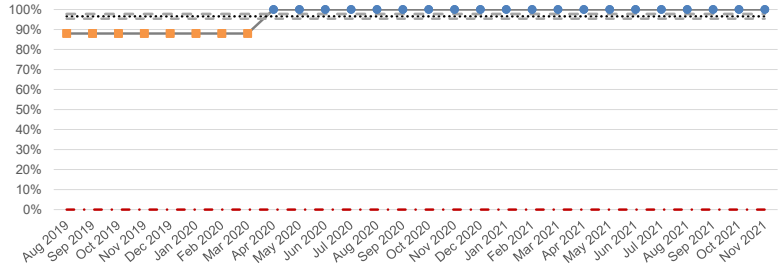
The official SHMI for the Trust remains within the 'as expected' range with a score of 108.98 for the period of August 2020 – July 2021.
DPOW now fall within the 'higher than expected' bracket for the second consecutive month with a SHMI of 116.65 (previous score 116.30). SGH SHMI (101.70) remains within the 'as expected' bracket (previous score 101.98).

Issues/Risks:
There is a risk of breaching the Trusts 'expected range' if the SHMI continues to slowly rise following the rebasing of figures.

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 facts which are fed back to clinical teams to learn lessons.

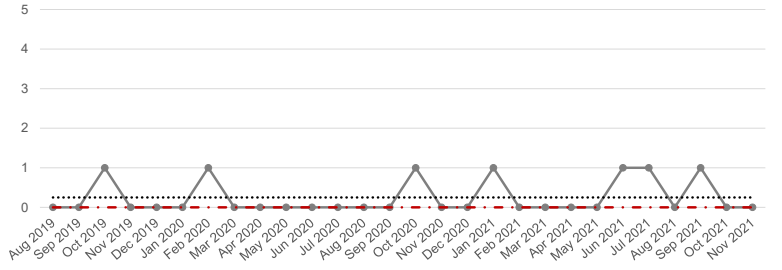
Mitigations:
SHMI performance is overseen by the Trust's Mortality Improvement Group (MIG). Mortality and the reduction of SHMI is a Trust Quality Priority for 21/22. This area is recognised as requiring further oversight and improvement as part of the for 22/23 quality priorities.

Patient Safety Alerts to be actioned by specified deadlines



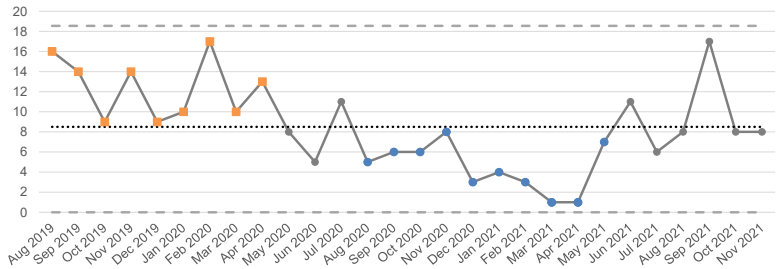
Nov 2021
100%
Target
No target
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
There is no target, therefore target assurance is not relevant

Occurrence of 'Never Events' (Number)



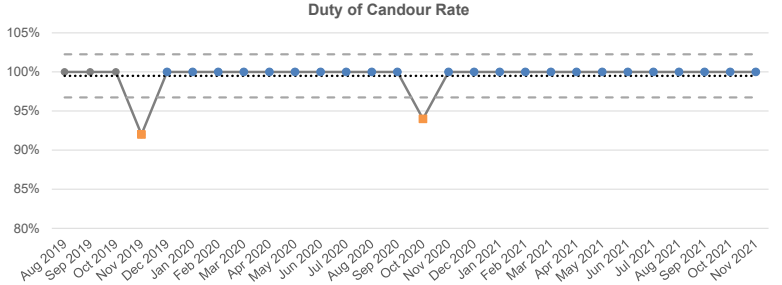
Nov 2021
0
Target
0
Variance
Due to the infrequency of Never Events a line chart is considered more appropriate than an SPC chart therefore variance is not relevant.
Assurance
Due to the infrequency of Never Events a line chart is considered more appropriate than an SPC chart therefore target assurance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

Number of Serious Incidents Raised in Month



Nov 2021
8
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Duty of Candour Rate



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

Data Analysis:
Patient Safety Alerts: Performance for November continued at 100%.
Never Events: Note the never events data are a subset of the serious incidents data. There were no never events recorded for November.
Serious Incidents: Note this data is updated retrospectively to refelect any descalated incidents and also includes the patient safety alerts. There were 8 serious incidents recorded for November. The data is within the expected range of variation.
Duty of Candour: Performance has remained stable for over a year and continues at 100%.

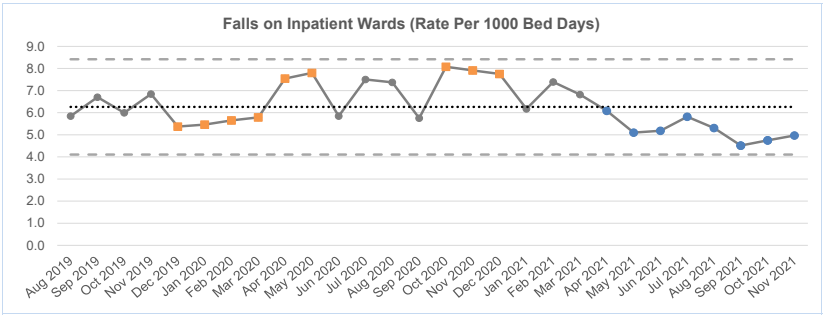
Commentary:
Never Events:
1 new Never Event declared in December 2021, a wrong joint injection, the WHO checklist was not undertaken.

Mitigations:
Immediate meeting chaired by Medical Director to identify immediate actions: reminder to all clinicians that the WHO checklist is mandatory for all cases, posters in each theatre. Each never event reported will identify key learning and mitigations. Theatres to focus audit day on learning from never events.

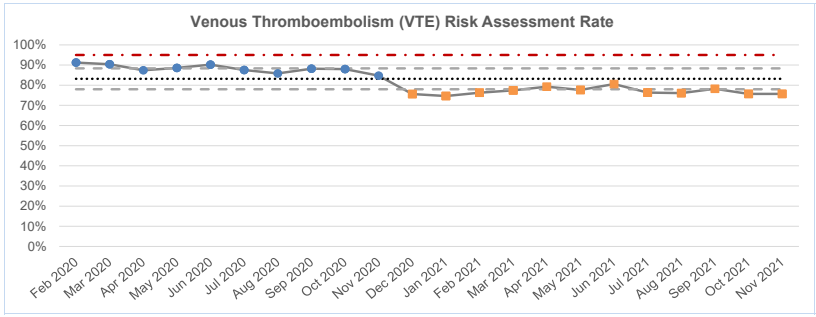
Duty of Candour: Whilst the Duty of Candour for all serious incidents is 100%, there is however a gap at present in relation to ensuring duty of candour is completed for all instances of moderate level harm. This presents the risk of non-compliance against regulations, which may result in a financial penalty.

Risk:Position in relation to Duty of candour for incidents other than serious incidents have been relatively unknown since Oct 2021.

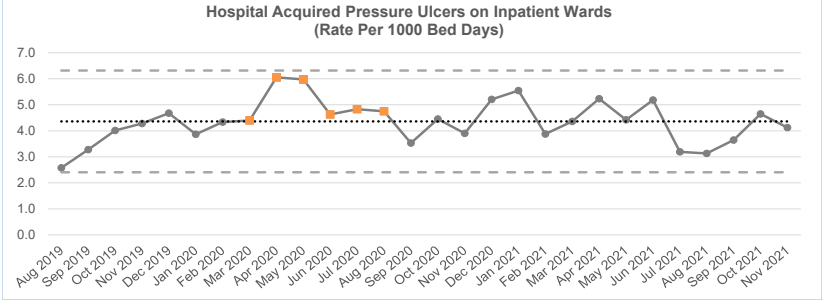
Actions: Working with Divisions to obtain assurance that all moderate (and above) harm instances have duty of candour completed (monitored through SI panel with significant improvement noted). Duty of Candour Reports are now availiable on Ulysses and will be going to SI Panel the w/c 17 January 2022.



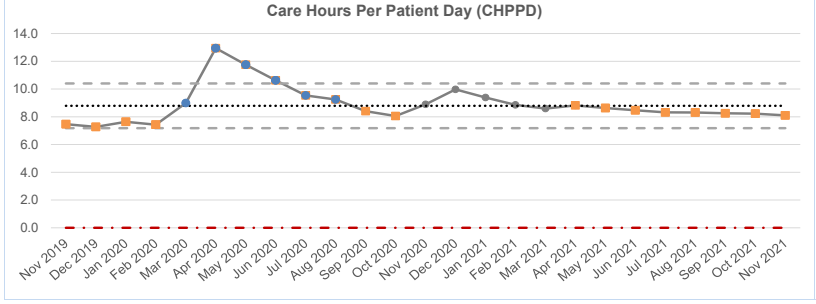
Nov 2021	5.0
Target	No target
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant



Nov 2021	75.7%
Target	95.0%
Variance	Special cause of concerning nature or lower pressure due to lower values
Assurance	Variation indicates consistently failing the target



Nov 2021	4.1
Target	No target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Nov 2021	8.1
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 an 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 aquired pressure ulcers was 4.1 per 1000 bed days for November. This is within the expected range of variation.
Care Hours Per Patient Day: There have been 8 consecutive months of poorer performance 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 has been incorrect due to a number of clinical areas being inaccurately included. This has been escalated through the EPMA and Information teams, the inclusion criteria has been reviewed and is in the process of being amended. This intervention is expected to be reflected in next months' figures, anticipating improvement to approximately 90% (based on manual calculations). The risk previously identified surrounding completing risk assessment for stranded patients in ED has now been resolved.

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	Nov 2021 **0** 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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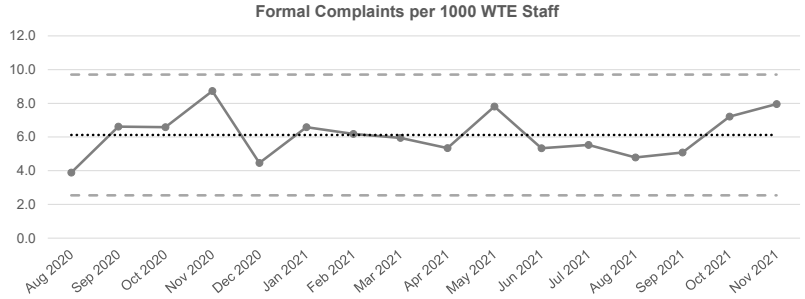
Data Analysis:
Mixed sex accommodation: The MSA return was suspended due to COVID and has now resumed. There is a nil return for November 2021.

Commentary:	



Nov 2021
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)

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

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Data Analysis:
Formal Complaints: In November there were 8 formal complaints.

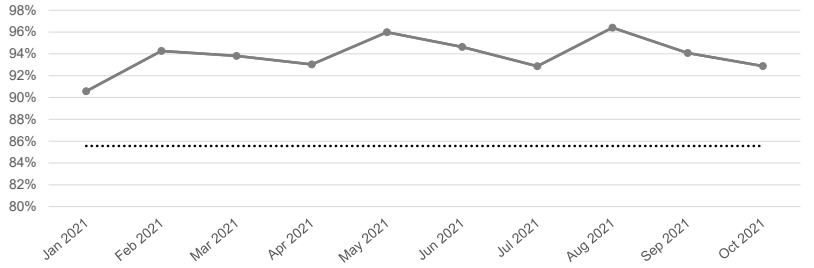
Commentary:
Formal Complaints
Formal complaints are received by the Trust patients or someone on their behalf such as a relative, MP, solicitor or CCG. These are triaged by the Complaints Manager to ensure the correct route of management is undertaken. The current Trust policy aims to respond to formal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

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

Actions:
> Continued support of lead investigator role
> SJR training for Lead Nurse involved in quality sign off process
> Development of complaint module within new incident system - Ulysses
> Review of Management of Feedback from Complaints, Concerns and Compliments Policy - as 1 year into new process
> Monthly review of closed out of timescale complaints for learning

Formal Complaints Cont/d...

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

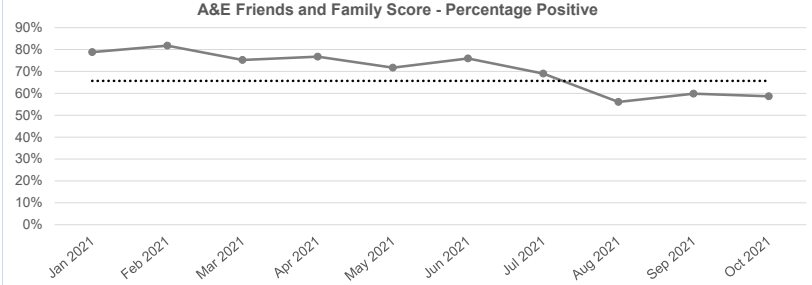


Oct 2021
92.9%

Target
No target

Variance
There is currently insufficient data for an SPC chart

Assurance
There is currently insufficient data for an SPC chart

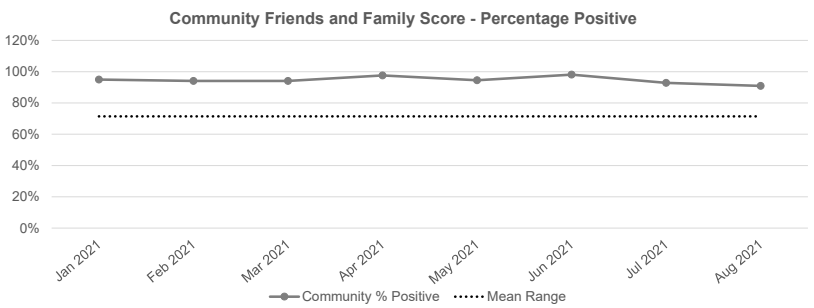


Oct 2021
58.7%

Target
No target

Variance
There is currently insufficient data for an SPC chart

Assurance
There is currently insufficient data for an SPC chart



Aug 2021
90.9%

Target
No target

Variance
There is currently insufficient data for an SPC chart

Assurance
There is currently insufficient data for an SPC chart

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Data Analysis:
Inpatient FFT: There are no scores for November due to issues with collecting the data.
A&E FFT: As above
Community FFT: There were no scores collected for September and October. If there are scores for November they are unavailable at this time due to issues with collecting the data.

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

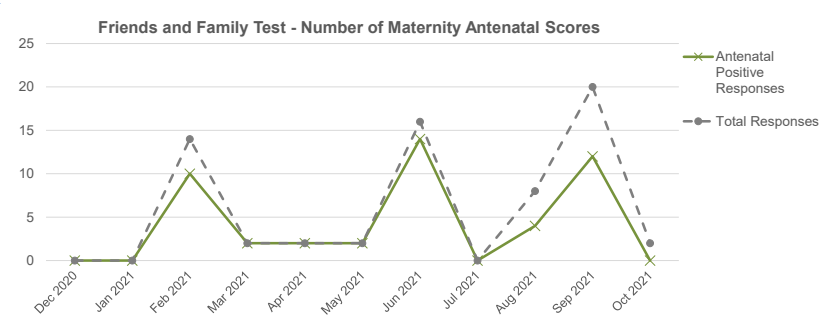
Actions:
> NHSEI funded band 7 role (until March 31st 2022) to support increased patient feedback
> Monthly meetings with IWANTGREATCARE and monthly performance meetings
> Monthly message and data sharing through Nursing & AHP leadership community
> Review of paper solution ordering to ensure good stock 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

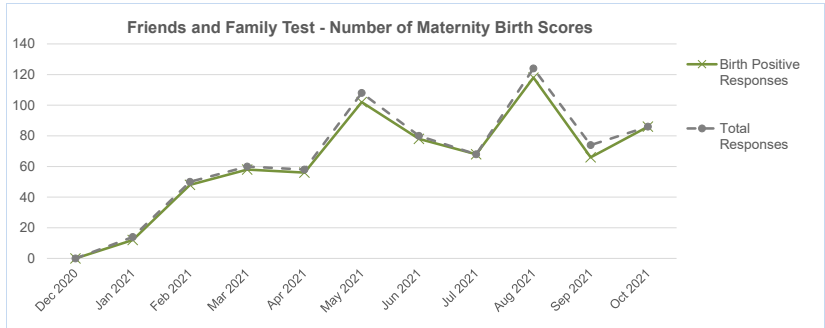
Inpatient FFT
Inpatient FFT is delivered via online/paper/QR.
Nationally the Trust is near the lower centile for inpatient response rates (82 out of 131), however consideration of patient numbers needs to be factored into this level of benchmarking.

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

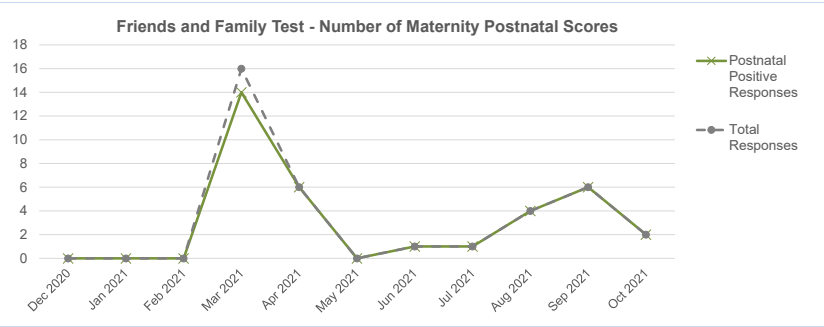
Community FFT
Community FFT is delivered via online/paper/QR.
Full internal review of community services to create improved collection systems



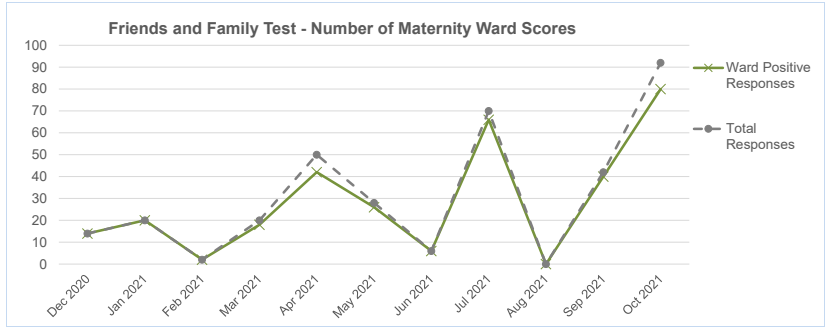
Oct 2021
0 out of 2
Target
No target
Variance
Insufficient data for an SPC chart
Assurance
Insufficient data for an SPC chart



Oct 2021
86 out of 86
Target
No target
Variance
Insufficient data for an SPC chart
Assurance
Insufficient data for an SPC chart



Oct 2021
2 out of 2
Target
No target
Variance
Insufficient data for an SPC chart
Assurance
Insufficient data for an SPC chart



Oct 2021
80 out of 92
Target
No target
Variance
Insufficient data for an SPC chart
Assurance
Insufficient data for an SPC chart

Data Analysis:
Maternity Antenatal FFT: There are no scores for November due to issues with collecting the data.
Maternity Birth FFT: As above
Maternity Postnatal FFT: As above
Maternity Ward FFT: As above

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.

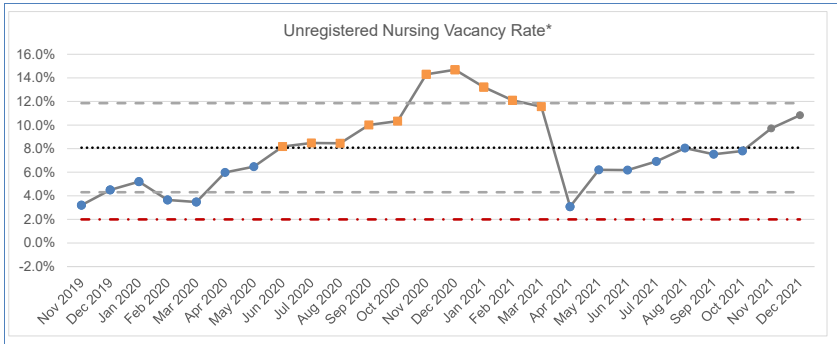
Issues and Risks:-
> Staff engagement with process resulting in poor response rates
> Delays in stock ordering
> Difficulties using data due to low numbers

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 Experiecne tablets have app insitu to aid online collection

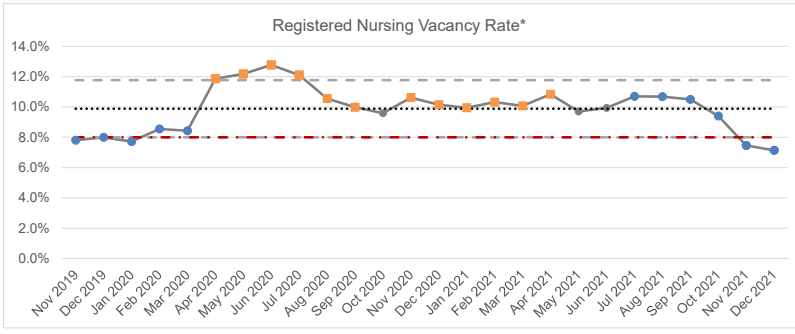
Mitigations:
> Monthly performance meeting with IWANTGREATCARE from July
> Review of paper processes commenced
> Consistent message to staff to utilise methods available

Workforce - Vacancies

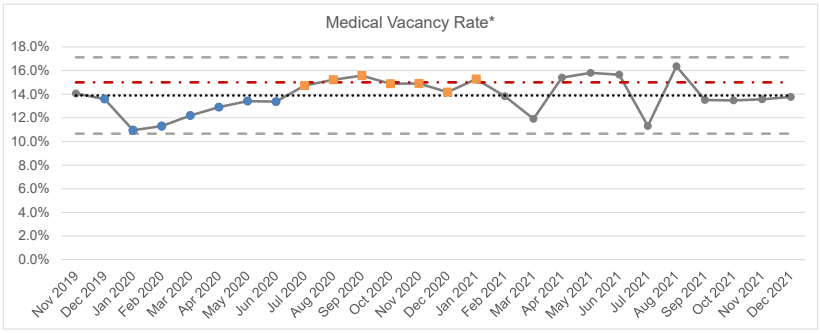
*Indicators marked with an asterix are unvalidated at the time of producing the IPR report.



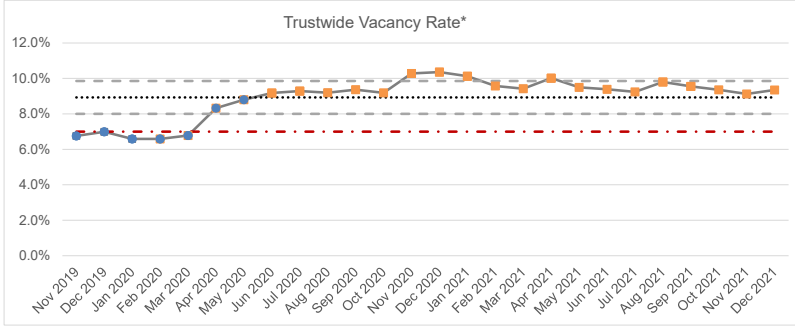
Dec 2021	Target	Variance	Assurance
10.8%	2.0%	Common cause - no significant change	Variation indicates consistently failing the target



Dec 2021	Target	Variance	Assurance
7.1%	8.0%	Special cause of improving nature or lower pressure due to lower values	Variation indicates inconsistently hitting passing and failing the traget



Dec 2021	Target	Variance	Assurance
13.8%	15.0%	Common cause - no significant change	Variation indicates inconsistently hitting passing and failing the traget



Dec 2021	Target	Variance	Assurance
9.4%	7.0%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates consistently 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. Whilst the target was achieved this month we cannot be confident that it will continue to do so. □
Trustwide Vacancy Rate*: The performance has been consistently in special cause since June 2020 and will continue to fail the target without process redesign.

Commentary:
Unregistered Nursing Vacancies:

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

Mitigations: A project group led by the Chief Nurse's office to oversee activity and consider mitigating actions. A bid has been submitted for further funding to support both recruitment of HCAs, particarly focussing on diversity, and to support a more robust induction process containing a supernumerary period. A pool of HCAs is appointed with 12.91 WTE commencing in January, and 5.57 WTE commencing in February so far. A further 22 applications have been received to be interviewed, and a rolling advert out to source further.. Information on the HCA role is 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.

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 with 61 starts taken place, and a further 8 scheduled to start in March. International nurses - 17 new starters arrived December undergoing OSCE prep, 6 arriving in January, and 11 in February. 41 candidates scheduled for interview shortly. 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.

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.

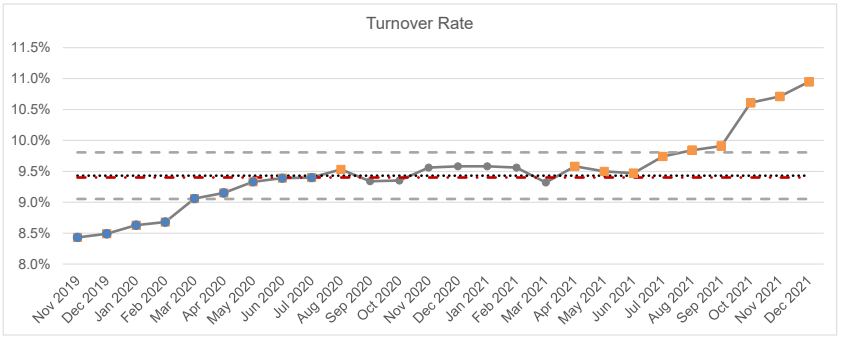
Mitigations: Recruitment team continuing to engage with candidates.. A pipeline of 30 medical staff has been established, with plans to start over the next 3 months, and a further 8 in the pipeline appointed for longer term starts. A network of private landlords has been established to support accomodation needs where the Trust is unable to accomodate locally, and work undertaken by the onsite accommodation team to free up onsite accommodation. 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.

Trustwide Vavancy 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.



Dec 2021
11.0%

Target
9.4%

Variance

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

Assurance

Variation indicates inconsistently hitting passing and failing the traget

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Nov 2021
6.2%

Target
4.1%

Variance

Common cause - no significant change

Assurance

Variation indicates consistently failing the target

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Data Analysis:
Turnover Rate: The turnover rate has been significantly higher for the past 9 months with an increasing trend for the past 6 months.
Sickness Rate: Since the spring sickness rates have generally increased steadily. It is extremely unlikely that this target will be achieved without process redesign.

Commentary:
Turnover Rate

The latest turnover data point (10.95%) 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.

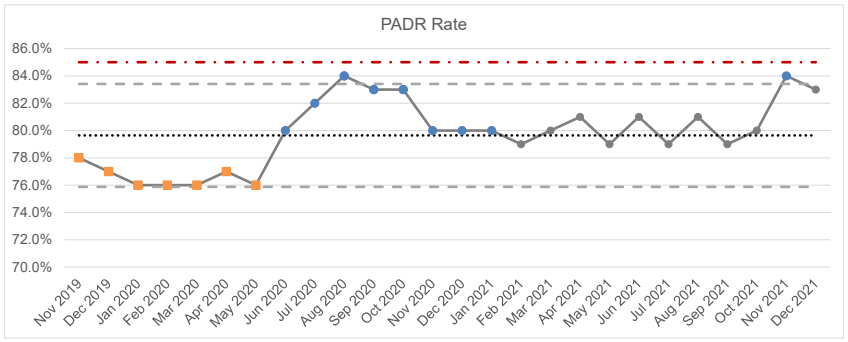
Mitigations: Planned earlier intervention in relation to known leavers. Creation of talent pools. Strengthen engagement levels; proactive health and wellbeing plan to address common themes affecting wellbeing-related retention. Deep dive of leavers data in Januaray 2022 to identify hotspot areas with focused interventions.

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

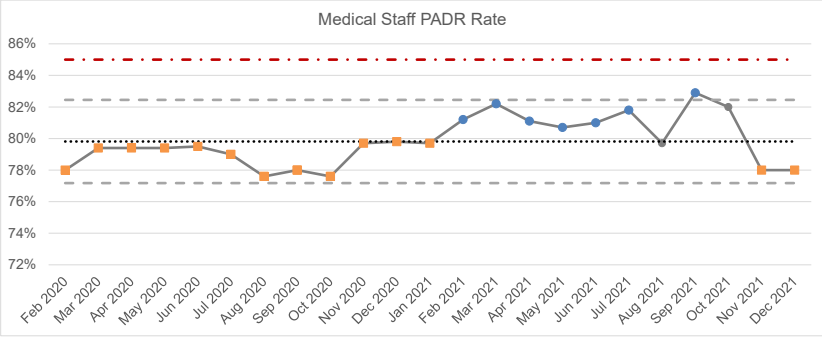
Issues/Risks: Staff who are isolating due to post travel, Household Member with Symptoms and Track and Trace are not reflected on the chart above, however this impacts staffing levels as the special leave type is starting to increase. Winter pressures combined with the impacts of the new Omicrom variant are increasing and are starting to impact. It is understood that the peak of this wave will be in January 2022 and begin to decline mid-February.

Actions: Daily sickness monitoring has recommenced with ICC and Infection Control lead to monitor specifically covid absences. A revised operational dashboard will be available early in 2022 that will allow managers to have a greater level of access to data in relation to sickness which will support the wider management. The Flu campaign has continues via the peer vaccinator model with links into the covid hub+. The covid booster programme is also continuing with a good uptake so far but does require marginal improvement in line with regional averages. High levels of vaccination should translate into a reduced sickness level throughout the winter months. The Trust has now launched winter incentives with the view to increase uptake of vacant shifts throughout the challenging winter period.

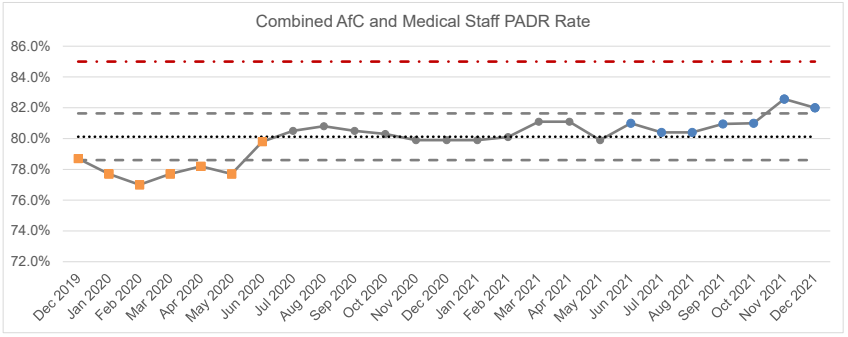
Mitigations: Continued close monitoring of sickness levels with increased operational reporting - volume, trends & themes. Targeted preventative intervention in known high pressure areas. Greater levels of health and wellbeing resource via PEO. Greater levels of Occupational Health clinician time and 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.



Dec 2021	Target	Variance	Assurance
83.0%	85.0%	Common cause - no significant change	Variation indicates consistently failing the target



Dec 2021	Target	Variance	Assurance
78.0%	85.0%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates consistently failing the target



Dec 2021	Target	Variance	Assurance
82.0%	85.0%	Special cause of improving nature or lower pressure due to higher values	Variation indicates consistently failing the target

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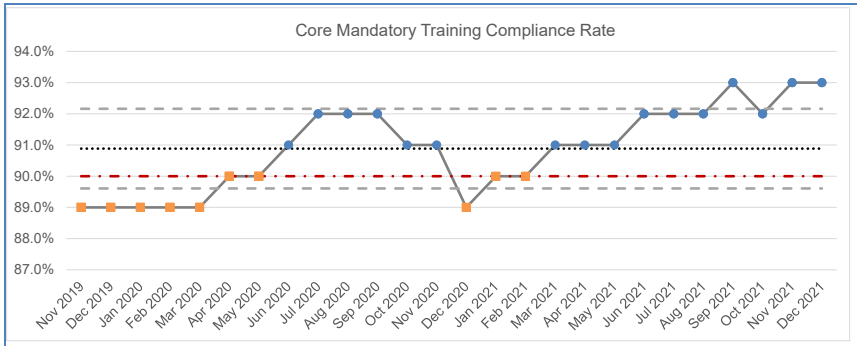
Data Analysis:
PADR Rate: After stable performance for almost a year the PADR rate showed special cause improvement in November with a similar figure in December. The target cannot be met without process redesign.
Medical Staff PADR Rate: Performance has recorded statistically signifcant deterioration in the past two months. Without process re-design, performance will continue to fail the target.
Combined AfC and Medical Staff PADR Rate: Performance has improved in recent months and has moved into special cause improvement. However, without process re-design performance will continue to fail the target.

Commentary:
PADR Rate:
The non medical PADR compliance position currently stands at 83% this is below the Trust target of 85% .
Medical Staff PADR Compliance currently stands at 78% as of December 2022 below the Trust target of 85% .
The combined appraisal complaince currently stands at 82% as of December 2021.

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.



Dec 2021
93.0%

Target
90.0%

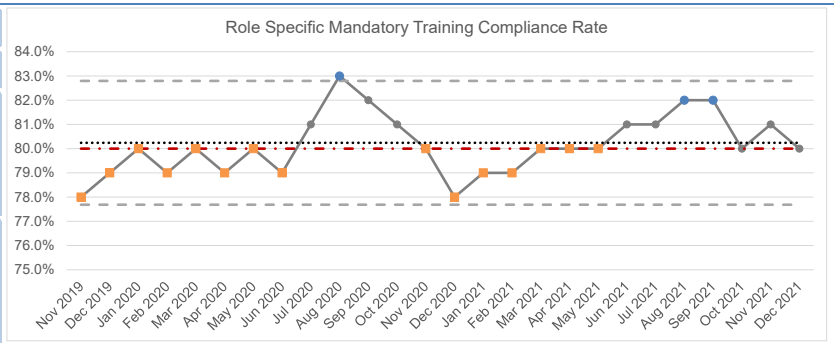
Variance

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

Assurance

Variation indicates inconsistently hitting passing and failing the traget

This space is intentionally blank



Dec 2021
80.0%

Target
80.0%

Variance

Common cause - no significant change

Assurance

Variation indicates inconsistently hitting passing and failing the traget

This space is intentionally blank

Data Analysis:
Core Mandatory Training: Performance has been in common cause improvement since March 2021 and the target has been consistently achieved over that time. However the target is still within the expected range of the data. 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% (December 2021). 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 80% by end of December 2021 and 85% by end of March 2022 , this is a slight change from the previous target which was 80% by September 2021. ETD will continue to monitor complaince leves proactivley risk assess in advance CQC inspections.

IPR 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 19/01/2022

* 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 metholody to the IPR and should be taken as indicative for this reason

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Access & Flow	Planned	% Under 18 Weeks Incomplete RTT Pathways	Dec-21	67.3%	92.0%	44	96/172	*Nov 2021
	Planned	Number of Incomplete RTT pathways 52 weeks	Dec-21	384	0	61	67/171	*Nov 2021
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Dec-21	31.0%	1.0%	25	120/160	*Nov 2021
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Dec-21	62.2%	85.0%	30	96/136	*Nov 2021
	Cancer	Cancer - Request To Test In 14 Days	Dec-21	86.7%	100.0%	80	28/136	*Nov 2021
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Dec-21	59.0%	95.0%	5	127/133	Dec 2021
	Urgent Care	Number Of Emergency Department Attendances	Dec-21	11,061	No Target	49	76/147	Dec 2021
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Dec-21	165	0	10	140/156	*Nov 2021
	Flow	Bed Occupancy Rate (General & Acute)	Dec-21	86.2%	92.0%	42	92 / 159	^ Jul/Aug/Sept 21
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Dec-21	10.6%	No Target	25	124/165	*Nov 2021
	COVID	Number of COVID patients in ICU beds (Weekly)	Dec-21	4	No Target	21 (All beds)	161 / 204	*Nov 2021
	COVID	Number of COVID patients in other beds (Weekly)	Dec-21	31	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	Nov-21	0	0	78	31/139	*Oct 2021
	Infection Control	Number of E Coli Infections	Nov-21	3	9	43	80/139	*Oct 2021
	Infection Control	Number of Trust Attributed C-Difficile Infections	Nov-21	1	3	94	9/139	*Oct 2021
	Infection Control	Number of MSSA Infections	Nov-21	4	0	54	64/139	*Oct 2021
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Jul-21	109	111.6	16	103/122	*Aug 2021
	Safe Care	Number of Serious Incidents Raised in Month	Nov-21	8	No Target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Nov-21	8.1	No Target	36	122/189	*Oct 2021
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Nov-21	75.7%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Nov-21	8.0	No Tagret	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Percentage of Positive Inpatient Scores	Oct-21	92.9%	No Target	58	57/133	*Nov 2021

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Nov-21	6.2%	4.1%	33	144/215	*Aug 2021

Appendix B - Scorecard Finance and Performance Committee

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

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Planned	Percentage Under 18 Weeks Incomplete RTT Pathways*	Dec 2021	67.3%	92.0%	Action Required	H	F	Board
	Number of Incomplete RTT pathways 52 weeks*	Dec 2021	384	0	Action Required		F	Board
	Total Inpatient Waiting List Size	Dec 2021	10,190	11,563		L	P	Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Dec 2021	31.0%	1.0%	Action Required	L	F	Board
	Number of Incomplete RTT Pathways*	Dec 2021	29,978	No target	Action Required	H	No target	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Dec 2021	15,186	No target			No target	FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Dec 2021	62.2%	85.0%	Action Required		F	Board
	Cancer Waiting Times - 104+ Days Backlog*	Dec 2021	34	0		n/a	n/a	Board
	Patients With Confirmed Diagnosis Transferred By Day 38*	Dec 2021	28.6%	75.0%	Action Required		F	Board
	Cancer Request To Test In 14 Days*	Dec 2021	86.7%	100.0%	Action Required	H	F	Board
	Cancer Waiting Times - 2 Week Wait*	Dec 2021	95.4%	93.0%			P	FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Dec 2021	89.4%	93.0%			?	FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Dec 2021	61.5%	75.0%			?	FPC
	Cancer Waiting Times - 31 Day First Treatment*	Dec 2021	98.1%	96.0%			?	FPC
	Cancer Waiting Times - 31 Day Surgery*	Dec 2021	84.6%	94.0%			?	FPC
	Cancer Waiting Times - 31 Day Drugs*	Dec 2021	100.0%	98.0%			?	FPC
	Cancer Waiting Times - 62 day Screening*	Dec 2021	82.4%	90.0%		H	?	FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Dec 2021	59.0%	95.0%	Action Required	L	F	Board
	Number Of Emergency Department Attendances	Dec 2021	11,061	No target		L	No target	Board
	Ambulance Handover Delays - Number 60+ Minutes	Dec 2021	600	0	Action Required	H	F	Board
	Decision to Admit - Number of 12 Hour Waits	Dec 2021	165	0	Action Required	H	?	Board
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Dec 2021	35.4%	92.0%			P	Board
	Patients with an Extended Stay of 21+ Days (Month End Snapshot)	Dec 2021	53	No target			No target	Board
	Inpatient Elective Average Length Of Stay	Dec 2021	2.2	2.4			?	Board
	Inpatient Non Elective Average Length Of Stay	Dec 2021	3.9	4.1		L	?	Board
	Number of Ward Medical Outliers (Sum of all Ward Admissions and Transfers)	Dec 2021	2,741	No target	Action Required	H	No target	Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Dec 2021	87.0%	85.0%			?	Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Dec 2021	16.4%	30.0%	Action Required		F	Board
	Bed Occupancy Rate (G&A)	Dec 2021	86.2%	92.0%			?	Board
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Dec 2021	30,120	9,000	Action Required		F	Board
	Outpatient Did Not Attend (DNA) Rate	Dec 2021	10.6%	No target	Action Required	H	No target	Board
	% Outpatient Non Face To Face Attendances	Dec 2021	30.4%	No target	Action Required	L	No target	Board
	% Outpatient summary letters with GPs within 7 days	Dec 2021	29.2%	50.0%	Action Required	L	F	FPC
COVID	Number of COVID patients in ICU beds (Weekly)	Dec 2021	4	No target			No target	Board
	Number of COVID patients in other beds (Weekly)	Dec 2021	31	No target			No target	Board
	% COVID staff absences (Weekly)	Dec 2021	41.4%	No target	Action Required	H	No target	Board

Appendix B - Scorecard Quality and Safety Committee

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

Northern Lincolnshire and Goole NHS Foundation Trust

Infection Control	Number of MRSA Infections	Nov 2021	0	0				Board
	Number of E Coli Infections	Nov 2021	3	9				Board
	Number of Trust Attributed C-Difficile Infections	Nov 2021	1	3				Board
	Number of MSSA Infections	Nov 2021	4	0				Board
	Number of Gram Negative Infections	Nov 2021	6	12				Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Oct 2021	102.8	As expected			As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Jul 2021	109.0	As expected			As expected	Board
	Number of patients dying within 24 hours of admission to hospital	Dec 2021	10	No target			n/a	Q&S
	Number of emergency admissions for people in the last 3 months of life	Dec 2021	174	No target			n/a	Q&S
	Out Of Hospital (OOH) SHMI	Aug 2021	132.2	110.0	**Action Required**			Q&S
	Structured Judgement Reviews - Rate Completed of those required	Nov 2021	40.0%	100.0%	**Action Required**			Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Nov 2021	100.0%	No target	**Action Required**		n/a	Board
	Number of Serious Incidents raised in month	Nov 2021	8	No target			n/a	Board
	Occurrence of 'Never Events' (Number)	Nov 2021	0	0		n/a	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)	Nov 2021	5.0	No target			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate per 1000 bed days)	Nov 2021	4.1	No target			n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Nov 2021	75.7%	95.0%	**Action Required**			Board
	Care Hours Per Patient Day (CHPPD)	Nov 2021	8.1	No target	**Action Required**		n/a	Board
	Mixed Sex Accommodation Breaches	Nov 2021	0.0	0		n/a	n/a	Board
Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Nov 2021	8.0	No target			n/a	Board
	Complaints Responded to on time (To be added in due course)							
	Compliments (To be added in due course)							
	Friends and Family Test (FFT)							
	Percentage of Positive Inpatient Scores	Oct 2021	92.9%	No target		n/a	n/a	Board
	Percentage of Positive A&E Scores	Oct 2021	58.7%	No target		n/a	n/a	Board
	Percentage of Positive Community Scores	Aug 2021	90.9%	No target		n/a	n/a	Board
	Number of Maternity Antenatal Scores	Oct 2021	0 out of 2	No target		n/a	n/a	Board
	Number of Maternity Birth Scores	Oct 2021	86 out of 86	No target		n/a	n/a	Board
	Number of Maternity Postnatal Scores	Oct 2021	2 out of 2	No target		n/a	n/a	Board
	Number of Maternity Ward Scores	Oct 2021	80 out of 92	No target		n/a	n/a	Board
Observations	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Dec 2021	90.3%	90.0%				Q&S
	Percentage of Child Observations Recorded On Time (with a 30 min grace)	Nov 2021	80.0%	90.0%				Q&S
	Escalation of NEWS in line with Policy	Nov 2021	9.0%	No target		n/a	n/a	Q&S
	Blood Glucose taken in the Emergency Department in Adult patients when NEWs score >1	Nov 2021	100.0%	100.0%				Q&S
	Blood Glucose taken in the Emergency Department in Paediatric patients when PEWs score >1	Nov 2021	85.0%	100.0%				Q&S
Sepsis	Rate of Patients Screened for Sepsis using the Adult Sepsis Screening and Action Tool (based on Manual Audit)	Nov 2021	47.0%	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)	Nov 2021	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)	Nov 2021	73.8%	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)	Nov 2021	18.8%	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	Nov 2021	87.5%	No target		n/a	n/a	Q&S
	Rate of Insulin administered on time within wards using EPMA	Nov 2021	99.1%	85.0%		n/a	n/a	Q&S
	Percentage of Medication Omissions for Ward Areas Using EPMA	Nov 2021	9.9%	No target		n/a	n/a	Q&S
Diabetes	Diabetes Audit Findings (percentage)	Nov 2021	79.7%	80.0%		n/a	n/a	Q&S
	Percentage of relevant staff who have completed mandatory diabetes training	Nov 2021	85.3%	90.0%	**Action Required**			Q&S
Re-admissions	Percentage of patients re-admitted as an emergency within 30 days	Dec 2021	9.0%	0.0%	**Action Required**			Q&S
Maternity	Emergency Caesarean Section Rate	Dec 2021	17.1%	15.2%	**Action Required**			Q&S

Appendix B - Scorecard Workforce Committee

Note 'Action Required' is stated when either Variation is showing special cause concern or Assurance indicates failing the target.
*Indicators marked with an asterix are unvalidated at the time of producing the IPR report.
^ Draft - The optimum method for analysing/presenting these figures is in development.

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Vacancies	Unregistered Nurse Vacancy Rate*	Dec 2021	10.8%	2.0%	Action Required		F	Board
	Registered Nurse Vacancy Rate*	Dec 2021	7.1%	8.0%		L	?	Board
	Medical Vacancy Rate*	Dec 2021	13.8%	15.0%			?	Board
	Trustwide Vacancy Rate*	Dec 2021	9.4%	7.0%	Action Required	H	F	Board
Staffing Levels	Turnover Rate	Dec 2021	11.0%	9.4%	Action Required	H	?	Board
	Sickness	Nov 2021	6.2%	4.1%	Action Required		F	Board
Staff Development	PADR Rate	Dec 2021	83.0%	85.0%	Action Required		F	Board
	Medical Staff PADR Rate	Dec 2021	78.0%	85.0%	Action Required	L	F	Board
	Combined AfC and Medical Staff PADR Rate	Dec 2021	82.0%	85.0%	Action Required	H	F	Board
	Core Mandatory Training Compliance Rate	Dec 2021	93.0%	90.0%		H	?	Board
	Role Specific Mandatory Training Compliance Rate	Dec 2021	80.0%	80.0%			?	Board
Disciplinary	Number of Disciplinary Cases Commenced	Dec 2021	0	No target		L	No target	WFC
	Average Length of Disciplinary Process (Weeks)	Dec 2021	0	12		L	?	WFC
	Number of Suspensions Commenced	Dec 2021	2	No target			No target	WFC
	Average Length of Suspension (Weeks)	Dec 2021	35	No target			No target	WFC

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1 February 2022	
Director Lead	Dr Kate Wood	
Contact Officer/Author	Angie Legge, Associate Director for Quality Governance	
Title of the Report	**Executive Quality Report**	
Purpose of the Report and Executive Summary (to include recommendations)	The purpose is to keep the Board appraised of key quality risks and mitigations. The most significant risk remains staffing. A self-assessment of the winter 2021 nurse staffing assurance framework from NHSI November 2021 was submitted to the Quality & Safety Committee in January 2022.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Director approval
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

Executive Quality Report

Purpose

The purpose of this Executive report is to appraise the Board of the key quality risks and mitigations.

Background

The Trust remains in quality special measures with regular meetings with NHSEI, linked to the CQC rating. Quality Performance data, including the quality priority measures, are available on the IPR.

Key Risks

The significant risks are:

- Staffing fill rates remains a concern for nursing and midwifery, both in hospital and community. Red flag staffing incidents continue to be reported. Safe staffing is monitored on Safecare Live and reviewed daily. Opel levels are being developed and piloted to flag the level of safety. A self assessment of the winter 2021 nurse staffing assurance framework from NHSI November 2021 was submitted to the Quality & Safety Committee in January 2022.
- Infection prevention remains significant due to the Covid-19 pandemic, with the rise in the Omicron variant, areas of concern are prevention of cross transmission, for which the Trust uses zoning, redirooms for isolation and cubiscreens, and a reduction in staffing availability due to the need to isolate.
- Reduced visiting during the pandemic has led to increased family concern impacting on complaints and PALS. Family Liaison assistants are in place until March 2022 and the Patient Contact Helpline to support information flows with families.
- There have been 6 Never Events in 2021/22. Local actions are in place, theatres are arranging some cultural work with teams and the Trust have secured agreement from NHSE to engage an ergonomist to optimise the accountable items process.
- Operational and redeployment pressures have impacted on the timeliness of serious incident investigations. The national timeframe for investigations remains on hold and investigations are risk assessed for prioritisation. Post investigation action completion continues to be monitored and delivered.

- VTE risk assessment compliance has been consistently below target. Risk assessments are available on Web V, and now on System One for the Emergency Care Centres. Performance is expected to improve as a result.
- Compliance with CNST remains a key challenge, with quarterly updates to Quality & Safety Committee. The key areas of challenge within the requirements are the multidisciplinary training and compliance with the Saving Babies Lives elements.

Risks also noted are:

- Facilities and funding for vulnerable patients, Changing Places are a legal requirement for new hospitals.
- Pressures ulcers (performance within expected levels) and falls (improving performance)
- Safeguarding, securing the safety of children particularly NE Lincolnshire, and noting an increase in attendance of children with mental health concerns, and the future implications of the Liberty Protection Standards anticipated April 2022. Safeguarding training remains below the 85% target at 66% for adults and 70% for children).

There remains continued good progression with the CQC action plan.

Quality Priorities

The Quality Priorities are monitored via the IPR. The highest risks from the 2021/22 priorities are deteriorating patients and sepsis, where performance is not yet fully embedded, and mortality, where the in hospital SHMI has sustained improvement in the 'as expected' range, but the Out of Hospital SHMI in North East Lincolnshire, which impacts on the overall Trust score, remains high at 132.

Recommendation

The Board is asked to note the report

NLG(22)007

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1 February 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
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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.

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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.
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Highlight Report to Trust Board

Report for Trust Board Meeting on:	February 2022
Report From:	Quality & Safety Committee on 17 December 2021 and 25th January 2022

Highlight Report:

The Committee received an assurance report from Surgery and Critical Care. Family Services presented a report on Maternity and progress with CNST requirements.

A plan to deliver 'Continuity of Carer' at scale was reviewed and approved.

An updated version of the IPC Assurance Framework was agreed.

The Medicines Optimisation report included an update on the progress with the Northumbria review; the Committee agreed to close its oversight of this issue.

The SI report noted no new Maternity serious incidents, but two new Never Events were identified and discussed.

The Nursing Assurance report raised concerns in regards to the nurse staffing fill rate, noting that while mitigations were in place to maintain safety, this remained a concern.

The Safeguarding quarterly report noted a SEND review in North Lincolnshire and an OFSTED report into NE Lincolnshire Council LA Children's Services, which found the latter service to be inadequate. The report went on to outline the measures undertaken to ensure NLAG were working to safeguard the children in the region. The Committee was satisfied that NLAG was doing everything it could to safeguard the children, but remained concerned about the inadequate findings for NE Lincolnshire Council Children's Services.

The Committee would like to commend the way the sustainability of the CQC actions are monitored and checked.

Continued progress was noted in the management of the Ophthalmology waiting list.

A report on the progress of the action plan following the investigation into the Majax.
Further clarification of sub committee oversight on related actions to be sought outside the meeting.

The recommendations for the Quality Priorities for 2022/23 (Appendix A) were supported and recommended for approval at Trust Board.

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 and are recommended to approve the Trust Quality Priorities for 2022/23 (Appendix A).

Mike Proctor
Non-Executive Director

Appendix A

Recommended Shortlisted Quality Priorities: 22/23

Following the consultation process and based on internal intelligence, the following 6 quality priority themes are recommended as the Trust's priorities on quality for 2022/23.

1. **Mortality Improvement (n=3):**
    a. Patient experience: Reduction in the number of patients dying within 24 hours of admission to hospital
    b. Patient experience: Reduction in the number of emergency admissions for people in the last 3 months of life
    c. Clinical effectiveness: Reduction in the out of hospital SHMI to 110, by March 2023.

2. **Deteriorating Patient (n=3):**
    a. Clinical effectiveness: 90% of patient observations recorded on time (*to include PEWS and OEWS)*
    b. Patient safety: Escalation of NEWS in line with policy
    c. Clinical Effectiveness: Clinical assessment undertaken within 15 minutes of arrival in ED.

3. **Sepsis (n=2):**
    a. Patient safety: Sepsis screen in 90% of patients with a sepsis six indicator (Adult and Children).
    b. Patient Safety: Sepsis Six completed within 1 hour for patients who have a Red Flag in 90% of patients (adults and children).

4. **Medication safety (n=3):**
    a. Patient safety: Improvements in recording patient weights in relation to paracetamol prescribing on the Integrated Admissions ward (IAAU)
    b. Patient experience: Reduction in medication omissions without a valid reason for ward areas using EPMA
    c. Clinical Effectiveness: Reduction / appropriateness of antibiotic prescribing *(indicator to be agreed with antimicrobial consultant).*

5. **Friends and Family Test and PALS (n=2):**
    a. Patient Experience: 60% of PALS concerns are managed within timescale (5 working days) Q1/Q2, aiming for 70% by Q4

b. Patient Experience: To improve the Friends and Family response rates: Inpatient 40%, ECC 20%, OPD 4%, Community 5%, Day case 25%.

6. Safety of Discharge (n=5):

a. Clinical Effectiveness: Discharge letter completed within 24 hours of discharge

b. Clinical Effectiveness: Outpatient Clinic Summary to be sent to the patient's General Practitioner within 7 days of the appointment

c. Patient safety: Improve the proportion of patients discharged before 12 noon *[Discharge to Assess (D2A) improvement project quality of care target)*

d. Patient safety: Improve the proportion of patients discharged before 5pm *[Discharge to Assess (D2A) improvement project quality of care target)*

e. Patient experience: Improving trend showing a reduction in length of hospital stay above 7, 14 and 21 days *[Discharge to Assess (D2A) improvement project quality of care target)*

National Quality Accounts Guidance Requirements:

Guidance recommends a minimum of 3 indicators in each domain of quality. From the above recommended quality priorities, this equates to:

- *Clinical Effectiveness: 6*
- *Patient Safety: 6*
- *Patient Experience: 6*

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	Tuesday 1 February 2022
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jane Warner, Associate Chief Nurse
Title of the Report	**Delivering Midwifery Continuity of Carer at full scale**
Purpose of the Report and Executive Summary (to include recommendations)	It is a requirement that the Board is sighted on this plan. It was presented at the Board delegate of the Quality and Safety Committee dueto Board timings. It has been reviewed by the Continuity of Carer Task and Finish group, a short-term sub-group of the Maternity Transformation Board, both chaired by Chief Nurse with Non-Exec Director support. The Maternity Improvement Advisor is also part of these groups.
Background Information and/or Supporting Document(s) (if applicable)	**Delivering Midwifery Continuity of Carer at full scale: Guidance on planning, implementation and monitoring 2021/22 (www.england.nhs.uk)**
Prior Approval Process	☐ TMB ☐ PRIMs ✓ Divisional SMT ✓ Other: HCV LMS, Better Births Strategy Group, 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)	
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

Delivering Midwifery Continuity of Carer at full scale – an implementation plan for the trust board.

Agenda item:		**Enclosure Number:**	
Date:	January 2022		
Author /Sponsoring Director/Presenter	Ann-Marie Robinson/Jane Warner/Nicky Foster		
Purpose of report	For board agreement and subsequent monitoring of a plan to achieve midwifery continuity of carer as the default model of care by March 2023.		

Purpose of Report		Tick all that apply ✓	
To provide assurance	√	For discussion and debate	√
For information only		For approval	√
To highlight an emerging risk or issue		For monitoring	√

Summary of Report:

The aim of this report is to provide the Trust Board with a detailed plan for a stepped approach towards implementation of Continuity of Carer (CofC) teams at full scale in compliance with national principles and standards, as outlined in the *NHS England 2022/23 priorities and operational planning guidance: implementation guidance*. The plan aims to deliver safer and more personalised patient care, support an engaged, healthy and resilient workforce and ensure financial sustainability. Consideration will be given to the need for maternity staff to be supported to recover from the challenges of the Coronavirus pandemic.

Details will be provided of the building blocks (see appendix A for assurance framework) needed to be in place by March 2022 so that CofC will be the default model of care offered to all eligible women by March 2023. Getting the building blocks in place will ensure our future CofC teams are sustainable and successful in delivering safer and more personalised care. An early aim is health equity - the prioritisation of those women already at greater risk of poorer outcomes and where the greatest potential impact can be made; to ensure that most women from ethnic minority backgrounds and those women from the most deprived areas are placed on a continuity of carer pathway by March 2022.

Implementing the plan to provide continuity of carer for all eligible women by March 2023, will support the trust's strategic plan 2019-2024 and meet the trust objectives to give great care, be a good employer, live within our means, work more collaboratively and provide strong leadership. The successful implementation of this plan will ensure that our maternity services are high performing and well led, offering an outstanding service that supports innovation and delivers high quality, safer care.

Recommendation:

- Accept the contents of this report.
- Support our maternity service in transformation of services to deliver this new model of care.
- The Maternity Incentive Scheme requires quarterly monitoring of this plan – agree for return of plan to board on a quarterly basis for review.
- Provide additional funds for staffing/equipment or estate requirements.

Background:

Midwifery Continuity of Carer has been proven to deliver safer and more personalised maternity care. Building on the recommendations of the Better Births report and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services, and available to all pregnant women in England. Where safe staffing allows, and the building blocks are in place this should be achieved by March 2023 – with rollout prioritised to those most likely to experience poorer outcomes first**.**

What does it mean to offer Midwifery Continuity of Carer as the 'default model of care'?

In line with *Better Births* and the *NHS Long Term Plan*, all women should be offered the opportunity to receive the benefits of care from the same small team of midwives across antenatal, intrapartum, and postnatal care. However, not all women will be in a position to receive continuity of carer, due to choosing to receive some of their care at another maternity service or, in a small number of cases, transfer of care to a specialist tertiary service for maternal / fetal medicine reasons.

Providing Continuity of Carer by default therefore means:

1. Offering all women Midwifery Continuity of Carer as early as possible antenatally; and
2. Putting in place clinical capacity to provide Continuity of Carer to all those receiving antenatal, intrapartum and postnatal care from the same provider.

As a first step, LMS agree a local plan that will include:

- The **number of women** expected to receive continuity of carer, when offered as the default model of care
- **When** this level of provision will be achieved by, and a redeployment plan into MCoC teams to staff it, phased alongside the fulfilment of safe staffing levels
- **How** continuity of carer teams are established in compliance with national principles and standards, to ensure high levels of relational continuity
- How **rollout will be prioritised** for those most likely to experience poor outcomes, including the development of enhanced models of continuity of carer
- **How care will be monitored locally**, and providers ensure accurate and complete reporting on provision of continuity of carer using the Maternity Services Data Set
- **Building blocks** that demonstrate readiness for implementation and sustainability assessment – ensuring all the key building blocks are in place.

Current position:

There are 3 established continuity of carer (CofC) teams across Northern Lincolnshire and Goole NHS Foundation Trust; 2 at Grimsby, 1 at Scunthorpe. The 2 teams at Grimsby deploy a shift based model of CofC whilst the team at Scunthorpe deploy a birth availability model of CofC. The recommendation from the national team is that the birth availability model should be adopted to offer the most flexibility and provide better relational CofC for women thus delivering better outcomes for women and their babies.

These teams have been developed within midwifery staffing from the existing establishment supported by non-recurrent funds from transformational monies. The non-recurrent funds have supported purchase of equipment, lease car costs and the Better Births Lead Midwife post. In 2020/21 the Trust regionally performed well, despite the additional challenge of a pandemic, and has been able to offer assurance to both the LMS and regional bodies.

CofC team	Daisy (DPoW)	Poppy (DPoW)	Athena (SGH)
Current caseload	23% of women at NLaG are on a CofC pathway		
Oct 2021 bookings as a % of overall	14%	17%	17%
Ethnic minorities	29%		44%
Deprivation	35%		77%
Intrapartum continuity achieved for women on pathway	67%		75%
Overall continuity achieved for women on pathway	58%		63%

The next wave of teams have been identified – 1 at Grimsby and 2 at Scunthorpe. However plans to implement these teams are currently paused due to the number of vacancies within the current establishment. Once vacancies have been recruited to we will assess our readiness for further implementation and whether transitional arrangements uphold the safety of care for all women across the service before proceeding with the next wave.

The Plan:

The plan is to roll out Continuity of Carer teams in 4 waves (wave 1 has already been completed). There will be a minimum of 3 months in between waves to allow for an evaluation of the sustainability of the newly implemented teams using a PDSA cycle and an assessment of the readiness for further implementation. It will give us the opportunity to observe if there are any emerging patterns such as a reduction in foot fall in postnatal ward/triage etc. We also want to check that there are no unintended consequences of implementation at each stage. The 3 months will also allow for training and upskilling of the staff to be redeployed into the next wave of teams. Recruitment into existing CofC teams and core teams will be prioritised prior to any new teams. This will ensure that safety of care for all women is upheld at each stage.

In addition, it will always be necessary for obstetric services to deploy a core team of midwives on a shift basis so as to ensure that sufficient numbers of midwives are always available to maintain the core service needs. At NLaG, there will always be a need for a core team at each site to provide outpatient services within the pregnancy assessment centre and inpatient services within the antenatal/postnatal areas. Once delivery of CofC has been achieved at full scale, approximately 60% of our clinical midwives will be on a continuity of carer team and 40% on a core team.

Safe staffing:

Assessment of staffing levels using the NHSE/I Continuity of Carer Workforce planning tool (see appendix B) has highlighted that, without an increase in our current establishment we will only be able to achieve partial implementation and will not be able to meet the national requirement to have all eligible women on a Continuity of carer pathway ~~by March 2023~~.

A recent review of the current funded establishment has been undertaken using Birthrate Plus. Birthrate Plus considers activity and acuity to determine the midwife to birth ratio and recommends the number of midwives required to deliver care across the entire pregnancy and birth journey in a traditional model. The Birthrate Plus assessment has recently been completed for both sites and the Trust is awaiting the results for the establishment at Grimsby and at Scunthorpe. It is anticipated that this will reflect the findings of the workforce planning tool.

Staffing pressures have hampered implementation and progress has been limited by challenges with midwifery staffing establishment. At the time of writing the vacancy rate at Grimsby stands at 9.8 wte and at Scunthorpe 12.0 wte. This is to meet the current establishment and before the outcome of the Birthrate Plus review results are known.

It is anticipated that full staffing cannot be achieved by March 2023 due to national recruitment challenges within midwifery, therefore alternative timescales are given; appendix C sets out a clear trajectory for reaching CofC at full scale phased alongside the fulfilment of required staffing levels. Our recruitment plan and implementation timeline takes into account challenges to recruitment. The length of the recruitment process, particularly in regards to overseas recruitment has been considered. An increase in applicants for vacancies will occur as current 3rd year student midwives seek to gain employment once qualified – it is anticipated that these NQMs will be ready to work Sept/Oct 2022 once they have gained their NMC registration. This explains the dates chosen for deployment of CofC teams to reach full scale. Our revised timescales will be assessed and agreed through regional assurance.

A targeted recruitment plan will include

i) Support from outside the division to launch a targeted recruitment drive to include overseas recruitment and a national recruitment campaign
ii) An update of job adverts and job descriptions to align with CofC becoming the default model of care.
iii) Work with staff, HR and unions to agree on appropriate uplift or on call payments,

considering LMNS wide agreement where appropriate or possible.

iv) Realistic recruitment time frames for recruitment and redeployment.

A review of the trust escalation policy is currently underway in order to update in line with roll out of CofC at full scale.

Planning spreadsheet

A timeline for implementation (Appendix E) demonstrates time allocated to putting in place the 'building blocks for sustainable models of Continuity of Carer.

We have used the NHSE/I workforce planning tool to plan the phased role out. (appendix B). This will demonstrate time frames for roll out, a redeployment/recruitment plan – (how many midwives and when). The tool accounts for staffing ratios demonstrating planned safe staffing at any given time during the process and providing assurance that appropriate staffing ratios have been considered.

In conjunction with the workforce planning tool, a planning spreadsheet (see appendix c) has been completed that demonstrates:

1. A total of 15 teams will be required to offer CofC for all eligible women that will be implemented across 4 waves.
2. Our CofC teams will comprise of mixed risk geographically based teams (as advised by the national team). Caseloads have been identified for each team and allocated by postcode.
3. In compliance with national principles and standards, each team will have no more than 8 Midwives in a team (headcount). The number of WTE on each team will be set by the size of the caseload for that geographical area.
4. Caseload ratios will be 1:42 as recommended and supported by the RCM. Each full time midwife will book 3-4 women per month and be their lead Midwife throughout the woman's maternity journey. Part time midwives will have their caseloads reduced according to WTE worked.
5. The percentage of women in each team that are of ethnic minority background and/or from decile 1 of the multi-deprivation index (based on 2020 bookings by postcode)
6. In line with principles of proportionate universalism, prioritisation of implementation will be given to teams with large percentages of ethnic minority groups and/or deprivation.
7. Recruitment/redeployment requirements at each wave to support a phased scale up.

Communication and engagement plan

A Stakeholder analysis has been performed identifying our key stakeholders and assessing their readiness for change. A communication and engagement plan will be developed to involve our key stakeholders and include organisational links for each key area such as HR, IT, Estates, the communications team and the RCM. This will be supported by an LMS wide communication plan.

An MVP (Maternity Voices Partnership) CofC subgroup has been set up to plan, co-ordinate and carry out engagement and coproduction with service users. This will be co-chaired by the MVP chair and the Better Births project midwife.

A series of engagement events will be planned for staff giving the opportunity to share the vision and assuage concerns in the workforce. The events will include presentations, workshops, Q&A sessions and 1:1 staff meetings to identify any work restrictions that may affect ability to work in a CofC team. There will be the opportunity for our workforce to hear from colleagues already working in CofC teams. The engagement events will be delivered by the senior management team and Better Births Project midwife with support from the LMS, regional lead and national lead for CofC.

Evidence of staff attendance will be provided and a log of responses/counter-responses will be shared with the workforce and any relevant key stakeholders.

Skill mix planning

A review of the skill mix within the whole service will be undertaken by means of a questionnaire disseminated to the clinical managers for completion of the staff working in their areas. Data collected will include:

1. The number of newly qualified midwives (NQM) (qualified <12months)
2. The number of band 5 midwives (qualified >12months and undertaking preceptorship)
3. The number of band 6 midwives
4. The number of maternity support workers (MSW) at band 3
5. The number of MSWs/HCAs at band 2
6. Any midwives with specialist qualifications (e.g critical care, NIPE)

This review will inform our redeployment plans and will ensure we have a healthy skill mix within each CofC team and the core teams. This will enable us to support a NQM and a band 5 midwife in each CofC team.

A redeployment plan for our MSWs will enable us to link an MSW to each team prioritising those teams working in areas of greatest need. MSWs will provide clinical and holistic support thus releasing additional time for the midwives to care for the women.

A bespoke engagement plan will be developed to ensure preparedness of AFC Band 7 labour co-ordinators to support programme of change, including training via an external provider. *(Leading with Kindness masterclass)*

Training and Team building

All maternity services must complete a training needs analysis. A CofC upskilling package has been developed and utilised during the implementation of the first 3 CofC teams in wave 1. This TNA will be further developed to include skill requirements for core areas. The TNA will then be completed by all midwives across the service. The TNA will identify the training requirements for

each midwife to able to move towards a new way of working. Training needs will vary between midwives as some will have already worked rotationally in recent times. A training plan will be developed for each midwife identifying the set of competencies that require upskilling/updating.

Upskilling of midwives will be achieved through provision of a series of workshops (e.g documentation, guidelines and clinical skills). Time will be allocated for staff to work supernumerary in other clinical areas undertaking "shadowing shifts" – working alongside a colleague. This could be undertaken within work time (with appropriate back fill) or as bank. The upskilling will be undertaken over a period of 3 months in between each wave implementation.

Funding has been allocated for the employment of a specialist midwife for clinical practice education who will support the provision of training.

Team building is required to ensure healthy, high-functioning teams therefore insights training will be provided for each of the CofC teams.

Linked Obstetrician

Each team of midwives must have a linked obstetrician; an individual who is an integral member of the team, who is available to the midwifery team by an agreed process. Obstetricians may be linked to more than one team.

An obstetric link for CofC has been established at DPoW for both CofC teams. An obstetric link is to be identified for the CofC teams at SGH.

Delivering CofC at full scale provides an opportunity to update how women are allocated to a consultant in order to better align the obstetricians with the CofC teams. With the support of an obstetric lead, a review of the current consultant allocation criteria for women on consultant led care pathways will be undertaken. Reconfiguration of consultant allocation will provide seamless links between the CofC midwives and the linked obstetrician thus improving co-ordination of care for women.

The role of the linked obstetrician and agreed processes/referral pathways will be included in the Standard Operating Procedure.

Standard operating Procedure (SOP)

A SOP has been completed for both models of Continuity of Carer that are currently being deployed at NLaG (a shift based model and a birth availability model). Both SOPs have been passed through the governance process and received ratification. Future CofC teams will adopt the same SOP to reduce variation in practice and ensure roles and responsibilities are clearly defined.

Midwifery Pay

NHSE/I provide information on payment calculations including the option of a salary uplift. An options appraisal, supported by HR, will be undertaken for changes in remuneration. 'Out of hours' work such as the night availability shift will be within the midwife's contracted hours to

ensure they do not work more than their contracted hours. A review of trust on call payments for midwives is underway as there is variation between sites and agreement of one arrangement for on call remuneration is required.

Estate and equipment

CofC teams will be community based. A review is currently being undertaken of where the traditional community teams are based. For a number of CofC teams, the current facilities used by the traditional teams will be retained by the replacement CofC team when implemented. For those CofC teams that require a new base, support from Estates is required to map community based resources and identify suitable facilities where future CofC teams will be based. Support from the finance team is required to map any additional costs.

A review of equipment requirements and costings for each CofC midwife has been undertaken. Equipment in use by traditional community teams will be retained by the replacement CofC teams when implemented. Additional equipment needs will be identified for each wave. (Appendix D). A review will be undertaken of current pool car provision against future needs and additional numbers identified. LMS funds for non-recurring costs to support implementation of CofC teams have supported the purchase of additional equipment for the teams in the first wave. A further offer for additional financial support for equipment to help implement CofC in the community has been sent to our LMS and we have been invited to submit a bid for additional funding to be spent by 31/3/22.

Evaluation and Review Process

Established systems are in place to audit each of the CofC measures as per the NHSE/I technical specifications. Systems analysts work with the Better Births project midwife to provide monthly CofC summaries and a formal evaluation of clinical outcomes is scheduled to take place in March 2022.

Whilst data submission via CMIS to the MSDS meets technical specification, the quality of the data is inconsistent. Support is required from the soon to be appointed Digital Midwife to embed good data practice into our service.

A highlight report of the trust's achievements and progress is submitted to the LMS on a monthly basis. This feeds into the HCV LMS CofC tracker which is completed monthly and submitted to the regional team. An assurance visit from the national team is scheduled for February 2022.

This implementation plan and milestone plan will be monitored at the Better Births Strategy Group, Obstetrics & Gynaecology Clinical Governance Meeting, Maternity Transformation Group with escalation to the Quality and Safety Committee which is a sub-group of the Board. There will be oversight by the Humber, Coast and Vale LMS.

This paper forms the revised action plan as evidence for point C of Safety Action 9 of the Maternity Incentive Scheme, year four. Board-level safety champions will oversee progress of the plan and review delivery against the plan on a quarterly basis. Dates will be set for initial review followed by quarterly review.

Appendix A - Readiness to implement and sustain MCoC assessment framework:

Item	Detail/Notes	RAG	Lead
Planning spreadsheet	Demonstrates safety from a staffing perspective: • How many women can receive MCoC - reviewing in area and out of area, cross boundary movement. • Where women are cared for at any given time, now and in MCoC models (see NHSE/I toolkit for example of this. • Midwifery deployment plan for MCoC including timescales and recruitment plan for a phased scale up to default position.		**Better Births Lead Midwife, Analyst**
Safe Staffing	• How many midwives required • How many in post • Recruitment plan to optimal midwifery staffing with time frames		**Better Births Lead Midwife**
Communication and engagement	• Provides evidence of staff engagement and logs responses/counter responses • Gives opportunity to share vision • Whether or not you plan to do a consultation		**Better Births Lead Midwife, Comms Team**
Skill mix	• Review of skill mix, including number of band 5 midwives placed in MCoC team. B5 midwives those working in the core ensuring appropriate support throughout. Band 5 (usually 1 per team) report being very well supported whilst undertaking preceptor programme. • Appropriate and planned use of MSW particularly in teams working in areas of greatest need. • Ensure preparedness of band 7 DS coordinators to support programme of change.		**Better Births Lead Midwife**
Training	Each midwife planning on working in the team has a personal Training Needs Analysis (TNA)		**Better Births Lead Midwife, Maternity Educator**
Team building	Time allocated for team building and softer midwifery development as midwives move to a new way of working. Consider organisational development support		**Better Births Lead Midwife, OD + Workforce support**

Linked Obstetrician	Has there been obstetric involvement and linked obstetricians identified? Is the referral to obstetrician process clearly set out in the SOP as well as other clinical guidance?		**Better Births Lead Midwife, Clinical Leads**
Standard Operating Policy (SOP)	Each Trust needs a SOP that outlines roles and responsibilities to support delivery of care in this way, it should pass through the maternity service governance processes as with other guidance documents.		**Better Births Lead Midwife**
Pay	RCM requests that no midwife should be financially disadvantaged for working in this way. Each Trust needs to review and manage but there is helpful information in the NHSE/I toolkit		**Deputy Head of Midwifery, HR support**
Estate and equipment	Place for midwives to see women. Equipment with which to provide care. Where problems are encountered this should be escalated at Trust Board quarterly review and to ICS.		**Estates re premises, Better Births Lead Midwife**
Evaluation	There will be local, regional, and national evaluation and reporting in place. Is there a system for this to occur smoothly?		**Better Births Lead Midwife**
Review Process	Date for initial plan to be review by Trust Board. Quarterly review dates set. Dates set for LMS and regional and national review.		**Associate Chief Midwife**

Appendix B - NHSE/I CofC Workforce Planning Tool:

DPoW				Total bookings	2454	Attrition: 11%	Total births	2190	
	Care location	**Birthrate Plus (2018)**	**Actual establishment**		**A/N and P/N care**			**Births**	**Recruitment**
Wave 1		2 teams			26%			23%	0
	CofC		14.58		640			506	
	Co-ordinators		7.72	1					
	Blue/Holly		21.84	5				1684	
	Jas/Honey		21.84	5					
	Community		19.21		1814				
	PAC		8.2						
	Specialist managers & 8a +		6.57						
TOTAL:			99.96						
Wave 2		3 teams			38%			35%	0
	CofC		22.24		934			772	
	Co-ordinators		7.72					1418	
	Blue/Holly		21.84	5					
	Jas/Honey		16.48	4					
	Community		16.91	1:90	1520				
	PAC		8.2						
	Specialist managers & 8a +		6.57						
TOTAL:			99.96						
Wave 3		5 teams			62%			57%	1.35
	CofC		36.16		1518.72			1255	
	Co-ordinators		7.72	1				935	
	Blue/Holly		16.48	4					
	Jas/Honey		16.48	4					
	Community		9.7	1:96	935.28				
	PAC		8.2						
	Specialist managers & 8a +		6.57						
TOTAL:			101.31						
Wave 4		8 teams			99%			92%	2.22
	CofC		57.8		2427.6			2006	
	Co-ordinators		7.72						
	Blue/Holly		11.12	3					
	Jas/Honey		11.12	3					
	Community		1		26.4				
	PAC		8.2						
	Specialist managers & 8a +		6.57						
TOTAL:			103.53						3.57

SGH				Total bookings	1863	Attrition: 17.6%	Total births	1535	
	Care location	**Birthrate Plus (2018)**	**Actual establishment**		**A/N and P/N care**			**Births**	**Recruitment**
Baseline	CofC								
	CDS	19.95	27.21						
	PAC	6.01	5.85						
	Wd 26	25.66	20.82						
	Community	21.39	17.62						
	Specialist managers & 8a +	6.57	6.57						
TOTAL:		79.58	78.07						
Wave 1		1 team			16%			16%	
	CofC		7.06		297			245	
	CDS		21.85	4				1290	
	PAC		5.85						
	Wd26		20.82						
	Community		15.92	1:98.4	1566				
	Specialist managers & 8a +		6.57						
TOTAL:			78.07						
Wave 2		3 teams			49%			49%	1.71
	CofC		21.69		911			753	
	CDS		16.49	3				782	
	PAC		5.85						
	Wd 26		20.82						
	Community		8.36	1:113	952				
	Specialist managers & 8a +		6.57						
TOTAL:			79.78						
Wave 3		5 teams			74%			74%	7.6
	CofC		32.69		1372.98			1134	
	CDS		16.49	3				401	
	PAC		5.85						
	Wd 26		20.82						
	Community		4.96	1:99	490.02				
	Specialist managers & 8a +		6.57						
TOTAL:			87.38						
Wave 4		7 teams			102%			102%	3.07
	CofC		45.09		1893.78			1565	
	CDS		11.12	2					
	PAC		5.85						
	Wd 26		20.82						
	Community		1						
	Specialist managers & 8a +		6.57						
TOTAL:			90.45						12.38

Appendix C – CofC Implementation Planning Spreadsheet:

Wave	Date	Team	Area/Base	Postcode	% of EMG	% of decile 1	WTE	To recruit
1	Jan 2020	Daisy	Grimsby	DN31 DN32 7	24%		7.29	
	Feb 2020	Poppy	Cleethorpes	DN35	8%		7.29	
2	28/11/22	Juniper	Grimsby	DN32 0 DN32 8 DN32 9	13%		7.66	
3	20/2/23		Nunsthorpe Scartho Waltham Hatcliffe	DN33 DN37 0	16%		7.06	1.35
			Yarborough Great Cotes Great Limber Laceby	DN34 DN37 7 DN37 8 DN37 9	16%		6.86	
4	15/5/23		Immingham Stallingborough Healing Keelby	DN40 DN41 LN7 DN36 4	14%		6.8	2.22
			Mablethorpe Maltby le Marsh Saltfleet Manby	LN12 LN11 7 LN11 8 LN13	12%		7.06	
			Tetney Louth Legbourne	DN36 5 LN11 0 LN11 8 LN11 9	6%		7.78	

Wave	Date	Team	Area/Base	Postcode	% of EMG	% of decile 1	WTE	To recruit
1	14/6/21	Athena	Scunthorpe/ CBR*	DN15 0 DN15 6 DN15 7 DN15 8 DN16 1	70%	51%	7.06	
2	28/11/22	Iris	Scunthorpe/ CBR*	DN15 7 DN15 8 DN16 1 DN17 1	3%	17%	14.63	1.71
		Venus	Scunthorpe/ CBR*	DN16 2 DN16 3 DN17 2	10%	12%		
3	20/2/23		Goole/ Goole Midwifery Centre - GDH	DN14 0 DN14 5 DN14 6 DN14 7 DN14 8 DN14 9 YO8 8	5%	10%	11	2.24 (+5.36Core)
			Isle/ Epworth health centre	DN17 3 DN17 4 DN9 1 DN9 2	2%	0%		
4	15/5/23		Barton and surrounding villages/ Barton Children's Centre	DN15 8 DN15 9 DN15 0 DN18 5 DN18 6 DN19 7 DN19 9	3%	0%	12.4	3.07
			Brigg and surrounding villages/ Barnard Court	DN17 3 DN21 3 DN21 4 DN21 5 DN20 8 DN20 9 DN20 0 DN38 6	7%	0%		

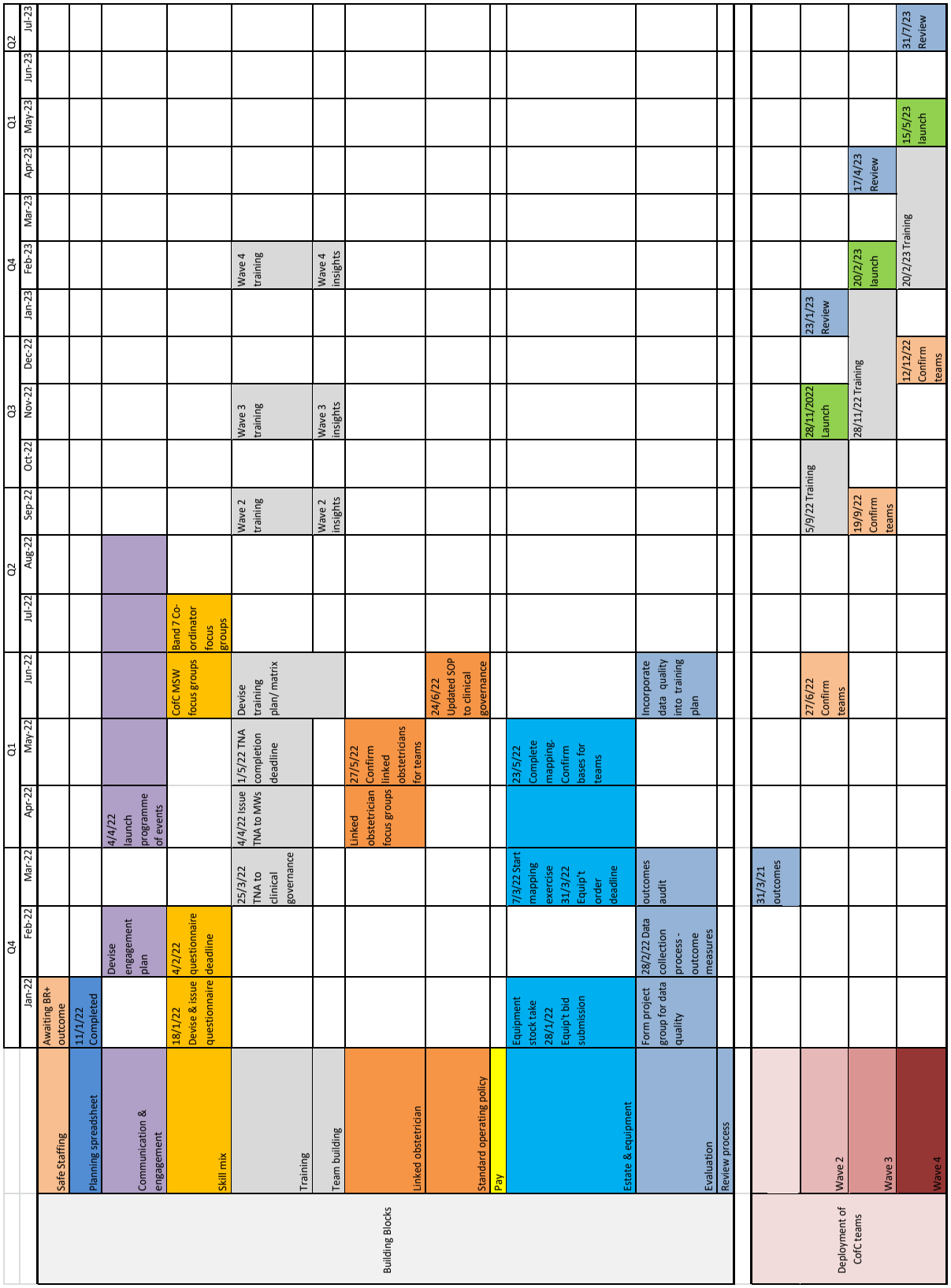
*Currently seeking alternative premises

Appendix D – Estate and Equipment

Equipment Cost per Continuity of Carer Midwife

Item	Supply Chain Code	Unit Price
Laptop bundle (4G)	Tech shop	819.00
Mobile phone	Tech shop	138.00
Midwifery kit bag	FGR887	52.88
Sphynometer	FFE819	21.00
Stethoscope	FFE1625	1.26
Pinards	FFE683	1.56
Doppler	FFY240	395.76
Thermometer	FWH225	1.06
Smokerlyser	FDD4408	202.80
Baby scales	FBU387	244.80
Baby scales carry bag	FBU565	32.47
Drug box	WYL970	4.54
		Total £1915.13

Appendix E – CofC Implementation Timeline:



NLG(22)010

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1st February 2022	
Director Lead	Shaun Stacey, Chief Operating Officer	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Executive Report – Operational Performance**	
Purpose of the Report and Executive Summary (to include recommendations)	The Operational Update details the current position with ED and ambulance waits, as well as the Discharge to Assess program and Elective and Cancer position.	
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

Urgent and Emergency Care

Highlights	Lowlights

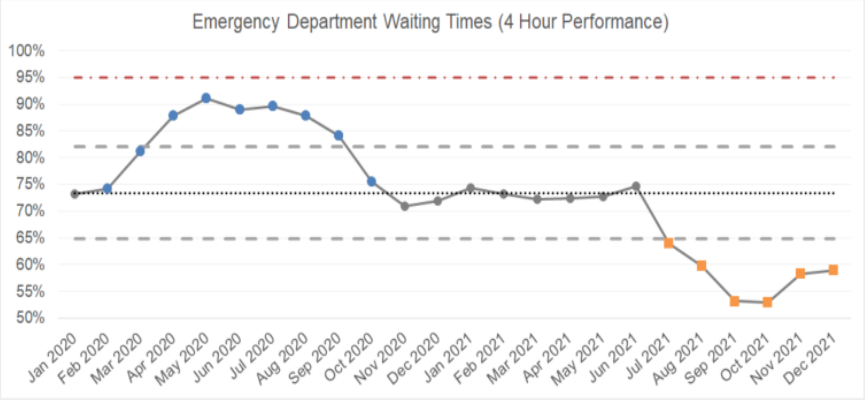
• The Urgent Care Service (UCS) at SGH is showing the following benefits:
  • UCS performance at 99.4% against the 4hr target (Dec21)
  • The waiting room is less crowded, patients are being seen quicker – Average full duration in UCS 1hr 21mins (Dec21)
  • Reduction in number of investigations carried out
  • Positive feedback from patients and clinicians
• The UCS model at DPOWH has gone live from 18th Jan
• NELCCG is continuing to work with the PCNs and systems teams to link the new UCS SystmOne module with the urgent GP hub appointments pilot to promote redirection of non-ED patients from streaming at DPOWH
• ED middle grade rota consultation took place during November. Feedback and suggestions to be reviewed ahead of publishing outcome
• Re-engagement with EMAS on direct to SDEC pathways to support non-conveyance to ED. EMAS exploring what has worked in other areas of the region that could be replicated for Northern Lincolnshire
• The new ED builds are progressing well with DPOWH expected completion in April 2022 and SGH late 2022
	• UCS at SGH has been unable to extend the service hours beyond 8pm yet due to a lack of workforce availability, both ENPs and GPs
	• UCS reporting issues results in ED only live reporting (no UCS) and delays in true 4hr performance figures
	• High levels of workforce sickness, covid-19 isolation, vacancies, low morale and impacts on staff wellbeing continue to challenge rota fill with reduction of bank/agency pick up
	• High reliance on agency doctors and nurses to support safe staffing numbers but adds challenge of less experience
	• Long delays in admitting patients from ED Resus into HDU/ITU with average 8hrs+ time spent in resus during Dec21 – This is resulting in a near continual full resus, poor patient care and added pressure on the ED workforce
	• ED attendances continue to be higher than last year with covid-19 implications and social distancing restricting the physical capacity
	• Increase in walk-in attendances with non-ED patients due to lack of alternative service availability/accessibility
	• Delays in diagnostic imaging at times and specialty in-reach not meeting the less than 30min attendance to review Emergency Care Standards

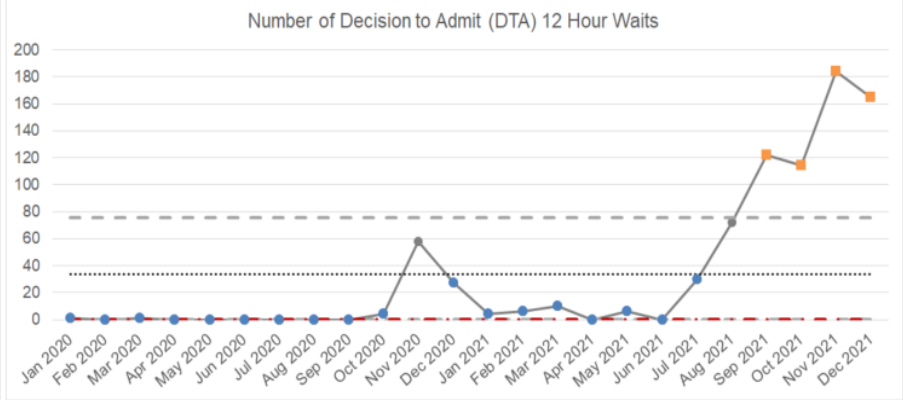
Risks

- Shortage in available workforce to meet service needs (skill mix and experience) – Reliance on agency doctors and nurses
- Risk of delays in booking in walk-in patients due to no capacity within ED waiting area to bring more patients into the ED
- Inappropriate attendances and conveyances to ED
- Covid-19 impacting physical capacity within the current ED footprint
- High acuity levels and patients remaining in resus for significant periods of time rather than being stabilised and transferred to a suitable service (ITU/HDU)

Urgent and Emergency Care

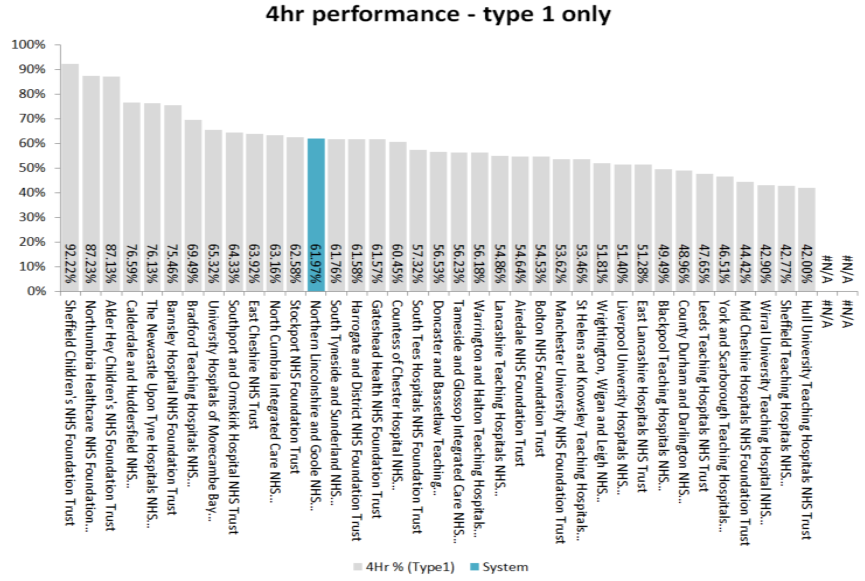
NLAG Position (December 2021)

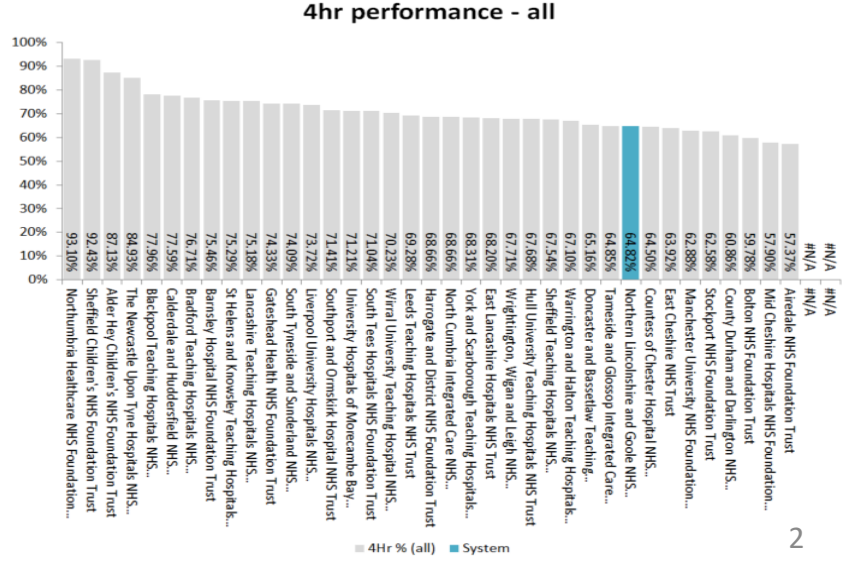




Regional Position (week ending 12/01/2022)

- NLAG in the top half of the region for performance against 4hr performance of type 1 activity
- NLAG is positioned in the forth quarter in the region for our performance for all activity types. This is because other Trusts have larger quantities of type 3 activity factored into this KPI compared to NLAG



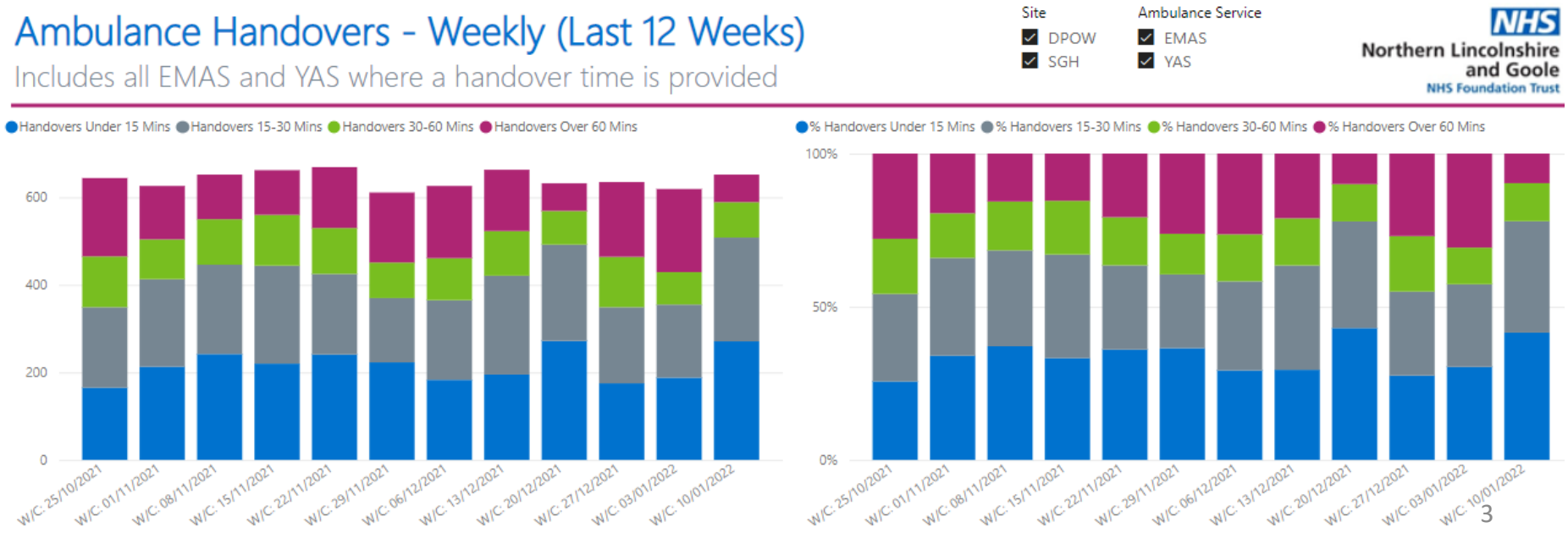


Ambulance Handovers

Highlights	Lowlights
• HCV wide ambulance improvement plan in place • Relaunch of 'direct to SDEC' ambulance pathway bypassing ED showing small increase in success of referrals • Patient self-handover protocol is compatible with UCS model for patients who meet UCS criteria	• December saw 34% of ambulance handovers completed in under 15mins and 21% taking 60mins+ (DPOWH 259, SGH 341). This is a deterioration on November's 35% and 19% respectively • Northern Lincolnshire is experiencing highest levels of acuity for EMAS conveyances impacting on resus capacity • EMAS and YAS experiencing staffing shortages, further reducing the number of paramedics in use

Risks

- Lack of patient flow through the system is resulting in exit block in ED for patients requiring admission delays in offloading patients from incoming ambulances
- Delayed ambulance handovers into ED results in reduced availability of ambulances to attend calls in the community and delayed patient care



Integrated Acute Assessment Unit / SDEC

Highlights	Lowlights
• Extension of DPOWH SDEC nursing provision from 8pm to 10pm, 7 days a week, to enable SDEC referrals to extend from 6pm to 7pm and support the rollout of UCS increased SDEC activity • The pathway to access SDEC has changed from a 'refer and accept' model to a 'notify and send' model • Patient Flow Improvement Group continues to oversee actions to improve SDEC accessibility and specialty input • FBC for new IAAU refurbishment and implementation of phase 3 of the IAAU workforce plan was submitted to NHSE/I and construction work will commence once the new ED build becomes operational at each site • WiFi mitel phones introduced on both sites, to be followed with a re-launch of direct EMAS referrals SOP • Work has begun analysing EMAS pathways to promote learning and provide ongoing support of direct referral pathways	• High levels of vacancies exist within the Acute Medicine team while recruitment continues and we are awaiting appointed medical staff to start • High reliance on bank and agency nursing for SDEC/Frailty Service creating challenges in maintaining consistent service provision • Work is still in progress on developing an IT systems integration solution for SDEC services and community (NHS111/GP/SPA) • Under utilisation of EMAS direct to SDEC pathway with mix of pathway not used by EMAS crews and failed referrals into SDEC. • Specialty SDEC capacity and access not sufficient to meet patient demand – Focus on this is part of newly established Patient Flow Improvement Group

Risks

- Reliance on sufficient daily discharges to enable flow out of IAAU is required to prevent bottleneck between ED and IAAU
- A lack of sufficient specialty SDEC capacity impacts on the ED workforce, patient waits and crowding in ED
- High vacancy levels in the medical workforce with a risk of burnout for Consultant ACPs working a high number of hours every week
- Outstanding financial approval of AAU business case delaying start of recruitment process for additional posts to cover extended hours

Discharge to Assess (D2A)

Highlights	Lowlights
• Current position - The trust is the best performing trust in the region for LLOS reporting at 9% for over 21 days this remains under the national ambition of 12% • Super discharge PDSA team in place to manage flow through all hospitals • Working with our system partners daily to ensure patients who require care when leaving the acute trust receive this within 24 hours of identification with a full escalation plan for delays in place • Improvement planning work taking place with system partners looking at the discharge process as a whole, system wide discharge improvement plan to then be agreed in the new year • Empowered ward workforce who feel okay to ask the questions why not home, why not today. • Engagement & education taking place at ward level around criteria to reside recording which will enable the trust to report a live position on discharge	• Medical and Nurse staffing numbers remain a challenge and this impacts on the overall flow on all sites and the continuation of effective board rounds. • A vast amount of work now needs to take place to improve the effectiveness of board rounds to ensure every patient has a plan, work taking place to ensure board rounds are effective through QI methodology and a PDSA approach • Significant pressures on partner organisations for home care, this has resulted in significant discharge delays and more placements to temporary care homes. • Significant pressures on partner organisations due to care home closures from outbreaks resulted in exit block from the trust • Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust

Risks

- Continued IT system & reporting improvements required to ensure all data is captured and reported accurately by our IT systems
- Significant system capacity issues across Northern Lincolnshire resulting in delayed discharges for patients on a discharge to assess pathway

Electives and Cancer

Highlights

- Cancer targets met for three of the nine KPIs in November including 2week wait –referral to fist seen in 14 days and 31 day subsequent treatment (Surgery), 31 day subsequent treatment (Drugs).
- The number of RTT 52 week plus waiters has decreased to 379 (as at 11/01/22) despite plans progressing to support mutual aid resulting in some patients transferred from Hull. Zero 104 week plus reported.
- H2 performance against plan for December 2021 is 91.7% and YTD total is 95.9%. Although there is a dip in December performance we continue to perform well at HCV level, meeting our ERF requirements.

Inpatient Elective, Daycase and Outpatient New and Review Activity Showing the 2019/20 Actual Activity, The 2021/22 Plar

	Oct 2021/22	Nov 2021/22	Dec 2021/22	Total
2019/20 Actual Activity	41,744	37,763	33,283	**112,790**
2021/22 Plan	37,448	40,655	36,356	**114,459**
2021/22 Actual Activity	36,947	39,549	33,323	**109,819**
Percentage of 2021/22 Plan Achieved	98.7%	97.3%	91.7%	**95.9%**
Percentage of 2021/22 Activity Against 2019/20 Activity	88.5%	104.7%	100.1%	**97.4%**

- Independent Sector usage continues to support with agreed H2 plans in place for St Hughs, Medefer, Medinet and Trent Cliffs.
- Inpatients Live Risk Stratification at 100% (as at 07/01/22)
- Annual Business Planning process underway for 2022/23

Lowlights

- 24 patients are waiting longer than 104 days for Cancer as at the end of November. Patients waiting 62 to 103 days remains high at 115.
- The following KPIs were not met in November.
  - Breast Symptomatic
  - 28 day Faster Diagnosis
  - 62 days RTT Urgent GP referral
  - 62 day RTT screening
  - 62 day RTT Consultant upgrade
  - 31 day Diagnosis to 1st treatment
- Following the planning guidance, each specialty will work up their plans to deliver the 25% reduction in OP Follow-ups. The local target in relation to the maximum number of overdue follow-up patients on the waiting list by March 23 has yet to be agreed
- Outpatient overdue follow-ups with no appointment booked and no risk stratification completed is 31.28% (as at 07/01/22)

Risks

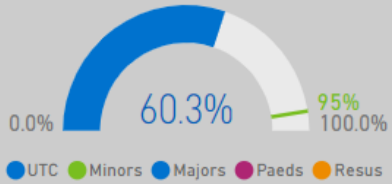
- Workforce risk around carried over annual leave
- COVID-19 related absence- significant impact affecting performance across all areas
- Capacity to deliver risk stratification for Outpatients
- Challenges to delivery of the elective recovery plan with a current risk to theatre staffing
- Offering ‘Mutual aid’ and the ‘levelling up’ of waiting lists at HCV level will have a negative effect of NLAG RTT position
- New National Priorities and Operational planning Guidance (Dec 24th) sets further challenges for operational delivery in 2022/23. A gap analysis is underway.

ED Performance

Month to Date

1 Jan 22 - 18 Jan 22

4 Hour Performance



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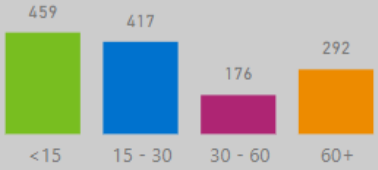
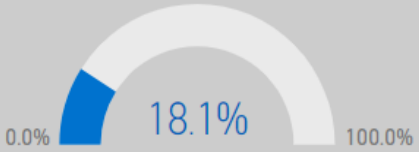
Ambulance Handover Time Brackets



Admission Conversion Rate

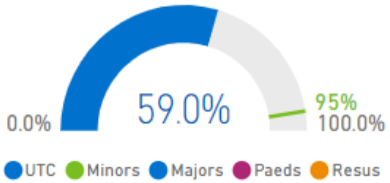


6,066 Attendances	292 Average Wait Mins
2,410 Breaches	2,489 Longest Wait Mins
1,098 Admissions	45.21 Average Handover Mins
1,344 Ambulance Arrivals	429 Longest Handover Mins
22.2% Ambulance Activity %	

Previous Month

1 Dec 21 - 31 Dec 21

4 Hour Performance



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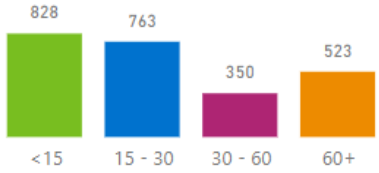
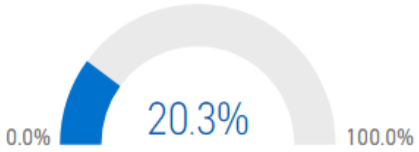
Ambulance Handover Time Brackets



Admission Conversion Rate

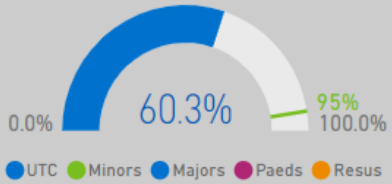


11,060 Attendances	289 Average Wait Mins
4,534 Breaches	3,179 Longest Wait Mins
2,240 Admissions	44.07 Average Handover Mins
2,464 Ambulance Arrivals	415 Longest Handover Mins
22.3% Ambulance Activity %	

Current Quarter

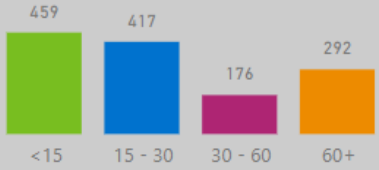
1 Jan 22 - 18 Jan 22

4 Hour Performance

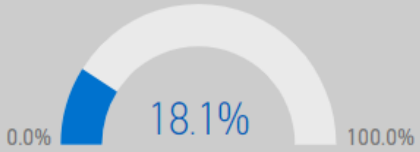


UTC Minors Majors Paeds Resus

Ambulance Handover Time Brackets



Admission Conversion Rate

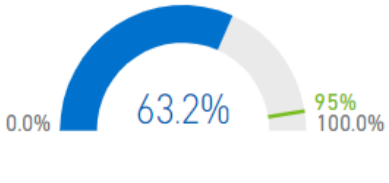


6,066 Attendances	292 Average Wait Mins
2,410 Breaches	2,489 Longest Wait Mins
1,098 Admissions	45.21 Average Handover Mins
1,344 Ambulance Arrivals	429 Longest Handover Mins
22.2% Ambulance Activity %	

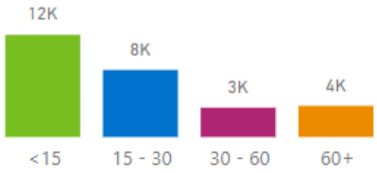
Financial Year to Date

1 Apr 21 - 18 Jan 22

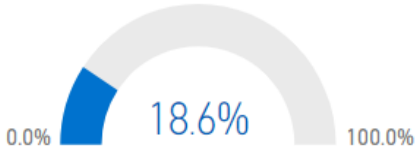
4 Hour Performance



Ambulance Handover Time Brackets



Admission Conversion Rate



118,605 Attendances	257 Average Wait Mins
43,657 Breaches	137,909 Longest Wait Mins
22,094 Admissions	32.04 Average Handover Mins
26,526 Ambulance Arrivals	476 Longest Handover Mins
22.4% Ambulance Activity %	

NLG(22)011

Name of the Meeting	**Trust Board of Directors – Public or Private**	
Date of the Meeting	1 February 2022	
Director Lead	Shauna McMahon, Chief Information Officer	
Contact Officer/Author	Shauna McMahon, Chief Information Officer	
Title of the Report	**Executive Report - Digital**	
Purpose of the Report and Executive Summary (to include recommendations)	Six month update on Digital Services. Report period: ending Dec. 31, 2021.	
Background Information and/or Supporting Document(s) (if applicable)	Report provides highlights for the board on digital strategy 2021-24 roadmap progress. Consolidates & summarizes key highlights from project reports, TMB and DSB updates into one document.	
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 x 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)		
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

Northern Lincolnshire and Goole NHS Foundation Trust

Digital Services

Trust Board 6-month Update

February 2022

Shauna McMahon, Chief Information Officer

shauna.mcmahon@nhs.net

Contents

Executive Summary

The second half of the year was extremely busy with projects initiated internally and externally. The challenge has been managing the internal needs while responding to National initiatives and funding such as the Technology Innovation Fund (TIF) that is announced with very little lead time to respond. The projects focus on one core theme – the Covid recovery, and secondly moving the trust to a digital -paper light – organization. We have developed a programme management team to manage the projects with expected due diligence for engagement, delivery, tracking time and resources. In addition, we are now working to improve our business analyst capabilities to improve our support to embed digital transformation across the organization so it becomes *how we work*. Both NLaG and HUTH Business Intelligence teams have supported the HASR work delivering data to enable geospatial modelling and further analysis of how patients could be better served across the region. The digital aspirant programme continued with approval to proceed with the new Patient Administration System implementation, WebV and Lorenzo click view enabling clinicians at both acute trusts to see patient activity at HUTH and NLaG. Digital supported a number of initiatives to improve the urgent and emergent care flow with a focus on SDEC, UEC, linking systems with SystemOne supporting the flow and access to information from A&E to primary care. The Business Intelligence team, working with NHSE/I has revamped the IPR and we now have a best practice format to work and build on. We are now focusing on the narrative, board and sub-committee reporting to

avoid duplication and working with operations to have the PRIMS reports more consistent across services. Coding and Information Governance are almost through the transfer of shared management. NLaG is managing Information Governance for the two trusts, while HUTH is managing the Clinical Coding.

One of our areas of concern is retention and recruitment challenges. NLaG and many other Trusts are struggling to recruit into system developer, clinical coding, and business intelligence roles. We have initiated relationships with external providers to build resilience and reduce impact on projects. This is especially critical for our WebV team. The management team collectively believe we will need to do a review of staffing and roles with market benchmarking for some of our current roles that retention has been a challenge.

As we close out this fiscal year and transition to 2023 an area of focus will be how we can support operations to imbed process changes for the long term. Also building a three-year capital plan that aligns with approved business planning that is underway end of January.

Digital transformation is about adopting new processes that change how work is accomplished, supports delivery of the organizations' objectives and where we can add qualitative or quantitative value.

Included with this summary is the project dashboard (Appendix A) showing progress to Dec. 31, 2021. The digital team and our supporting colleagues are proud of the work we have accomplished and trust you will be encouraged to see the progress made and how we are advancing our patient focused, digital first strategy.

Our Vision:

"To embrace digital technologies so we can provide a workplace that enables our staff to deliver the best possible care for our patients and to improve health outcomes in our community

National Digital Programme

Two significant documents were released from NHSX in the last half of the year. The *What Good Looks Like (WGLL)*framework and *Who Pays for What?*

The NHS also released the national guidance for operational recovery.

The WGLL builds on established good practice to provide guidance for care leaders to digitize, connect and transform services safely and securely. The aim is to improve the outcomes, experience and safety or our citizens.[i]

WGLL is included in both the ICS design framework and the NHS Operational Planning and Contracting Guidance,[ii] reflecting the expectation that the standards in the WGLL framework will be used to accelerate digital and data transformation. The guidance describes what success looks like for an ICS and for organizations.

The WGLL framework has 7 success measures:

1. Well led
2. Ensure smart foundations
3. Safe practice
4. Support people
5. Empower citizens
6. Improve care
7. Healthy populations

NHSX is now engaging with system CIO, CCIO, CNIO's to launch toolkits that will help providers with achieving the levels of success. Some of the items include a minimum viable product that outlines the expected functions that suppliers must meet to provide an EPR in the NHS. Other toolkits relate to the IT Architecture expected to ensure ICS and providers can support the applications and integration required for future service delivery. One of the early tools being launched in 2023 is an assessment framework which we will use to measure our level of digital maturity. This will help identify gaps and prioritise areas for local improvement. Assessments will be repeatable so organizations can track progress year-on-year. Frontline support in terms of funding and expertise will also be available. In the last quarter of fiscal 21/22 we have started to

benefit from the funds through the Targeted Investment Fund (TIF). NLaG has received funds to support Cyber Security work, Connected Health Network, Attend Anywhere, as some examples. In addition, we have a regional maternity system recently procured so all women can access their maternity notes and information through smart phone or other device by 2023/24. The system will provide information in digital format to those that are supporting mums-to-be. We will remove paper processes for this population.

NLaG is an active participate with our ICS helping to shape the digital and data strategy, establish governance and working on "levelling up" plans for the region.

Who Pays for What? recognized the challenges in the past with multiple funding sources being released at variable times with no clear target or focus. The Unified Tech Fund (UTF) was created and brought various funding lots together with a framework of what was in scope and out of scope.

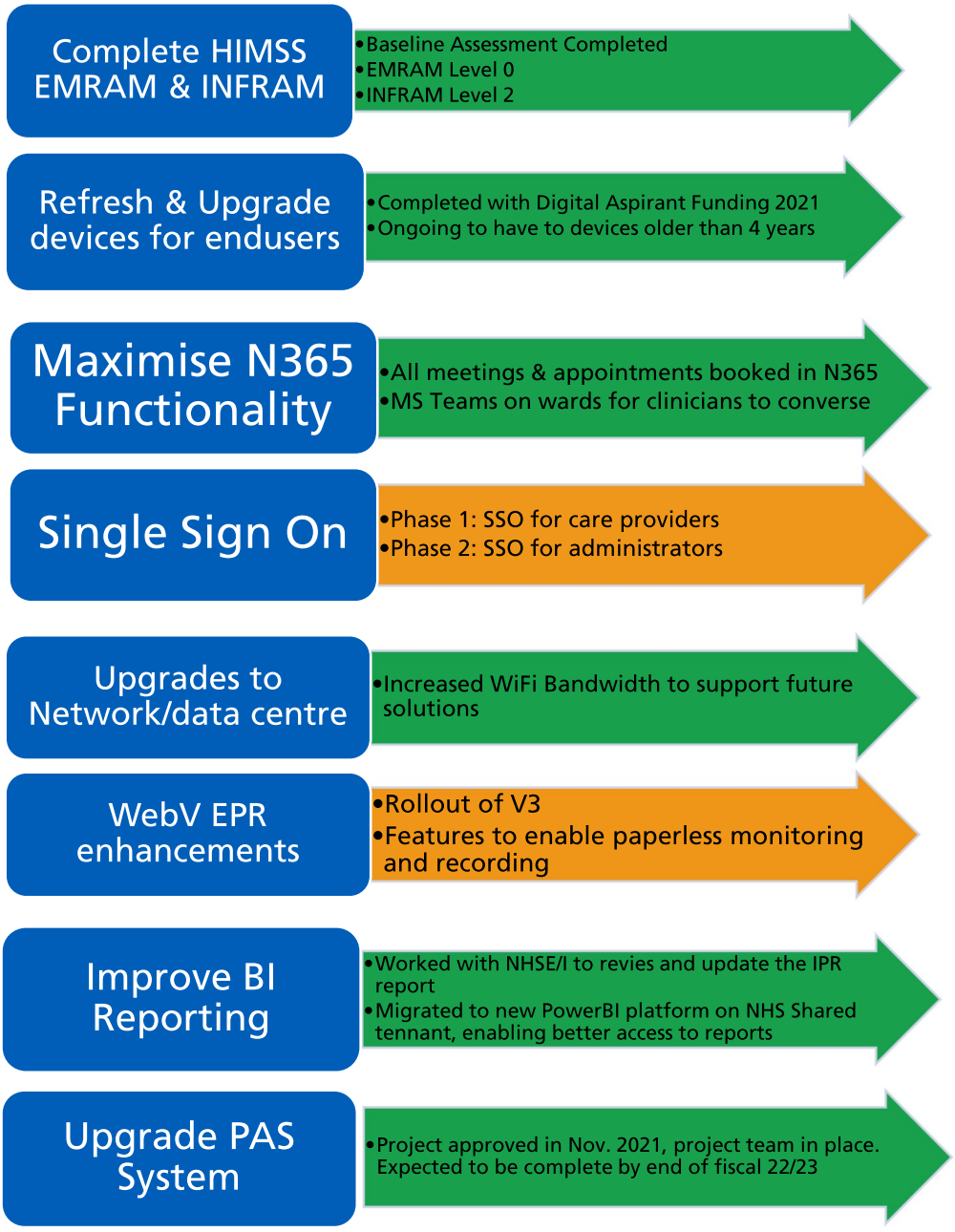
The UTF prospectus outlines the money available, scope, and criteria for application to the following areas of funding:

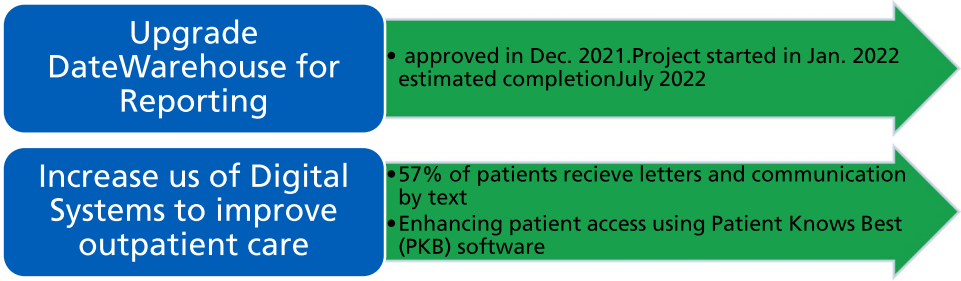
- Frontline digitisation
- Shared care records
- Cyber security capital infrastructure
- Cyber security remediation revenue
- Digital productivity
- Pharmacy, optometry, dentistry, ambulance, community (PODAC)
- Diagnostics
- Elective recovery technology fund
- Digital maternity
- Digitising social care

NLaG has worked with our ICS colleagues to create our ICS funding priorities. As an ICS our digital strategy is based on the principle that we will adopt open standards and an open platform for our digital environment. We do not want to be held to one supplier but prefer to adopt the priority - data and information is to be on an open platform so we can control and manage how we share our data. We are continuing to work with our ICS colleagues to "level up" across our region.

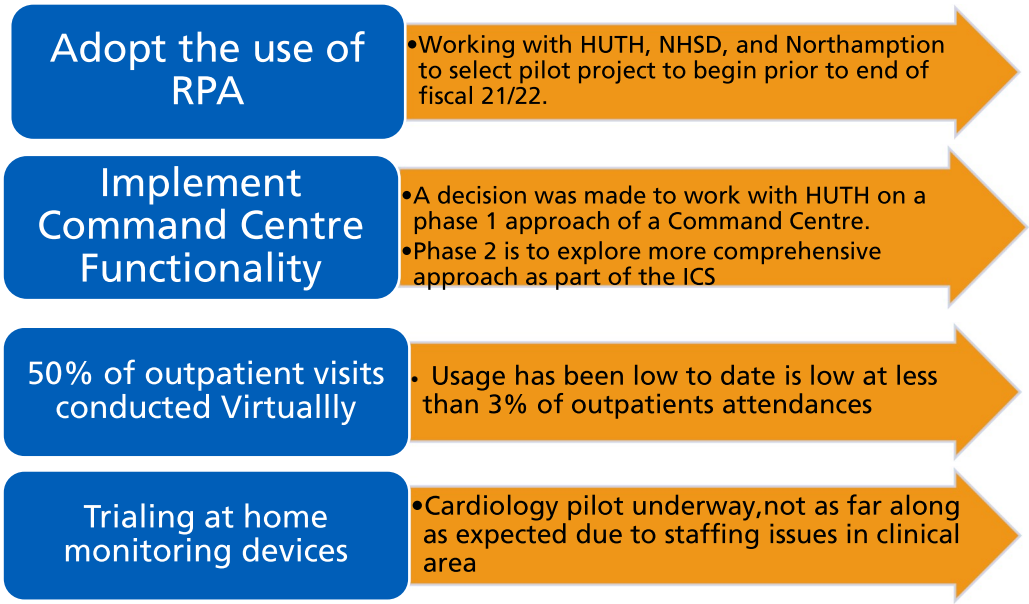
Our Digital Roadmap 2021-2024

Level 1 Maturity Map





Level 2 Maturity Map



Clinical Updates

Chief Medical Information Officer; Dr Alistair Pickering

In the last six months I have continued to focus on building relationships with the clinicians and focusing on the areas where we have identified gaps in establishing digital patient pathways. I have been working to understand the processes in A&E while working with digital services to identify gaps and improve on those areas. I am leading the Theatres digital improvement group and have led the renewed focus on completing the Results Acknowledgement process for diagnostic reports. In addition, I am working on the risk stratification process for those that are waiting for care and to triage those most at risk by developing a more automated way to stratify those patients.

In January 2022, I will assume the Chair role of the Digital Strategy Board. This aligns with the vision of having clinically lead digital governance. I continue to facilitate the digital requirements and potential that is evolving as part of the HASR work and ICS digital agenda. As noted in this report, my focus in 2022 will be moving the paper processes to digital, and finding ways to streamline the work for the delivery of clinical care.

Chief Nursing & AHP Information Officer; Martin Sykes

SCAN4SAFETY
Patient. Product. Place. Process.

Since joining Northern Lincolnshire & Goole NHS trust in August 2021 I have tried to see as many of the teams as possible, and observe how everyone works, and the challenges that they face on a daily basis. One of the challenges that I have adopted is to see our trust work towards achieving the scan4safety standards. By utilising barcode scanning across all aspects of patient care, we can ensure that for every process that takes place we have the right patient, the right product in the right place. This will improve the safety of the care we deliver, reducing the rate of clinical incidents, providing additional time for our clinical teams to devote to patient care, as well as saving money that can then be spent where it is needed most.

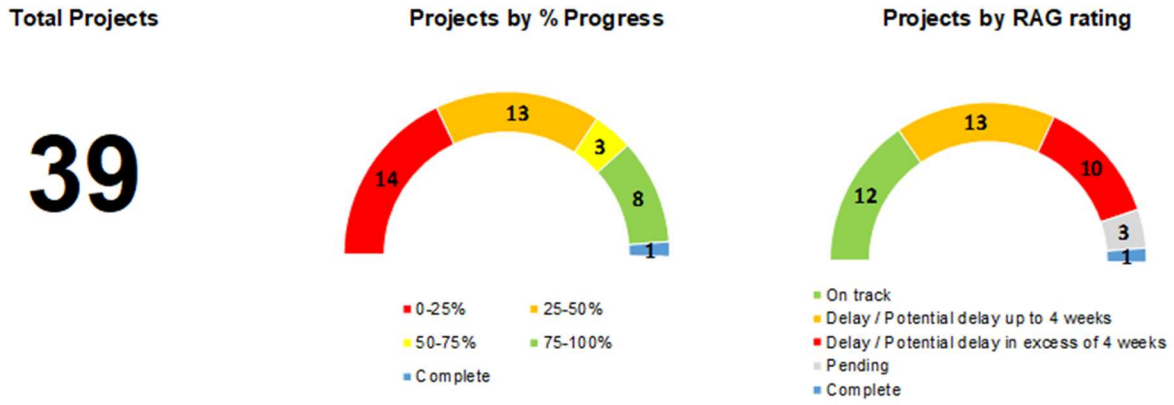
In addition to my CN&AHPIO role I am also the Clinical Safety Officer for NLaG, and in this role I ensure that any software that we use for patient care is safe to use, and this has included the approval of the TytoCare products used by our paediatric teams to enable effective care of patients whilst they stay at home.

Before I started my role at NLaG I had become a Topol Digital Fellow with Health Education England. This 1-year fellowship has enabled me to learn a variety of digital skills, agile project planning, and allowing time to concentrate on a digital project. I am coming to the end of this year long fellowship, and I have completed my project to identify the features that are required and desired in a digital package to run an effective Patient Initiated Follow Up for oncology services. I am looking to publish this work soon and hope to scale this work to other services. The Topol Fellowship is also a network of likeminded digital clinical NHS staff, from a variety of backgrounds, which I will continue to be able to connect with as a Topol Alumni, to provide mutual support, advice, and guidance as we all develop our own digital clinical careers.

Adopting Digital

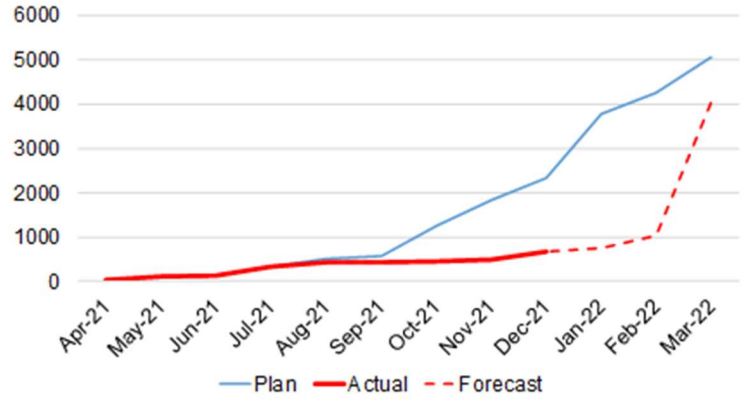
It is an exciting but challenging time in the Trust's journey of Digital Adoption. A significant programme of work is being delivered through the Digital Transformation Programme Management Office (PMO). This recently created function is bringing a level of oversight and coordination across all projects within the Digital Aspirant Programme, together with other digital initiatives. This ranges from significant projects such as the Trust's PAS replacement, all the way through to storage enhancements for clinical imaging.

There are currently 39 tracked projects on the programme, with an additional number in waiting following approval through the digital governance approval process. A breakdown of the 39 individual projects can be found in Appendix A.



Funding for the wider programme is being provided by a number of external Public Dividend Capital (PDC) opportunities (including the Digital Aspirant programme funding), combined with existing capital/revenue allocations. The overall programme including matching funding has an allocation of £5m in 2021/22. At the end of Q3 2021/22, spend has been limited to £674k, however large capital proposals have recently been approved, meaning the majority of spend will be committed before year end and the remaining balance managed effectively.

Programme Funding



Funding	5,060
Spend to Date	674
Remaining	4,386

Digital Highlights

Digital Supporting Patient Care

Digital Patient Communication

Digital out-patient letters have been implemented in all specialities achieving £64k of savings July to Dec 2021. On track to deliver the predicted business case savings of £123k per annum. 162,000 letters have been sent digitally with 57% of patients having accessed the digital portal.

Patient Knows Best (PKB)

Pilot in Cardiology has commenced but limited progress has been made due to clinical nurse resourcing issues in the Speciality.
At home equipment currently in procurement.
Capital funding for licenses has been obtained via TIF to support rollout across all specialities across the ICS in 2022-23 - this does not include revenue funding for project implementation (potential resolution on 20th Jan).

Connected Health Network (CHN)

A £1.2m capital investment has been secured through the ICS TIF bid to support with costs for a digital solution for the CHN model across the ICS.
Does not include revenue funding for project implementation (potential resolution on 29th Jan).
TPP SystmOne currently building a demo module for testing with the project team. Demo module scheduled for Feb/March 2022.

Video Consultations

Video Consultation platform Attend Anywhere was implemented in April 2020. Virtual reception staff are in place on all 3 sites.
TIF bid has secured funding for licences for Attend Anywhere platform until March 2024.

Video consultation usage is low at less than 3% of outpatients attendances.
ICS is using Harrogate to pilot use of Teams as a vehicle for video consultations – outcome will influence choice of future software platform.

WebV

Out-Patient Module - Pilots undertaken in Orthopaedics and Cardiology Services. Additional functionality is now available in the form of dictation software (Dit3), agreement to re-pilot this functionality prior to extending the module further.
Electronic Discharge Summaries – Development of a day-case template and increased auto-population of existing system data has been progressing for the last 6 months.

Clinical Coding

The Clinical Data Improvement Program (CDIP) as a focused project will end March 31, 2022. That does not mean the work ends. As this moves into business as usual, the team will continue to work with clinicians to ensure the information required to report the SHMI and quality data for coding continues to improve.

Following the successes of year 2, the final year of CDIP has seen a greater number of challenges. Engagement between Clinicians and the Coding Team continues to be problematic with pressures on services and staffing due to the pandemic and sickness. The quality of health records remains an ongoing challenge for the team, where documentation is either missing or mis-filed. At the point of being received by the coding team, this is adding to the time taken to process a set of case notes. Plans are underway to transition this monitoring and improvement of these issues under regular operational oversight once the programme finishes.

Additional electronic toolsets including a new Clinical Encoder have been delayed due to dependencies with the main PAS replacement project. This now forms one of the workstreams within that wider project, due to go-live in Q3 2022/23. Some additional efficiency is expected to be delivered from the new system, which will reduce manual overheads of the coding process. Other processes continue to be standardised with the HUTH Clinical Coding department, such IQVIA Coding Analysis which is now in use across both Trusts. IGVIA is a data analytics company and is used to analyse clinical coding data and provide insights on where improvements can be made as well as other insights for data improvement that they are able to quickly analyse on their platform.

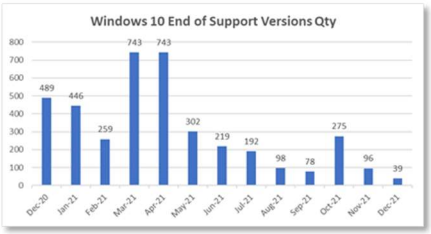
Our latest SHMI score for January 2022 is 107.8 which continues to be in the 'as expected' range. This remains stable and has shown a slight reducing trend over the last 3 months. Similar issues in clinician availability and case note quality are also impacting the coding of mortality data. Full clinical reviews for 100% of deceased patients with In-hospital and out of hospital deaths are continuing, however the impact of this process due to clinician and staff availability remains a constant challenge. A new digital application is being launched in the next 6 weeks, which aims to alleviate some of the manual aspects and assist with tracking of this process. The application is an internally developed application by our digital developers called Cobra. Modifications are being made to help track the mortality tasks. We have used Cobra for other things such as clinical harm review and is essentially a workflow system. Some small adaptations will allow it to be use for mortality review tracking.

Information Technology

Windows 7 to Windows 10 Migration

Digital Services has successfully migrated 99.6% of its computers from Windows 7 to Windows 10 meeting the NHS Digital target of less than 1% of estate remaining on Windows 7. The remaining Windows 7 machines either cannot be upgraded (i.e. medical device) or a system that these devices connects to requires an upgrade in order to be able to move the device to Windows 10. We are working with suppliers and Trust services on implementing these upgrades where available

Windows 10 Operating Systems – Unsupported Editions



Microsoft periodically ends support for certain Windows 10 editions and as a Trust we must ensure that we upgrade these with supported editions. Several editions have fallen out of support over the last year and we have been pushing out regular updates for these. We are currently down to 39 unsupported Windows 10 devices which we are locating and upgrading.

IT Service Management System

A new IT Service Management (ITSM) system has been purchased to allow Digital Services to undertake its services in a more efficient way using the IT Service industry standard service model ITIL. The system will allow us to better manage IT Assets, Service Calls, Monitoring of Systems, Security Access, Change Control, Contracts and much more. This service will begin to go live in stages from March 2022.

Mobile Devices (Tablets / Smartphones)

The choice of mobile devices has increased significantly now that we are able to rollout and support both Apple iOS devices as well as Android devices using the newly introduced mobile device management system (MDM). This system allows us to easily deploy mobile apps to these devices remotely, secure the devices against cyber threats and update them remotely when required.

Microsoft 365 (Teams, Word, Excel, PowerPoint and much more …)

We have started our journey to move online to Microsoft 365 in the cloud for all our 'Office Applications' and so far, we have seen the move from a variety of unified communications systems such as Skype for Business, Zoom and GoToMeeting to all Trust staff using Microsoft Teams to video conference and collaborate. Further work is being undertaken to look at adding Telephony Voice integration to Microsoft Teams to give a truly 'mobile' work from anywhere experience to support home/hybrid workers and this should be available in Q2 2022.

New Microsoft 365 versions of standard office packages such as Word, Excel, PowerPoint, OneNote, etc. are currently being rolled out across the Trust and these new office packages will receive regular updates with new functionality coming with each update.

Further plans with Microsoft 365 include creating in the cloud office e-document store accessible from the internet on any device mobile, tablet, computer which will be available in March 2022. A communications 'hub' to provide central Trust messages will follow closely afterwards which will include rich dynamic content. Currently 100% of staff have office online, and we are at 383/3000 (12%) of the M365 apps for enterprise are rolled out.

New Devices Deployment

New laptops, desktops, computer screens and mobile devices continue to be deployed to ensure staff have up to date modern equipment which can run the latest software and systems to assist staff in undertaking their duties quickly and efficiently. We have so far delivered over 350 new 24" computer monitors, 700 Laptops/Desktops and 17 new large ward screens.

Upgraded Wi-Fi Network Points & Internet Speed

The Wi-Fi network infrastructure continues to be updated with old wireless access points being replaced by new ones. These new wireless access point will provide more stable and improved wireless connectivity for many devices such as Vocera, mobile phones, laptops, tablets, medical devices and support more devices talking through a single access point as well as providing improved access speeds. Over 180 WiFi Access Points have been upgraded so far including new network switches to support these. In addition to this we have upgraded our connection to the internet giving a 100% increase in speed.

ePMA

Funding was granted to NLaG to implement electronic prescribing across all adult inpatient services at all three hospital sites within the trust. All adult medical, surgical and maternity in-patient wards are now using ePMA for electronic prescriptions, ahead of schedule and within budget.

In addition to this, the VTE assessments have been adopted within the ePMA package, which has resulted in full compliance for VTE assessment compliance. In December 2021, additional Emergency Care wards were set up for DPoW & SGH, which has enabled clinicians to commence an ePMA chart for patients in the emergency department, so that medications can be administered, whilst the patients are waiting for a bed to become available on a ward.

Work has now begun to investigate if the ePMA can be used to manage medications for paediatric patients, and if successful, NLaG will be the first NHS trust to achieve this, using the EMIS ePMA solution.

There is also additional work being undertaken to enable electronic prescriptions to be generated for outpatient services, which will create a completely paperless medication prescription service.

WebV Development

Next Major Release Update

- V3.7
    - To include
        - Document Upload
        - Yorkshire Humber Care Record (YHCR)
        - Instant Messaging
        - IPC Monitor Outbreak
        - V3 Reason to Reside (V3 Discharge Module Phase 1)
    - Final customer requests for v3.7 being agreed
        - NNUH complete
        - NCIC Agreed
        - HDFT in progress
        - Currently small development 3 items outstanding before QA stage.
- V3.8
    - To include
        - V2 - V3 Core, Information Screens (including bi-directional interface with PAS for ADTs), e-Observations.
        - Cardiology Order Comms
        - Clinical Handover Module

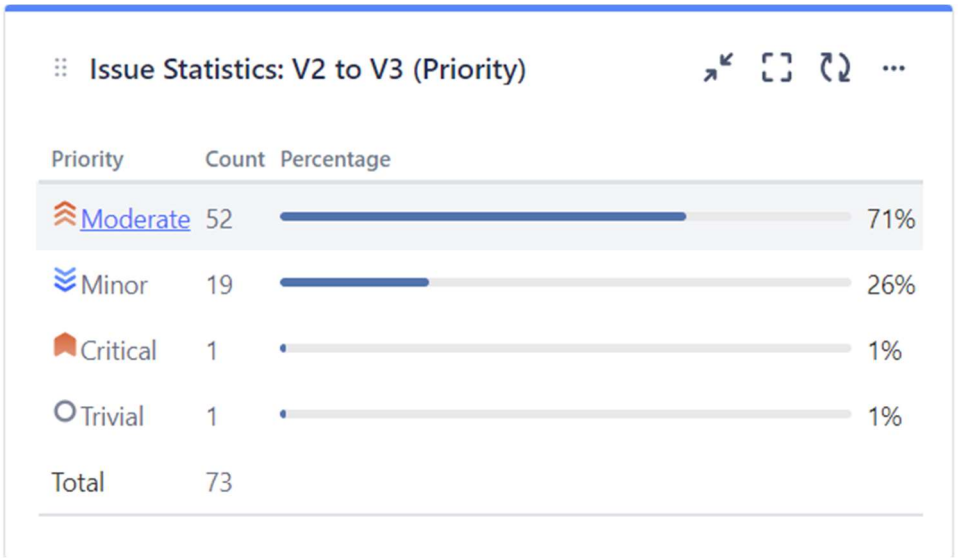
WebV continues to evolve in an "agile" way. There are currently 154 Items awaiting Development.

Version 3 Migration Progress

- Paediatric Admission Document
    - Planned Restart April 2022
- Clinical Noting
    - GNRC and Paediatrics Implemented and LIVE
    - Wider rollout to begin on Stroke following formal project kick off.
- Adult Admission Document
    - Project Scoping Stage, Lead Martin Sykes
- Diagnostics Order Comms (Pathology and Radiology)

  - 2 week Pilot underway (GPs and Acute care), once pilot complete wider rollout to begins.
- Results Acknowledgement
  - Go Live on 2nd February.
- Outpatients Module
  - Pilot on Cardiology ongoing, Gynaecology and Orthopaedics planned.
- Comorbidities Implementation
  - Rollout Project in scoping
- Theatres System
  - Specification Document with S&CC for approval

A review of the 154 development request, the 2 most pressing are changes to handover process and Cardiology user stories. The diagram below shows the priority tracking.



Cardiology User Stories to be done for the module

Developing our Team

Technology and digital services are now part of our everyday lives. The opportunities available for people to work in digital roles continues to expand. The NHS is competing with the private sector to secure skilled employees and turnover is costly and impacts the ability to deliver projects. There are many strategies to retain great employees, one of which is supporting their development in ways that helps boost confidence and pride in being a digital professional. NLaG digital became an organizational member of the British Computer Society (BCS) in 2021. This membership is providing an opportunity for some of our employees to achieve their RITTech, FEDiP, or other recognized credential that will raise the professionalism of the team. BCS also offers a breadth of continuous learning and engagement opportunities that our employees can participate in to keep them current and achieve a level of professional recognition they might not have had the chance to do so. We had our first session in January and have six champions facilitating this work. We also provide access to an online learning platform called Udemy.

Areas to Focus Improvement

- Embed process changes using digital solutions and remove paper based process
- Track printing and minimize/ remove printing where digital working is enabled
- Track what clinical documentation is not entered direct into a system, and digitize those processes
- Meet DSPT compliance with specific attention on the asset register and business continuity and recovery plan, and achieve cyber essentials standard for digital
- Continue work with ICS to populate the YHCR, integration of business intelligence and analytics and population health management reporting for system reporting
- Using the minimum viable product as a guide, complete the functions expected of an EPR and increase our HIMSS EMRAM and INFRAM scores

The next 6 months

- 70% completion of the PAS implementation
- Completed the new Data Warehouse implementation
- Activiate a minimum of one BOT as part of the RPA project
- Complete the business case and prepare procurement strategy for the Enterprise Document Management Solution (EDMS)
- Begin implementation of Single Sign On (SSO)
- Launch the Digital Board Development sessions (March 2022, Cyber Session in Autumn, review in March 2023)
- Business planning cycle is starting last week of January with operational teams meeting to review plans and priorities. Digital will review those and add to our current in progress plans to create a 3 yr capital plan.

To conclude, this past six months has been one of the most ambitious and busiest for digital services. There are more projects running, some quite complex, covering a number of service delivery areas than in previous years. We have improved our infrastructure, the next fiscal year, will be one where we will put emphasis on closing gaps to deliver a seamless digital pathway for patients, and work to meet the expected standards for "what good looks like".

Appreciating that our healthcare colleagues are exhausted and all of us are hopeful we are moving out of the pandemic, in digital our focus is on how to reduce the gaps in digital and make life easier for our end users and patients to work within the system. In addition, we will look at ways to bring more digital innovation into our organization.

The support of the Board, Executive and Governors is critical to the organisations ongoing digital journey.

Appendix 1: Digital Programme Details

Digital Transformation Programme

Author(s): Chris Evans/Steve Mattern
Date: 17th January 2022

Report No: 06
Reporting Period: December 2021

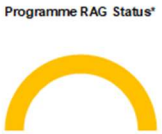
NHS Northern Lincolnshire and Goole NHS Foundation Trust

Summary

Key year 1 & 2 Digital Aspirant projects are continuing to progress alongside projects on the wider Digital Transformation Programme. Current slippage is being managed across the programme. A meeting is scheduled with NHSX mid January to discuss status and a possible change control notice to realign timescales to those being reported through the Trust's internal governance processes.

The PMO continues to review projects, both ongoing and requested, identifying those which require prioritisation and resource requirements. While progress is being seen, YTD spend remains low as large capital amounts are currently being authorised before year end. Spend forecast estimates an underspend for £926k at year end. Discussion over options for capital transfer to 2022/23 is encouraged. If unavailable, spend will be committed, prior to year end rather than being relinquished. The programme is reporting Amber status for this month due to underspend status.

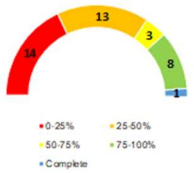
Programme Rating



Digital Transformation Projects Status

Total Projects

39

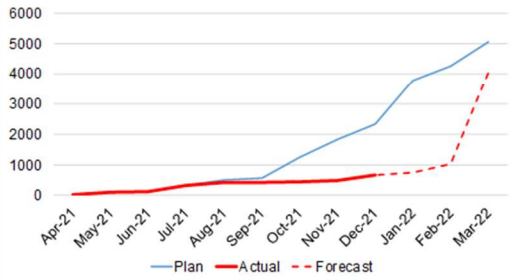


Milestone Schedule

Milestone	Description	Date	Status
FM1	Funding Milestone 1	Mar-21	Complete
FM2	Funding Milestone 2	Sep-21	Complete

On track | Potential delay / delay up to 4 weeks | Potential delay / delay in excess of 4 weeks

Programme Funding

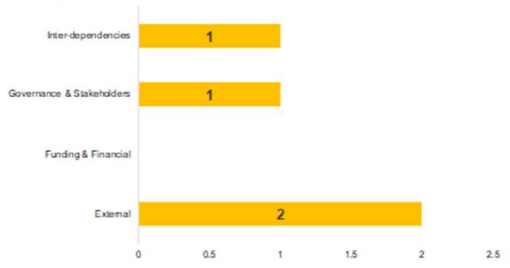


Funding	5,060
Spend to Date	674
Remaining	4,386

Programme Risks

Reported Risks

Risk Categories



Programme Detail

Projects	Status	Narrative	Projects	Status	Narrative
IT Equipment Replacement	Red	30/12: 43% of the equipment has been installed. Options to speed up rollout under review. 1 resource starting Jan/Feb to help with rollout.	Windows 10 Enterprise Migration	Red	30/12: All devices that can be have been upgraded. The rest are reliant on system dependencies which are awaiting upgrades. All Windows 7 devices that can be have Extended Support (IT Security updates only) installed until January 2022, this will need to be re-bought to take us to January 2023
IT Network Infrastructure	Red	30/12: 46% of the equipment has been installed	Virtual Server Farm Hardware	Red	30/12: Work continues with the migration, RIS, QPulse, Central and Sentinel completed. Pauses when the trust is in Opel 4
IT Service Management System	Amber	17/01: New project manager starting to pick this up.	ePMA Project	Green	04/01: All Medical, Surgical and Maternity in-patient wards are now on ePMA. Work will commence in the New Year to look at Paediatric services. • The ePMA – WebV discharge link has been tested on Ward C6, over several weeks, and has successfully transferred the correct information to the GPs. Further expansion of test wards will be needed to undertake the WebV validation process. Following this, the ePMA and WebV teams will then jointly send out the training videos and comms trust wide. It is anticipated that roll-out across the Trust will be site by site to ensure all relevant staff are aware of the change in process before the transition occurs. • ePMA – WebV Contextual link, work has restarted to look at the contextual link to launch ePMA from WebV without the need to sign in twice. • VTE assessments – the Information Team are now working on removing the non-ePMA wards from the Trust reporting Hub so in future the reports will accurately reflect the compliance
Foetal Ultrasound System	Amber	17/01: Testing of non-obstetrics system slowing down due to supplier resource availability. Obstetrics config started last week.	WebV V3.7	Amber/Green	04/01: As part of moving all customers onto a single version release path, WebV are moving some customer minor release items into V3.7 in order to draw a line under requirements. Ongoing.
Xltek EEG System	Amber/Green	04/01: Project documentation being updated. Planning underway to agree implementation date early 2022.	Outsourced Providers (Medefer etc)	Green	30/12: Reviewing project scope to link in with further IT infrastructure objectives in Q4. Rolled out to a number of specialties and continuing, more operational involvement with input as required from systems. Rollout continues as BAU.
Huntleigh CTG Archiving	Green	17/01: Handover to BAU in progress.	DictateIT Upgrade	Green	04/01: Cohort 1 – Live. Working on decommissioning 3 Depts on DIT2. Audit of Assisted Speech Recognition in-progress. Pre-engagement sessions arranged in Jan 2022 for 3 Departments in Cohort 2, planning go live dates in Feb 2022
Spacelabs Cardio Navigator	Green	17/01: Handover to BAU in progress.	Symphony Version 3.0	On Hold	04/01: On-hold waiting on phase 2. Work due to start in 01/22 and complete by end 03/22.
Data Centre Enterprise Architecture	Amber/Green	30/11: Looking at potential data centres going forward. Looking at if we could get existing suppliers to do some free work. Not a significant priority currently.	Symphony Utilisation Enhancement (inc bed request)	Red	04/01: Symphony changes live 07/09/21. WebV changes for electronic bed request from Symphony testing bug fix. Aim to implement by end Jan 22.
WebV / Lorenzo Integration	Amber/Green	04/01: WebV out to Lorenzo is currently at validation stage, NLG still awaiting HUTH approve access to Lorenzo TEST in order for us to test our link.	Symphony Utilisation Phase 2 (SCR/CP-IS)	On-Hold	04/01: Still awaiting formal approval. Testing/run through setup with the Supplier taking place ealry Jan 2022. Communications to be drafted to users & training material provided.
Lorenzo PAS Replacement	Amber/Green	17/01: All workstreams now running. To-be process mapping to start this week. Identifying how to set up clinics in Lorenzo.	ED New builds Tech Workstream	Amber/ Red	30/12 - PM and BA starting next week on this work. PM will develop a more robust plan for Grimsby go-live in May 22.
Enterprise Content Management (EDMS)	Green	14/01: Scoping continuing, and looking to pull together what the next 3 months looks like. Looking at supplier options.	ICS Maternity System	Green	13/01: Preferred supplier identified as Clevermed. Contract negotiations are underway. This will allow alignment with Badger in Neonatal from same supplier.

Projects	Status	Narrative	Projects	Status	Narrative
Single Sign On	Green	30/12 - Business case paper being updated around benefits and financial model being reviewed around capital models.	E-Rostering - Community	Complete	12/01: The upgrade to V11 has been completed and the project closed.
Robotic Process Automation (RPA)	Amber	17/01: PM started Jan complete the justification case and manage the pilot with the aim of delivering a process automation by the end of March. They will also run workshops to identify how we could scale up through next year.	Somerset/E-Referral/IPT Module	On-Hold	04/01: Pending decision on funding for the work.
Command Centre (HASR)	Green	30/12 - Kick off meeting with Cloud2 on 13th Jan. NLaG ops reps are engaged and attending.	Patient Knows Best - Patient Portal	Green	13/01: The document interfaces for Cardiology reports, Inpatient Discharge Summaries and Outpatient Correspondence have all been built but the Trust is unable to test due to issues that need resolving with the suppliers. Live and being piloted in cardiology. Some delay until resource available to monitor and
Data Warehouse	Green	17/01:Supplier sending draft of joint contract with HuTH. Planning demo for 28/1. Meeting on 8/2 re links with PAS and Data Warehouse	Digitial Comms - Digital Letters	Amber	13/01: Outpatient letters in closure, patient and staff surveys to be sent out. Work to start in Inpatient and Endoscopy letters and on text reminders.
Next Generation Firewalls (HSCN) - Caretower (supplier)	Red	30/12: Project Meeting was held on 22nd Dec. Supplier actioned to update the deployment plan for approximate dates for next steps	Ophthalmology Digital Processes	Amber/ Red	17/01: Data extraction from the field analysers is anticipated to take 65 hours, which with the project resource availability of 1 dpw will cause significant delays.
NGF - Remote Access Service (RAS)	Red	Senior Network Engineer continues to have Wednesdays as dedicated time to work on project	Pathology Long Term Storage	Red	05/01: Confirmation of funding received - approx £752K. Awaiting quotes and looking to direct award with existing supplier. Funding to be spent by 31/03/22.
Two Factor Authentication (RAS)	Red	7th Jan meeting to plan the communication for the deployment of new VPN with MFA	Opthalmology Community Hub	Amber	04/01: The development split into 4 groups:Digital (initial discussion with James, Graham and David to discuss scope of project), they are awaiting further detail on property and next steps. Property – in the process of identifying suitable premises within Scunthorpe High Street then work to commence on proposal for building works required. Activity/Flow – being worked through with clinicians and CNS staff to understand model. Equipment – equipment list being drawn up
Office N365 Enterprise Migration	Amber	17/01: New project manager starting to pick this up.	Augmented reality glasses - Community nurses	Pending	13/01: Technical discussion set up for 17/1 to find out more and review interface with Systmone. Clinical meeting set up for the following week. Pre-project stage.
IoT Enterprise Management	Green	30/12: Required for DPST, risks due to timescale and resources. Further demo 3rd wk of Jan. Funding to be spend by end March 22.			

References

What Good Looks Like?
https://www.nhsx.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/

Data Security and Protection Toolkit
https://www.dsptoolkit.nhs.uk/

Sustainable ICT and Digital Services Strategy 2020-2025
https://www.gov.uk/government/publications/greening-government-ict-and-digital-services-strategy-2020-2025/greening-government-ict-and-digital-services-strategy-2020-2025

Net Zero Carbon
https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2021/06/B0507-how-to-produce-a-green-plan-three-year-strategy-towards-net-zero-june-2021.pdf

Technology Code of Practise
https://www.gov.uk/government/publications/technology-code-of-practice/technology-code-of-practice

Digital Technology Assessment Criteria (DTAC)
https://www.nhsx.nhs.uk/key-tools-and-info/digital-technology-assessment-criteria-dtac/

Professional Records Standards Body (PRSB)
https://theprsb.org/standards/

Who Pays for What?
https://www.nhsx.nhs.uk/digitise-connect-transform/who-pays-for-what/

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	1 February 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 from 22 December 2021 - Performance**
Purpose of the Report and Executive Summary (to include recommendations)	• A&E 4-hour performance and ambulance delays over 60 minutes had deteriorated, but the UCS model at SGH continued to treat 98% of patients within 4 hours. • The Trust had started taking patients from other Trusts' waiting lists as part of levelling up across the ICS. • Diagnostic performance had improved considerably, but it would be another 2 months before improvements in Non-Obstetric Ultrasound would be seen. • The Trust had been unable to meet the 62-day cancer standard, due to high demand and lack of oncologists. The Cancer Alliance were working to improve performance. • Outpatient transformation continued with good results, but non face to face consultation had declined • Deep dive on progress with sustainability initiatives
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting
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:	1 February 2022
Report From:	Finance & Performance Committee – 22 12 21

Highlight Report:

- A&E performance and ambulance delays over 60 minutes had deteriorated mainly due to difficulties discharging patients to appropriate care settings, which affected between 30 and 50 patients a day. Discharge to assess performance was in the top 3 regionally and top 6 nationally. The UCS model at SGH treated 98% of patients within 4 hours. A UCS at DPOW was planned in January 2022, but that would not assist the flow of majors through A&E.
- MRI and CT waiting times had reduced to a level of 1-2 days, leading to an improvement in Diagnostic performance and better patient care, but it would be another 2 months before improvements in NOUS would be seen.
- The Cancer Alliance was working jointly on seven areas to improve performance against the 62 day standard.
- The Trust remained on track to clear 52 week waiters by 31-3-22, but a requirement to level up the ICS would impact on NLAG waiting list recovery. The impact would be reported in monthly performance reports to F&PC.
- Outpatient transformation continued, but there had been a decline in non-face to face consultations. The results of a recent patient survey showed that 93% of patients found them more convenient, 41% preferred them and patients also responded favourably on being listened to and having the opportunity to ask questions. Those results would be shared with clinicians, as there was a perception that patients preferred traditional face to face consultations.
- A deep dive report on progress with Sustainability initiatives was received. The biggest risk to delivery of planned improvements was the need to gain agreement to spend grant money allocated for 2021/22 on work that could not be completed until 2022/23. If agreement could not be reached, work would have to stop and the Trust would have to reapply for funding to complete the work in 2023/24, as the application deadline for 2022/23 had passed.

Confirm or Challenge of the Board Assurance Framework:

A deep dive into BAF Strategic Risk SO1 1.5 was completed.

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

NLG(22)013

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	01 February 2022	
Director Lead	Christine Brereton, Director of People	
Contact Officer/Author	Christine Brereton, Director of People	
Title of the Report	Executive Report – Workforce and Leadership	
Purpose of the Report and Executive Summary (to include recommendations)	The people report outlines highlights, low lights, and risks in month. The risks are aligned to the People Risk Register and are consistently triangulated.	
Background Information and/or Supporting Document(s) (if applicable)	Not applicable	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Not applicable
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)	Not 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

People Directorate December 2021

Highlights	Lowlights	Risks
Workforce Committee A deep dive into Trust wide sickness was produced and tabled at the committee which outlines an overview of the current and previous sickness levels and trends experienced by the Trust, including risks and mitigation. The committee also received the standard agenda items in line with the programme of work such as the People Strategy Q2 report and the Freedom to Speak Up Q2 report.	**Turnover** Turnover has gradually deteriorated over time since the start of the pandemic in April 2020 to present**.** The latest turnover data point is 10.95 % which is just over the Trust target of 9.4% which indicates that the turnover position is not improving or seeing signs of recovery in relation to pre-pandemic levels of turnover of 9%. A deep dive to identify hotspot areas is to be undertaken areas where interventions are needed.	

WORKFORCE:

1st April - Mandatory vaccinations (Vaccination a Condition of Deployment (VCOD) Programme)
The Trust has had a project group in place since mid-December working on this initiative led by SRO Christine Brereton. The project has been very focused on engaging, enabling, supporting and educating unvaccinated individuals in order that they can make an informed choice. The trust has been asking staff to declare their vaccination status. The first milestone is 3rd February whereby staff will have needed to have their 1st dose if they are in scope of the regulations and be able to have their 2nd dose by 1st April 2022. National guidance has been received and the trust is following this. A more formal process will be put in place for those staff who remain unvaccinated. This will be put in place from 4th February 2022.

COVID Booster/FLU Campaign / Mandatory Vaccination –
The Covid booster campaign has been running throughout October and November seeing hub closures at the end of November due to low uptake following a period of high engagement. Resources have been provided to support the community vaccination programme at staff where redirected there. The hospital hub for staff vaccination were reinstated in January to support the VCOD programme and this has been widely communicated to staff.

11th November – Mandatory vaccination in Care Homes
All outstanding staff in focus of the 11th November legislation will be brought in line with the management process for the April 1st legislation that applies more broadly.

Omicron
The Trust continue to update guidance in relation to Covid-19 as and when national guidance is released. Highlights for December have mainly been in relation to isolation measures and 28 day self-certification for sickness.

Risk Assessments
Work continues with risk assessments and is part of the on-boarding process for new starters and is managed by recruitment. Work continues to finalise those outstanding.

AFC Panel Process
Panels are now booked throughout January and February in line with the new co-

Corporate risk now added to the register in relation to the potential risk to the provision of care with a potentially reduced workforce. This risk continues to be mitigated in line with the reducing trend of unvaccinated staff.

designed process with NHS Employers. Training will take place early February which will enable greater panel availability and therefore quicker timescales. **Formal HR Process** The Trust continues consider disciplinary cases in line with the pilot launch of Just and Learning Cultures that enables managers to deal with adverse incidents involving staff in a more meaningful and learning way. A revised disciplinary policy and JLC framework are due for ratification in March 2022 to formalise these processes.		Delay in publishing a revised disciplinary policy in line with national Dido Harding recommendations.
Trust wide Vacancies Trust wide vacancies have reduced in month by 20.41 WTE, with an overall vacancy of 9.45% which remains within control limits in line with the Trust's IPR. Recruitment activity continued across various work streams including recruitment for international nursing, medical and dental, unregistered nursing, and AHPs. Various projects are underway including targeting areas previously not utilised, continuing use of the medical training initiative, and reviewing processes. Travel difficulties are delaying starts for new employees for overseas, with regular engagement taking place to facilitate starts as quickly as possible.	**Vacancies** Covid continues to make international recruitment difficult due to the closure of borders. Travel guidance has relaxed, however given identification of new covid strains it is likely that travel restrictions will now again increase. Sourcing accommodation remains a concern, particularly family accommodation. Recruitment and accommodation teams continue to work together to explore options however rental accommodation is currently is short supply.	**Recruitment -** Failure to recruit to clinical hard to fill posts will result in an increased vacancy rate with increased agency cost and compromised service delivery.
Sickness Absence - Over the last 3 months the sickness rates have slowly increased to 6.2% as of November 2021. The increased sickness rate is due to an increase in the number of covid related absences. Short term sickness is being driven by gastrointestinal problems and influenza (covid inclusive). Daily monitoring has recommenced with ICC and Infection Control lead to monitor specifically covid absences.		**Sickness –** Levels of sickness have increased and are likely to continue do so in the winter months causing workforce pressures

Trade Union Partnership The Trust is currently focused on reviewing facility time with TU's. This involves a review of current agreed time against demand. The Trust has agreed additional facility time with the RCN as an outlier who now have an additional 25 hours per week to utilise.		
LEADERSHIP CULTURE & OD **Staffing:** Band 7 ODBP Leadership appointed	**Staffing:** Some posts within the team remain unfilled which is causing delays to service delivery on our OD objectives.	
Equality Diversity and Inclusion: The Trust Diversity Calendar has been published to showcase and promote key events. The October version promoted Black History Month and we held a number of drop-in sessions / engagement events during October to celebrate the benefits diversity brings to our Trust. Additionally, we shared the nationally recognised 'History Teacher' children's diversity book with our staff, which was kindly commissioned and donated by the Trade Union Unison. The November and December calendar has been published and this is promoting Disability History Month and some further events are being planned.	Low NSS response rate as anticipated but +2% up on 2020	
Culture & Engagement Transformation Programme The People Pulse Survey commenced Dec 2021 and closes 31st January 2022. The National Staff Survey closed 26th Nov 21; comprehensive communications campaign proved effective with +2% increase in response rate:2020 @ 36% 2021 @ 38%; analysis of results will commence Jan 2022 for Trust wide reporting and action planning aligned within Culture Transformation work; Focus group work to support NSS and Culture Transformation commenced with VCOD/HWB/EDI engagement sessions Dec 21 onwards		
Health & Wellbeing: Running until March 2022, we are part of the NHSEI HWB Trailblazer pilot consisting of 7 streams of HWB activity, supported with a Community of Practice.Workstreams 1-4 are in progress. Workstream 1: Data Gathering, continues to be gathered from a wide range of sources to provide the necessary intelligence to run the diagnostic tool efficiently. Workstream 2: Baseline	**HWB:** Considering how best to utilise underspend resources for HWB to ensure that they have maximum impact before the end of the financial year	**HWB:** ICS monies would potentially need to be returned if they cannot be spent by the end of the financial year**.**

Scoping, initial data has been entered into the diagnostic tool and a very basic diagnostic carried out to understand the position before January pressures and target interventions accordingly. Baseline scoping will be repeated at the end of January when further robust data is available. On site counselling is now available one day a week at Grimsby and one day a week at Scunthorpe. A new approach trialled with Remploy to support staff who are experiencing stress or mental health issues which are impacting upon their work has now been successfully embedded, with a clinic on 1st December attracting 8 attendees, of which 6 have already converted to engaging with the service and 2 are expected to do so, giving a confirmed conversion rate of 75% and a potential conversion rate of between 87.5% - 100%. CISM training has been completed by 4 staff members who are now qualified CISM de-briefers, next steps are currently being planned by HCV to develop a regional network of CISM trained de-briefers who can respond when a traumatic incident occurs. The HWBBP has joined the HCV's Task and Finish Group to support the development of the CISM policy. Several HWB training events are due to take place. Resilience Training in partnership with the HCV Resilience Hub has been arranged, with 4 cohorts of staff from OD, HR, Training and Development, Recruitment. Nursing, Medical and Communities and Therapies taking part in training in January and February, focusing on individual, team and leadership resilience, to bolster the ability of staff across the divisions to better face challenges at work and better support their staff in doing likewise. MECC/Health Champions Training is also taking place in partnership with C&T, with North Lincolnshire Council acting as delivery partners – first session on 1st February. HWB Steering Group has been refreshed and additional membership included to lead on HWB strategy and support the delivery of the Trailblazer Pilot. Revised TOR's have been presented and are currently being finalised. The January meeting of the group will focus on short term interventions which can be put in place to support staff through the pressures of the next few months. Schwartz Rounds are being planned, with the first round to hopefully take place in June 2022, several key staff have already been identified to lead the rounds		

and a meeting with the Point of Care Foundation is taking place at the end of January to discuss next steps.

The HCV Resilience Hub are working with staff in ITU to deliver weekly Team Resilience and Wellbeing sessions until the end of January, following which evaluation of this intervention will be carried out.

The HWB ODBP is making contact with all managers of red wards, to discuss what additional support staff in these areas may need and create bespoke support packages.

EDUCATION & TRAINING

Mandatory training and appraisal*:*

Core mandatory training is currently 93% for the Trust, role specific 80% and PADR 83%, there has been a slight rise in compliance over the past 3 months. The training team continue to work closely with HRBPs and divisions to ensure data is correct and put in place support to target low compliance. Focussed work on areas of non-compliance continues. This was discussed at the Workforce Committee.

Statutory and Mandatory Training Review:

The ETD has commenced an overarching review of the statutory and mandatory training requirements for the Trust. Moving the Core (statutory) training to the Core Skills Training Framework (aligning with most Trusts nationally) and further paring down our Role Specific mandatory training will reduce the time required to complete and maintain compliance. The review will include refresh of relevant subjects, building contemporary E-learning modules where required, and including some statutory requirements in pre-onboarding processes to further reduce the amount of time new starters have to spend in completing this training.

Apprenticeships:

The total number of apprenticeships ongoing in the Trust is currently 200 learners and 17 new starts between October – December 2021. Focussed work is ongoing with apprenticeship providers to enhance the understanding of apprenticeships to attract larger cohorts and working with departments to support current workforce initiatives.

Corporate Induction: Refresh of programme underway **LEADERSHIP DEVELOPMENT** **Leadership Development Strategy:** Presented to Chief Executive; 1:1's with executive stakeholders planned Jan 2021 followed by Board 5th April; scoping for values based leadership programme underway; leadership baseline skills inventory in design; baseline skills modules refresh assessment commenced; People Leader Induction and core skills modules – design underway **Executive Development**: A series of executive development sessions have been recommended for inclusion in Board Development to support advocacy for the Culture & Engagement Transformation Programme.	**Annual Appraisal**: Not compliant with Trust target- currently 83% against a target of 85%. **Mandatory Training**: Currently achieving 93% against a target of 90% for core mandatory training and 80% against a target of 85%for role specific mandatory training- remains on People risk register until consistently achieving. **Apprenticeships:** The Trust does not currently meet its public sector requirements of 2.3% of the organisation headcount for new apprenticeship starts.	**Mandatory Training and Appraisal:** Due to the current capacity issues in staffing, staff are not being released for training, some training has had 100% DNAs due to operational demands. ETD continues to regularly assess risk **Apprenticeships:** The ability to fully utilise the apprenticeship levy without increased activity to recruit to vacancies. **Leadership Dev/mt:** Securing funding required for delivery

NLG(22)014

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1 February 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 M09**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights the reported financial position of Month 9 of the 2021/22 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.

Finance Update Report 2021/22: Month 9

1. **Report Outline:**

This report covers the Trust's financial performance for the year to date ending 31st December 2021. It covers the following areas:

- Financial Position Overview;
- COVID-19 Expenditure;
- Temporary Staffing Analysis;
- Savings Programme;
- Elective Recovery Funding;
- Capital;
- Balance Sheet, Cash and Working Capital;
- Underlying Financial Position
- Conclusion

2. **Financial Position Overview:**

	M9 £m
Current month Actual I&E Surplus/(Deficit)	**0.56**
Current month Planned I&E Surplus/(Deficit)	**0.39**
Current month Variance I&E Surplus/(Deficit)	**0.17**
YTD Actual I&E Surplus/(Deficit)	**0.37**
YTD Planned I&E Account Surplus/(Deficit)	**0.38**
YTD Variance From Plan – I&E Surplus/(Deficit)	**(0.02)**

The Trust reported a £0.56m surplus for the month of December, which was £0.17m better than plan. The year-to-date position is now a £0.37m surplus, which is £0.02m worse than plan.

Income was £0.07m better than plan in month

• Clinical income was £0.15m above plan mainly due to minor favourable variances on private patient, overseas and injury recovery income. ERF income was £0.47m above plan (see paragraph below). Covid outside envelope income was £0.11m below plan due to a pause on vaccinations in November/December as a result of low uptake and low vaccination stock. Other income was £0.15m above plan due to additional QSM funding support. Donated income, excluded from NHSE&I financial targets, was £0.68m below plan due to continued delays in the Salix Energy scheme.

• Elective Recovery Funding (ERF) – the Trust achieved £0.72m ERF income in month, £0.47m above December's plan, due to backdated ERF for October and November following national changes on how the fund is distributed. There has been ERF income achieved by several specialties in H2. This is subject to volatility and subsequent validation as the Trust achievement of ERF income is dependent on the overall ICS position.

Pay was £0.49m overspent in month

• Medical staff was £0.4m overspent primarily due to Anaesthetic Middle Grade rota delays, agency premiums for covering vacancies in Urology, Ophthalmology, Gynaecology and Paediatrics, additional waiting list expenditure in Cellular Pathology, and an estimate for unfunded Middle Grade pay reforms.

• Nursing was £0.03m overspent in month. There were underspends due to Midwifery vacancies, but these were offset by Trust-wide overspends due to use of escalation and surge beds, increased staff absence and implementation of Chief Nurse safety recommendations.

• Other Pay variances include admin underspends partly offset by £0.03m Flowers costs, for which the Trust has not been reimbursed (£0.27m year-to-date).

Non Pay was £0.42m underspent in month

• This was mostly due to independent sector outsourcing underspends, partly offset by additional ERF activity in General Theatres, Orthopaedics and Ophthalmology, and high cost drugs overspends relating to additional outpatient ERF activity across Gastroenterology and Respiratory.

Post EBITDA items were £0.24m underspent in month

• This was mainly on depreciation and dividends due to capital programme delays.

COVID-19 Specific Expenditure

• The Trust has incurred £9.96m year-to-date expenditure as a direct consequence of the pandemic, marginally within its covid expenditure funding of £10.81m (£11.35m total covid funding less £0.54m funding for loss of car parking income and loss of other income).

3. COVID-19 Expenditure:

The Trust incurred £9.96m additional expenditure year-to-date relating to Covid-19. This compared to year-to-date covid expenditure funding of £10.81m (£11.35m total covid funding less £0.54m funding for loss of car parking income and loss of other income), including £1.16m outside envelope income. Covid-19 income outside envelope was due to testing, vaccination and student nurse costs.

The year to date covid expenditure by NHSI category is displayed in the table below:

Expenditure Category	Year-to-date 21-22		
	Pay (£k)	Non-pay (£k)	Total (£k)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	2,290	0	2,290
Existing workforce additional shifts to meet increased demand	4,177	0	4,177
Backfill for higher sickness absence	1,587	0	1,587
Total Testing - In Envelope	360	68	428
PPE associated costs	0	7	7
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0	6	6
Remote management of patients	6	0	6
Segregation of patient pathways	0	43	43
Decontamination	0	199	199
Additional PTS costs	0	7	7
After care and support costs (community, mental health, primary care)	0	45	45
Outside Envelope - COVID-19 - Vaccination Programme - Provider/ Hospital hubs	133	8	141
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	15	34	49
Outside Envelope - COVID-19 virus testing - Rapid / point of care testing - locally procured reagents costs	0	747	747
Outside Envelope - COVID-19 virus testing - Rapid / point of care testing (for DHSC provided Samba2, DNA Nudge, Primer Design, LumiraDx and Abbott ID NOW)	25	0	25
Outside Envelope - NIHR SIREN testing - research staff costs	18	0	18
Outside Envelope - Antibody Assays	0	34	34
Total COVID-19 Expenditure	8,751	1,204	9,955
Total Trust Operating Expenditure (including COVID-19 expenditure and all other operating expenditure)	245,093	100,874	345,967
COVID-19 % of Total Trust Operating Expenditure	3.6%	1.2%	2.9%

The material reasons for this expenditure were:

- Additional shifts put on due to Covid-19 process impacts on ward reconfigurations, red and green patients, zoning and segregation
- Additional ED shifts at consultant and middle grade levels
- Self-isolation and on-call exemption costs for covering high-risk staff
- Bank incentive rates (ceased from 31st July 2021)
- Virtual ward and SPA costs
- Purchase of additional Rediroom canopies and additional screens

Indicative funding for covid inside envelope expenditure shows a reduction of 57% in 2022/23, therefore the Trust must look to minimise these costs where possible and as a matter of urgency look to assess its expected exit run-rate for COVID-19 specific expenditure.

The Trust forecast expenditure is also however largely influenced by NHS national guidance on Infection Prevention and Control, and on staff risk assessments for on-call exemptions. The trust needs to agree as soon as possible where it will reduce its covid expenditure and increase its activity productivity back to 19-20 levels.

The current Trust forecast covid-19 expenditure, displayed by reason and in descending order, is as follows:

21-22 Covid Expenditure Forecast - By Reason, Descending Order

Expenditure Category	Actual (£k)									Forecast (£k)			Total (£k)
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Ward / Bed Changes	275	347	284	415	386	688	375	391	383	366	366	366	4,643
Shielding and Isolation	439	382	358	386	316	232	202	209	140	134	121	121	3,042
Bank Incentives	188	163	166	150	9	6	6	4	15	14	14	14	749
Swabbing Centres	33	69	49	46	51	60	45	43	51	49	49	49	595
Patient Facilitators / Liaison Staff	38	47	44	39	29	32	23	24	24	20	19	19	357
Decontamination	18	35	25	21	59	25	18	26	25	24	24	24	325
Hot Clinics - Orthopaedics	13	29	29	29	29	29	29	29	25	24	24	24	315
ED SpDr & Consultants	65	65	65	0	0	0	0	0	0	0	0	0	196
Other	40	24	22	17	0	1	19	11	4	3	3	3	148
Virtual Ward	32	33	29	14	(10)	8	(0)	0	0	0	0	0	107
AAU Extended Days	5	5	8	6	5	5	5	5	5	5	5	5	63
Staff Counselling	8	1	9	1	3	7	5	5	5	5	5	5	60
Redirom Canopies	29	0	2	0	0	30	0	0	0	0	0	0	60
SPA Expansison	9	9	9	8	(7)	0	0	0	0	0	0	0	27
Lateral Flow	0	0	13	2	0	0	0	0	0	0	0	0	15
Inside Envelope Forecast	**1,193**	**1,211**	**1,112**	**1,133**	**871**	**1,123**	**728**	**747**	**677**	**645**	**630**	**630**	**10,700**
Testing	96	85	80	117	70	65	104	107	119	141	141	141	1,264
Vaccinations	46	27	(7)	3	0	3	27	23	24	16	10	12	184
Band 4 - Nursing Students	95	38	3	0	0	3	0	0	0	0	0	0	139
International Recuitment Quarantine	0	0	0	0	6	0	0	0	11	17	8	7	48
NIHR SIREN testing - Research Staff Costs	0	0	0	12	2	1	1	1	1	1	0	0	19
Outside Envelope Forecast	**236**	**150**	**76**	**132**	**77**	**72**	**132**	**131**	**154**	**175**	**159**	**160**	**1,653**
Grand Total	**1,430**	**1,361**	**1,188**	**1,265**	**948**	**1,195**	**861**	**878**	**831**	**819**	**789**	**790**	**12,354**

Inside Envelope Divisional Breakdown:

Chief Nurse	22	30	30	25	19	20	18	21	16	12	11	11	235
CSS	91	39	38	31	9	37	7	5	3	3	3	3	269
CTS & FS	238	214	185	187	110	117	82	66	87	84	84	84	1,538
Digital	1	1	2	1	0	0	0	0	0	0	0	0	5
E&F	68	82	70	54	71	45	50	47	49	47	47	47	678
Finance	0	0	0	0	0	0	0	0	0	0	0	0	1
MD	0	0	0	0	0	0	0	0	0	0	0	0	1
Medicine	406	482	412	471	385	693	382	390	388	371	371	371	5,123
POE	9	4	25	4	2	7	5	5	5	5	5	5	81
Surgery	359	358	350	360	274	205	183	212	128	123	110	110	2,770
Inside Envelope Forecast	**1,193**	**1,211**	**1,112**	**1,133**	**871**	**1,123**	**728**	**747**	**677**	**645**	**630**	**630**	**10,700**

4. Temporary Staffing Analysis:

As at Month 9, the Trust has spent £50.7m on variable pay, £10.1m more than the corresponding period witnessed in 2020-21.

Medical & Nursing staffing groups have seen the largest increases in spend, being a £3.9m and £4.4m increase respectively.

Of the £3.9m of Medical Staffing increase spend, £2.0m can be attributed to additional capacity through additional sessions which is offset by Elective Recovery funding support. The remaining increase in spend relates to increased premium vacancy cover, predominantly within the Surgical Division.

Ward reconfigurations due to COVID-19 IPC measures, use of surge beds, increased absence due to COVID-19, bank incentives and implementation of Chief Nurse safety recommendations are the main drivers in nursing increased spend.

The increased spends in administrative and Estates support staffing is largely attributable to the extension of the bank incentives and for COVID related backfill, both of which are currently funded through COVID additional funding.

Variable Pay by Staff Group:

Variable Pay by Staff Group	M09 YTD 20/21 (£k)	M09 YTD 21/22 (£k)	Year on Year Variance (£k)
Admin & Clerical	1,163	1,722	(558)
Maintenance	68	70	(2)
Medical	20,967	24,883	(3,916)
Nursing	15,080	19,492	(4,411)
Other	3	3	1
Scientific	1,953	2,585	(632)
Support	1,427	1,975	(548)
Total	**40,663**	**50,730**	**(10,068)**

Variable Pay by Type:

Variable Pay Type	M09 YTD 20/21 (£k)	M09 YTD 21/22 (£k)	Year on Year Variance (£k)
Agency	14,689	20,632	(5,943)
Bank	10,622	12,857	(2,235)
Locum	10,816	10,457	358
Rad/Path Claims	753	979	(226)
Add Sessions	1,512	3,553	(2,040)
Overtime	2,271	2,252	19
Total	**40,663**	**50,730**	**(10,068)**

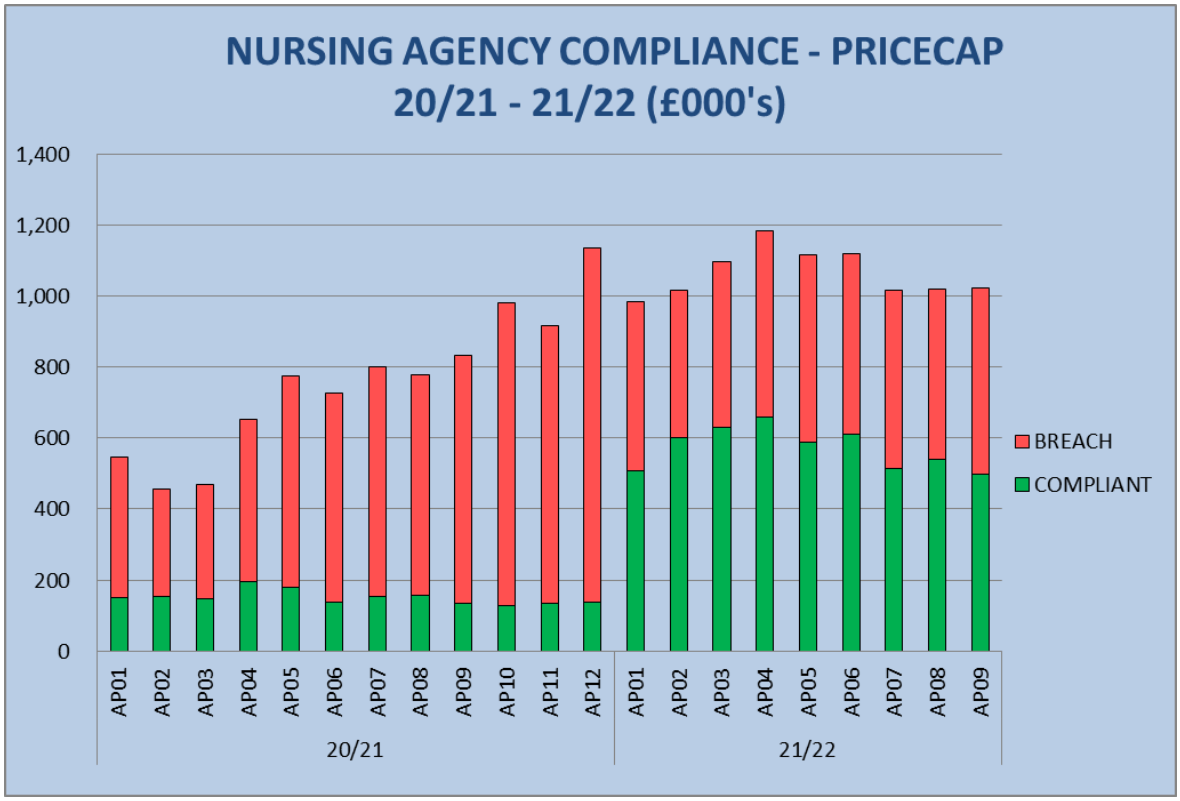
Variable Pay by Division / Directorate:

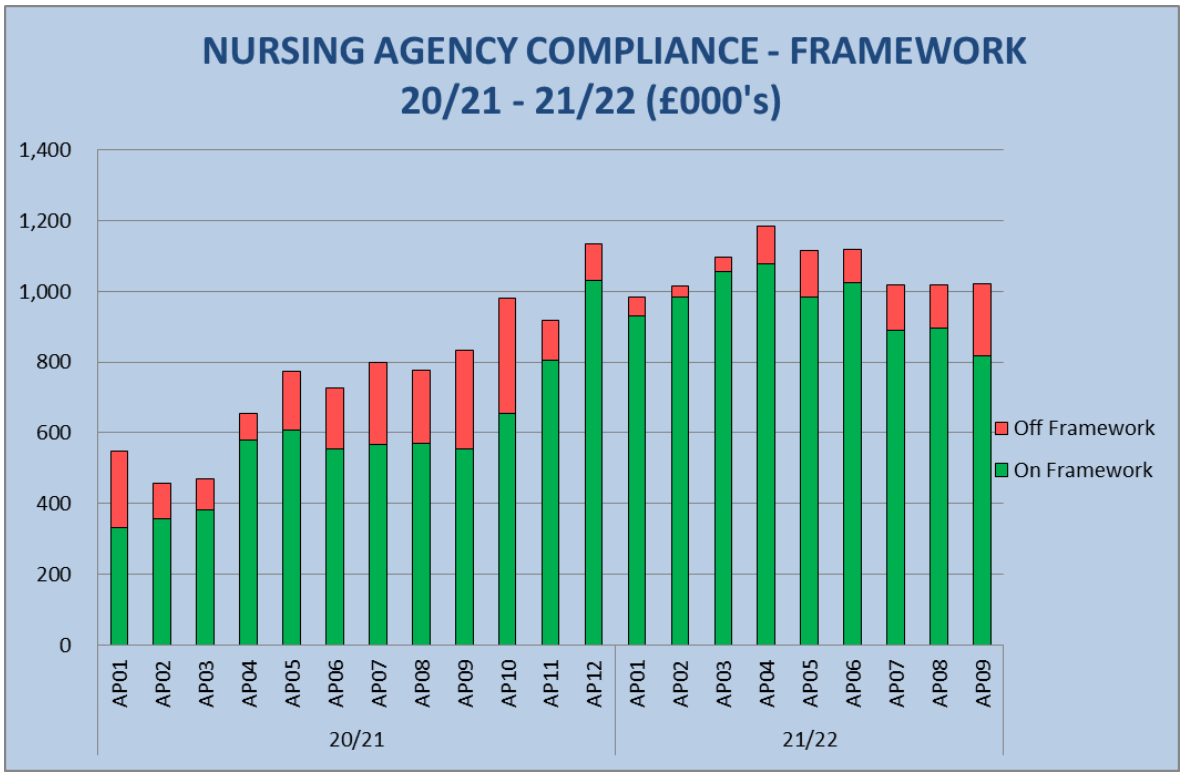
Directorate	Division	TOTAL		
		20/21	21/22	Var
Operations	Clinical Support Services	3,222	5,025	(1,803)
	Family Services	4,139	4,514	(375)
	Medicine	19,523	23,403	(3,880)
	Surgery & Critical Care	10,771	13,638	(2,867)
	Therapy & Community Services	1,119	1,675	(556)
Operations Total		**38,775**	**48,256**	**(9,481)**
Estates and Facilities Total		**1,488**	**2,034**	**(547)**
Corporate Total		**401**	**441**	**(40)**
Grand Total		**40,663**	**50,730**	**(10,068)**

Nursing

Nursing variable pay has increased by £4.4m compared to the first nine months of 2020/21.

Whilst the Trust has been successful in improving its price and framework compliance compared to last financial year, overall agency usage is considerably higher year-to-date than the equivalent period in 2020-21.





To assess the full nursing, spend position, rather than just the variable pay increases, the table below demonstrates the full year on year change both in terms of budget and actual spend.

	2020/21			2021/22			Variance	
	Budget	Spend	Variance	Budget	Spend	Variance	Budget	Spend
Substantive	70,063	66,800	3,263	79,627	68,969	10,659	9,565	2,169
Bank	7,340	8,544	(1,204)	5,262	9,324	(4,062)	(2,078)	781
Agency	4,116	5,935	(1,819)	2,406	9,609	(7,203)	(1,709)	3,674
Total	**81,518**	**81,278**	**240**	**87,296**	**87,902**	**(606)**	**5,778**	**6,624**

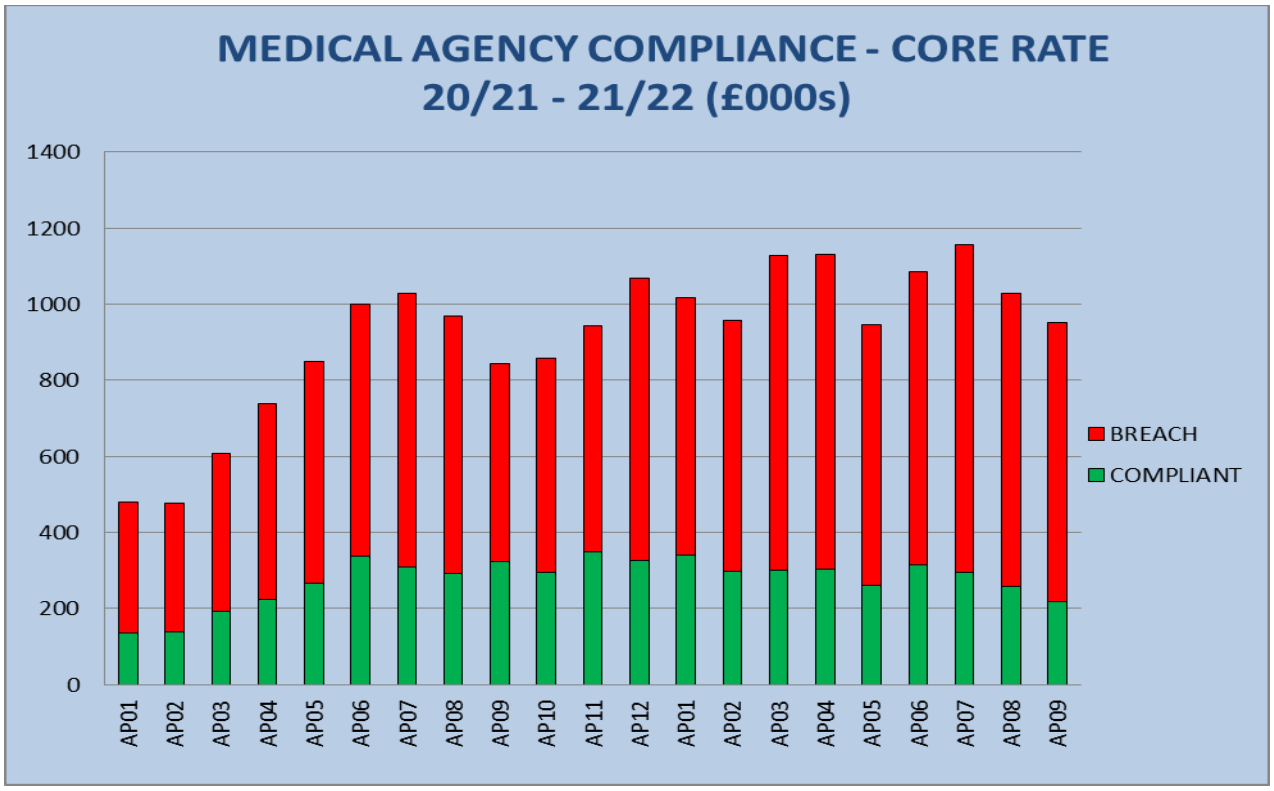
	2020/21			2021/22			Variance	
	Budget*	Spend	Variance	Budget	Spend	Variance	Budget	Spend
Chief Nurses Office	3,310	3,198	112	2,568	2,438	131	(741)	(760)
Chief Executive's Office	4	4	(0)	0	0	0	(4)	(4)
Estates and Facilities	0	0	0	0	1	(1)	0	1
Medical Directors Office	38	38	(1)	46	41	5	8	3
Clinical Support Services	4,143	4,141	2	4,332	4,555	(223)	189	414
Family Services	16,333	16,113	221	17,384	16,414	970	1,051	301
Medicine	32,010	32,055	(45)	36,060	37,058	(997)	4,051	5,003
Surgery & Critical Care	17,712	17,908	(195)	18,749	19,222	(474)	1,036	1,315
Therapy & Community Services	7,257	7,230	28	7,515	7,575	(60)	258	346
Digital Services	26	26	(0)	27	16	11	1	(10)
People and Org Effectiveness	685	566	119	615	582	33	(70)	16
TOTAL	**81,518**	**81,278**	**240**	**87,296**	**87,902**	**(606)**	**5,778**	**6,624**

The overall nursing position continues the trend seen in previous months with cost pressures in Medicine and Surgery offset by slippage on the planned midwifery expansion.

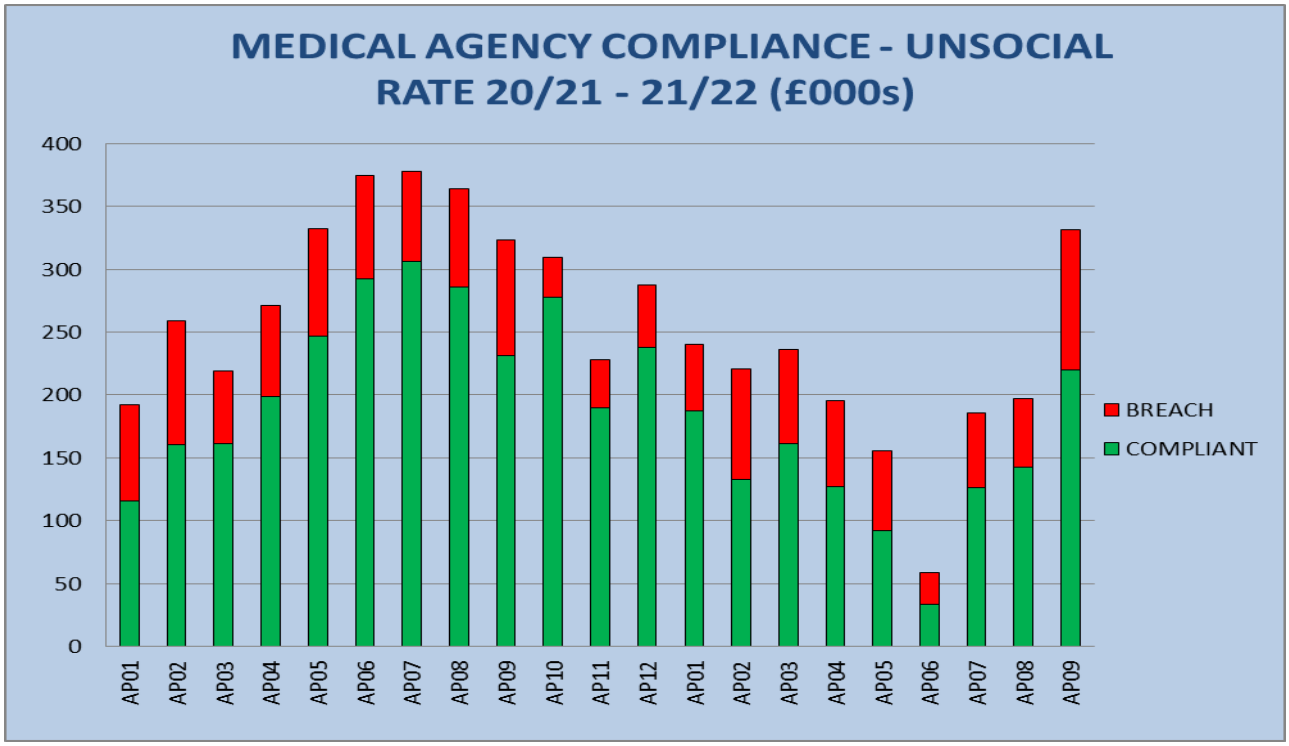
Medical Staffing

As seen in Nursing, Medical staffing variable pay has increased by £3.9m compared to the first nine months of 2020/21.

The Trust is starting to see a declining rate of compliance in core hours rates, and this remains a low percentage overall, whilst total usage is considerably higher than the equivalent year-to-date period in 2020-21.



Unsocial hour rates have generally shown a downward trend, but this has significantly reversed in December, although compliance is better than that seen in core hour usage.



As per nursing spend, the table below demonstrates the full year on year change both in terms of budget and actual spend. Cost pressures remain predominantly within Surgery due to increased usage of premium agency to cover vacancies.

	2020/21			2021/22			Variance	
	Budget	Spend	Variance	Budget	Spend	Variance	Budget	Spend
Substantive	47,134	44,340	2,794	57,586	47,180	10,405	10,451	2,840
Locum	10,715	12,385	(1,669)	5,828	12,671	(6,843)	(4,888)	286
Agency	5,684	7,932	(2,247)	3,833	9,931	(6,097)	(1,851)	1,999
Total	**63,534**	**64,657**	**(1,122)**	**67,247**	**69,782**	**(2,535)**	**3,712**	**5,125**

	2020/21			2021/22			Variance	
	Budget	Spend	Variance	Budget	Spend	Variance	Budget	Spend
Chief Executive's Office	0	0	0	4	4	0	4	4
Chief Nurses Office	0	0	0	19	17	1	19	17
People & Org. Development	86	0	86	0	0	0	(86)	(0)
Medical Directors Office	1,836	1,820	16	2,102	2,085	17	266	265
Strategic Devlopment	0	0	0	23	23	0	23	23
Trust Reserves	1,536	1,525	11	1,276	1,485	(209)	(260)	(39)
Clinical Support Services	4,818	4,850	(32)	5,314	5,622	(308)	496	772
Family Services	9,561	9,685	(124)	9,758	9,873	(115)	197	188
Medicine	22,522	22,698	(175)	24,109	24,128	(19)	1,587	1,431
Surgery & Critical Care	22,193	23,092	(899)	23,620	25,538	(1,919)	1,426	2,446
Therapy & Community Services	982	987	(5)	1,023	1,006	17	41	19
TOTAL	**63,534**	**64,657**	**(1,122)**	**67,247**	**69,782**	**(2,535)**	**3,712**	**5,125**

(The full Variable Staffing Analysis is embedded in Appendix 3)

5. Savings Programme:

At the end of December the Trust had achieved savings of £7,985 against its plan of £7,316k an over achievement of £669k.

CIP DELIVERY BY WORKSTREAM & DIVISION/DIRECTORATE

Workstream	Annual Plan £000s	Current Month December 21				Year to Date at December 21				Forecast Year end		
		Plan £000s	Actual £000s	Variance £000s	Risk RAG	Plan £000s	Actual £000s	Variance £000s	Risk RAG	Actual £000s	Variance £000s	Risk RAG
Clinical Workforce - Nursing and Midwifery	1,047	143	135	-8		618	709	92		882	-165	
QI & Efficiency	2,262	216	230	14		1,635	1,248	-388		1,940	-321	
Digital Transformation	104	9	6	-3		76	50	-26		68	-36	
Income	2	0	0	-0		2	0	-2		0	-2	
Grip & Control	40	3	0	-3		30	13	-17		20	-20	
Unidentified	638	89	0	-89		370	0	-370		0	-638	
Grand Total	**10,552**	**1,078**	**1,088**	**10**		**7,316**	**7,985**	**669**		**10,411**	**-141**	
Recurrent	8,486	931	824	-107		5,656	4,889	-766		6,874	-1,612	
Grand Total	**10,552**	**1,078**	**1,088**	**10**		**7,316**	**7,985**	**669**		**10,411**	**141**	
Surgery & Critical Care	1,865	216	153	-62		1,196	988	-209		1,339	-526	
Family Services	1,038	100	40	-59		753	596	-157		741	-296	
Clinical Support Services	1,874	220	186	-34		1,214	1,203	-12		1,691	-183	
Community & Therapy Services	748	74	40	-34		526	364	-162		460	-288	
Operations Directorate	24	-0	4	5		24	89	65		101	77	
Total Operations	**8,236**	**879**	**770**	**-109**		**5,590**	**5,353**	**-237**		**7,118**	**-1,118**	
Finance	197	19	3	-16		141	344	204		349	152	
Strategic Development	14	1	5	3		10	41	31		54	40	
Total Corporate Directorates	**974**	**74**	**157**	**83**		**765**	**1,794**	**1,028**		**2,049**	**1,076**	
Estates & Facilities	760	67	65	-2		572	645	73		795	35	
Trust	582	58	97	39		389	194	-196		448	-134	
Grand Total	**10,552**	**1,078**	**1,088**	**10**		**7,316**	**7,985**	**669**		**10,411**	**141**	

The Trust is making encouraging progress towards its year-end target of £10,552k and at the end of December is now only forecasting a £141k deficit. This improvement relates to the unwinding of risk provision and the stronger than expected recruitment position.

In-month delivery was solid and the increased target was covered by the continued over delivery in the Corporate, Medical Staffing and Non-pay workstreams and steady performance across the others. The main in-month variances are:

1. Corporate vacancy over delivery by £35k in-month, £702k year to date (YTD).
2. Medical and Nursing recruitment was collectively £129k above plan mitigating non-delivery on agency rates £60k and bank incentive scheme £24k. The forecasting for these areas is heavily risk adjusted hence the large in-month movements
3. Further legal fees reductions (£6k in-month and £219k YTD), reduced travel costs (£20k in-month and £103k YTD) and the introduction of a managed service contract for repairs (£32k YTD) provided for a non-pay over delivery.

Although the additional £1.56m H2 requirement presented a significant challenge the Trust is only marginally adrift of this target. However in-year delivery is heavily reliant on non-recurrent projects. The challenge for the Trust going forward is to convert some of these into recurrent delivery.

The main risks to delivering the £10.552 million are

1. Operational issues which have been necessitating increased use of agency staffing and keeping agency rate high on average. For these reasons agency savings have not been assumed in H2
2. The level of unidentified savings now in plans.
3. Recruitment pipeline is promising for the second period of the year and the plan assumptions have been heavily risk adjusted. However, these staff need to continue to be on-boarded and agency staff need to be replaced particularly in nursing to deliver the savings. It is recognised that although recruitment has been strong and has seen a reduction in agency the Trust continues to face operational pressures which necessitate the continued use of agency staff.
4. Slippage has been a problem throughout H1 albeit on smaller schemes however this needs to be addressed to ensure full delivery in H2
5. Engagement from the management teams as risk mitigation and further development will require their active participation during a very busy period
6. A recurrent shortfall of potentially £3.5m in this financial year.
7. Procurement savings, due to capacity issues, initially planned to be identified and enacted from quarter two have been pushed back until quarter three and quarter four

(The full CIP report is embedded in Appendix 4)

6. Elective Recovery Funding

The Trust failed to achieve the minimum baseline thresholds from Q2 following the increase to the minimum thresholds to 95% from July. Funding received in Q1 covered the totality of expenditure incurred within H1 but minimised any potential upside the Trust could have earned if the base thresholds had not been adjusted.

£m	H1 Plan	H1 Actual
Income	9.8	**3.8**
Expenditure	(6.7)	**(3.8)**
Contribution	**3.0**	**0.1**

Due to changes to the ERF calculation methodology the Trust received retrospective funding for October and November and has also received funding for December's activity delivery. The Trust financial plan assumed £0.75m of ERF for October to March so is now in line with plan. Slippage on Independent Sector contracts minimises ERF earned. However, due to the receipt of the ERF+ funding to cover the committed IS contracts, the slippage on these contracts presents an upside to the Trust of £0.6m. It is anticipated that the contracts will recover over the remaining final quarter.

£m

H2	AP07	AP08	AP09	AP10	AP11	AP12	Total
Income ERF	0.3	0.1	0.3				**0.7**
Income ERF+	1.0	1.0	1.0				**3.0**
Expenditure	(0.7)	(0.8)	(0.8)				**(2.4)**
Contribution	**0.6**	**0.3**	**0.5**				**1.3**

7. Capital Plan:

	NHSI Plan £mil	YTD Plan £mil	YTD Actual £mil	YTD Variance £mil
Major Schemes				
Major Equipment Replacement	4.59	4.59	2.94	(1.65)
DPoW Reconfiguration Programme	1.07	1.07	0.10	(0.97)
SGH & GDH Reconfiguration Programme	1.70	1.70	0.10	(1.60)
STP Funding Fees	5.28	0.00	0.06	0.06
Emergency departments	23.39	16.17	15.33	(0.84)
Oxygen Emergency capital	1.87	1.87	0.12	(1.75)
Feasibility Fees	0.09	0.09	0.03	(0.07)
Community Diagnostics	0.30	0.30	0.07	(0.23)
Facilities Maintenance Programme	4.39	2.46	1.54	(0.92)
IM&T Programme	4.96	3.50	0.51	(2.99)
Equipment Renewal Programme	2.02	1.77	1.06	(0.71)
Discretionary Funding	0.00	0.00	0.00	0.00
Donated/Grant funded	41.64	41.64	7.25	(34.38)
Capital Programme Total	**91.29**	**75.15**	**29.11**	**(46.05)**

The capital spend at 31st December was £29.11m, £46.05m behind plan. Key variances are as follows:

- Major equipment replacement –SGH MRI – the works are continuing. The scheme will be completed by the end of January 2022. The current spend is £1.65m behind plan.

- DPOW reconfiguration; the endoscopy enema room is expected to be completed late December/early January. Work has begun on the removal of CCU modular building.

- SGH reconfiguration includes the refurbishment of ward 25. This contract has now been awarded and works has started on site with completion July 2022.

- The Oxygen works at DPOW have now commenced the works are expected to be completed by 31st March 2022.

- Facilities backlog maintenance schemes are behind plan. Phase 2 of the fire alarms at DPOW is under way and work is on track to be completed by March 2022. The Trust has also received extra funding for roof replacement, orders have been now placed.

- The IM&T plan is currently £2.99m behind plan; the Trust is working with Hull University Hospitals regarding the implementation of the Lorenzo system which is funded from the Digital Aspirant £2.3m. All funding must be spent by the end of March 2022.

- Equipment replacement is £0.71m behind plan. All orders for equipment have now been placed.

- The grant funded schemes are currently behind plan by £34.38m. BEIS funding of £1.3m completed in October. The programme relating to Salix funding of £40.3m is continuing. The Trust is currently forecast to spend approximately £10m this financial year. Talks are continuing with Salix to explore possibilities to extend the remaining funding into 2022/23.

8. Balance Sheet, Cash and Working Capital:

The balance sheet summary is as follows:

	Last Month £mil	This Month £mil
Total Fixed Assets	209.08	212.63
Stocks & WIP	3.69	3.92
Debtors	14.56	11.83
Prepayments	6.68	6.34
Cash	28.32	46.49
Total Current Assets	53.25	68.58
Creditors : Revenue	40.00	38.62
Creditors : Capital	5.18	5.39
Accruals	15.22	15.30
Deferred Income	4.13	6.82
Finance Lease Obligations	0.00	0.00
Loans < 1 year	0.01	0.03
Provisions	1.93	2.30
Total Current Liabilities	66.47	68.45
Net Current Assets/(Liabilities)	(13.21)	0.12
Debtors Due > 1 Year	0.89	0.89
Creditors Due > 1 Year	0.00	0.00
Loans > 1 Year	9.54	9.54
Finance Lease Obligations > 1 Year	0.02	0.02
Provisions - Non Current	5.43	5.43
TOTAL ASSETS/(LIABILITIES)	181.77	198.65
TOTAL CAPITAL & RESERVES	181.77	198.65

- Stock has increased in month, stock levels have increased in Pharmacy, Pathology and Theatres.

- Debtors have reduced this month, the Trust has now received the £2.2m of the Salix funding.

- The Trust has seen an increase in deferred income, this includes £2.9m of target investment income for future months and £1.1m of Health Education income for January 2022.

- Revenue creditors and accruals have reduced in month relating to the payment of trade creditors. The BPPC figures for the Trust are continuing to be above 90% for non-NHS invoices, the in-month value paid within 30 days deteriorated slightly to 92.85%, and the number of invoices paid 91.17%. NHS invoices increased in month to 94.48% relating to the value paid within 30 days and 91.67% for the number paid. All invoices need to be authorised promptly in order to comply with this target. NHSE/I are now monitoring Trusts on their performance, the target is 90%.

The cash balance at 31st December was £46.5m, an in-month decrease of £18.2m, with key commitments as follows:

	£m	£m
Cash Balance as at 31st December		**46.49**
Commitments:		
Income received in advance	6.82	
Capital creditors	5.39	
Capital loan repayments	0.17	
December PAYE/NI/Pension	10.83	
Public Dividend Capital payment	1.56	
Annual leave income	4.49	
Capital PDC received	10.27	
Grant funding due	-1.52	
Invoices due for payment not yet authorised	4.27	
To support other creditors due	2.32	
		(44.59)
NHSi minimum balance		**1.90**

Cashflow to March 2022:

The table below outlines the cashflow forecast to 31st March 2022.

	Apr-21 £000s	May-21 £000s	Jun-21 £000s	Jul-21 £000s	Aug-21 £000s	Sep-21 £000s	Oct-21 £000s	Nov-21 £000s	Dec-21 £000s	Jan-22 £000s	Feb-22 £000s	Mar-22 £000s
Opening Balance:	**54,399**	**44,697**	**40,876**	**32,690**	**35,256**	**36,858**	**33,035**	**33,980**	**28,321**	**46,490**	**44,921**	**42,253**
Operating Income:												
Clinical Income	36,869	35,986	37,846	36,434	41,790	37,732	47,617	36,263	44,353	38,249	35,112	35,112
Non Clinical Income	4,653	1,216	1,328	3,798	1,536	897	987	856	867	538	1,437	1,437
Capital Funding			1,577	327	298	0	343	0	18,164	7,910	4,989	6,038
Total Income Cashflow	**41,522**	**37,202**	**40,751**	**40,560**	**43,624**	**38,629**	**48,947**	**37,119**	**63,384**	**46,697**	**41,538**	**42,587**
Operating Expenditure:												
Pay	(25,131)	(24,968)	(30,511)	(19,404)	(24,576)	(27,036)	(27,110)	(25,531)	(25,474)	(25,657)	(26,270)	(26,447)
Non Pay	(13,024)	(12,200)	(12,301)	(16,136)	(14,310)	(11,479)	(17,192)	(12,488)	(15,555)	(12,785)	(9,258)	(10,685)
Total Expenditure Cashflow	**(38,155)**	**(37,168)**	**(42,812)**	**(35,540)**	**(38,886)**	**(38,516)**	**(44,301)**	**(38,018)**	**(41,029)**	**(38,442)**	**(35,528)**	**(37,132)**
Investing Activities:												
Capital Programme	(13,069)	(3,070)	(6,124)	(2,454)	(3,136)	(2,934)	(3,701)	(3,981)	(4,187)	(9,824)	(8,678)	(5,770)
Total Investing Activities	**(13,069)**	**(3,070)**	**(6,124)**	**(2,454)**	**(3,136)**	**(2,934)**	**(3,701)**	**(3,981)**	**(4,187)**	**(9,824)**	**(8,678)**	**(5,770)**
Other Cash Flow Items:												
PDC Dividend	0	0	0	0	0	(1,002)	0	0	0	0	0	(3,113)
Loans	0	(785)	0	0	0	0	0	(779)	0	0	0	0
Total Other Cash Flow Items:	**0**	**(785)**	**0**	**0**	**0**	**(1,002)**	**0**	**(779)**	**0**	**0**	**0**	**(3,113)**
Closing Cash Balance	**44,697**	**40,876**	**32,690**	**35,256**	**36,858**	**33,035**	**33,980**	**28,321**	**46,490**	**44,921**	**42,253**	**38,825**

9. Underlying Financial Position:

The Trust assessed its underlying financial position as part of its 2021/22 planning cycle (**Appendix 5**) which had an underlying deficit of £20.52m. This included ongoing Financial Recovery Funding support of £45.98m as per the indicative values provided by NHSIE as part of the Long Term Plan submitted in November 2019. Therefore, if this is removed, its true underlying deficit without additional funding support is circa £66.5m.

The Trust continues to assess the recurrent impacts on its underlying financial position. The following provides an update at this point for the known in year developments to the Trust's initial planning assumptions resulting in a revised underlying deficit of £20.32m:

Underlying Deficit 2021/22 incl FRF	**(20.52)**
In Year Developments	
H2 Block Income Adj	8.08
H2 tariff Efficiency FYE (0.82%)	(2.17)
2021-22 Pay Awards	(8.04)
Recurrent COVID Funding Reduction	(13.52)
Recurrent COVID Expenditure Reduction	3.13
Non Recurrent FOT Savings Delivery	(3.54)
Middle Grade Pay Reform	(0.50)
Ockenden Funding	1.48
Ockenden Additional Investments	(0.93)
Investment Programme Update	0.36
Flowers Recurrent Expenditure	(0.36)
Non Clinical Income Recovery	1.66
Revised Underlying Deficit 2021/22 incl FRF	**(34.87)**
Block Income Top Up Adj	14.53
Underlying Deficit 2021/22 incl FRF	**(20.32)**

- Revised core block income funding includes the uplift for the 2021-22 pay awards of £8.04m to cover the associated increase in expenditure.

- The full year effect of the H2 additional efficiency requirement of 0.82% is £3.43m. The Trust is expected to deliver £1.3m in 2021/22 of the H2 stretch target, albeit non recurrently. The Trust already has a challenging 2% efficiency plan as part of its initial underlying position assumptions.

- H2 underlying planning guidance states the H2 block income values should form the basis of the Trust income assumptions for the underlying position. Whilst this gives certainty to the income values the Trust should receive it removes the ability to earn the CDIP Year 3 Coding Gains reported last month of £2.16m.

- Planning guidance states that Trust's should not expect ongoing COVID-19 funding as part of its underlying income base. However, the Trust current expected exit run rate on COVID-19 expenditure is estimated to have a recurrent impact of £10.39m.

- Non-Clinical Income recovery has been increased to include the re-introduction for car parking charges for all eligible staff.

- Additional top up support deemed non recurrent as part of the H1 underlying position is included of £14.53m in line with H2 block income guidance.

- Non-Recurrent Savings Delivery – The Trust is currently forecasting to deliver the majority of its £10.5m CIP programme in year. However, £3.54m is forecast to be delivered non-recurrently presenting a recurrent shortfall. The Trust must look to convert non recurrent schemes to recurrent savings delivery where possible in year, particularly in Corporate back office functions whilst also pursuing additional new recurrent new schemes.

- Middle Grade Pay Reform – The revised Specialty Grade Doctor contract came into place from 1st April 2021. Current SAS doctors employed have the option to move to the new terms and conditions or retain their existing terms. Employees have until the end of September 2021 to express an interest with arrears paid back to April 2021. At this point, it is unclear the level of employees that may transfer but initial reviews undertaken indicate a potential cost pressure of £0.5m. No additional funding support will be provided.

- Ockenden - The Trust has been successful of securing additional funding of £1.48m to support the costs associated in implementing the Ockenden review recommendations. The Trust had previously committed funding to implement expansion in Midwives to Birth Rate Plus Review levels which now the secured funding will replenish, whilst leaving £0.93m to fund the residual recommendations in the bid.

- Investment Programme Update – The Trust set aside £11.72m for new investment funding requirements. At the planning cycle period, not all proposed investments were fully developed and therefore costs were estimated whilst the business cases and formal sign off process was undertaken. Work is still ongoing to finalise the full investment programme requirements, but at this point the outline planning assumptions have improved by £0.36m. The Trust must continue to review its proposed investment plans, and limit further investments where ever possible unless essential to ensure patient safety.

- Flowers Recurrent Expenditure – The Trust received additional funding support in 2020-21 for the impact of the Flowers Legal Case. It was envisaged at the planning stage that funding support would continue but it has now been confirmed that no ongoing support will be provided with a recurrent full year impact of circa £0.36m.

10. Conclusion:

The Trust had a £0.17m underspend in month and is £0.02m overspent year-to-date. The Trust has a challenging remainder to the financial year but is forecast to be plan compliant and report a balanced financial position. The material financial issues for the Trust over the coming months include:

- A revised H2 financial framework with additional efficiency requirements and reduced COVID-19 funding.
- Maximising its planned care activity delivery over the remaining final quarter, with the potential to earn additional income through the Elective Recovery Fund.
- Keeping its additional winter expenditure within the additional £1.8m funding envelope.
- Delivering its CIP programme, mitigating risks to delivery and conversion of non-recurrent savings into recurrent delivery schemes and identifying new schemes in readiness for 22-23 where possible.
- Reducing its additional Covid-19 expenditure as soon as possible, in light of the reduced H2 funding and the proposed 57% reduction in Covid-19 funding for 22-23.
- Agreeing its nursing establishment following the recent Chief Nurse safety recommendations.

Brian Shipley
Deputy Director of Finance
January 2022

Appendix 1 – Income & Expenditure Month 8 (November 2021)

Income & Expenditure	Annual Plan to 31st March 2022 £'000	Current Month			Year to Date		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Clinical Income	349,593	29,820	29,974	154	260,685	264,938	4,253
ERF Income	11,266	251	721	470	10,514	4,556	(5,958)
TIF	5,905	984	985	1	2,952	2,953	1
Block Top Up	60,160	5,042	5,118	76	45,034	45,783	750
Covid Inside Envelope Block	13,019	1,023	1,022	(1)	9,950	9,946	(4)
Covid Outside the Envelope	1,839	246	141	(105)	1,401	1,160	(241)
Other Income	37,081	2,953	3,107	154	28,183	28,227	44
Donated Income	57,684	1,105	428	(677)	44,839	7,254	(37,585)
Total Operating Income	**536,547**	**41,424**	**41,496**	**71**	**403,558**	**364,816**	**(38,742)**
Clinical Pay	(255,013)	(21,179)	(21,718)	(539)	(190,033)	(193,027)	(2,994)
Other Pay	(66,075)	(5,918)	(5,867)	51	(50,401)	(52,066)	(1,665)
Total Pay	**(321,088)**	**(27,097)**	**(27,586)**	**(489)**	**(240,434)**	**(245,093)**	**(4,659)**
Clinical Non Pay	(70,449)	(5,892)	(6,182)	(290)	(52,996)	(51,810)	1,186
Other Non Pay	(72,928)	(6,025)	(5,318)	708	(53,131)	(49,064)	4,067
Total Non Pay	**(143,377)**	**(11,917)**	**(11,499)**	**418**	**(106,127)**	**(100,874)**	**5,253**
Operating Expenditure	**(464,465)**	**(39,014)**	**(39,085)**	**(70)**	**(346,561)**	**(345,967)**	**594**
EBITDA	**72,081**	**2,410**	**2,411**	**1**	**56,997**	**18,849**	**(38,148)**
Depreciation	(12,538)	(1,156)	(927)	229	(8,893)	(8,266)	627
Interest Expenses & Other Costs	(182)	(15)	(7)	8	(139)	(289)	(150)
Dividend	(5,192)	(555)	(555)	0	(3,795)	(3,385)	410
Total Post EBITDA Items	**(17,911)**	**(1,726)**	**(1,488)**	**238**	**(12,827)**	**(11,939)**	**887**
Remove Capital Donated I&E Impact	(54,182)	(292)	(362)	(70)	(43,789)	(6,688)	37,101
Remove net loss on disposal of DHSC donated equipment	0	0	0	0	0	145	145
I&E Surplus / (Deficit)	**(12)**	**392**	**561**	**169**	**380**	**366**	**(15)**

Appendix 2 – Budgetary Performance Month 9:

The summary table highlights budget variances by area:

BUDGETARY PERFORMANCE				
	Annual Budget (£000s)	YTD Budget (£000s)	YTD Actual (£000s)	Variance (£000s)
Operations Directorate	(0.9)	(0.6)	(0.6)	0.1
Clinical Support Services	(69.3)	(52.4)	(52.3)	0.1
Family Services	(43.4)	(32.7)	(32.2)	0.5
Surgery & Critical Care	(82.4)	(63.4)	(65.8)	(2.4)
Medicine	(115.0)	(88.2)	(89.6)	(1.4)
Therapy & Community Services	(30.9)	(23.3)	(23.5)	(0.2)
Sub Total – Operations	**(341.9)**	**(260.6)**	**(264.0)**	**(3.4)**
Trust Management	(1.8)	(1.3)	(1.1)	0.3
Medical Director's Office	(22.9)	(17.1)	(16.9)	0.2
Chief Nurses Office	(5.1)	(3.8)	(3.7)	0.2
Finance	(4.8)	(3.7)	(3.4)	0.3
People & Organisational Effectiveness	(5.6)	(4.3)	(4.6)	(0.3)
Estates & Facilities	(30.6)	(22.7)	(22.7)	(0.0)
Strategic Development	(1.1)	(1.0)	(1.0)	0.0
Digital Services	(10.0)	(7.5)	(6.8)	0.7
Central & Capital Charges	38.5	31.8	(4.9)	(36.7)
Central Income	459.1	345.6	338.1	(7.5)
Trust Reserves	(19.6)	(11.1)	(2.0)	9.1
Sub Total – Corporate Directorates	**396.1**	**304.8**	**270.9**	**(33.8)**
Trust Total	**54.2**	**44.2**	**6.9**	**(37.3)**
Excluded Items	**(54.2)**	**(43.8)**	**(6.7)**	**37.1**
TOTAL	**(0.0)**	**0.4**	**0.2**	**(0.2)**

Appendix 3 – Detailed Variable Staffing Analysis

Temporary Staffing Month 9

Appendix 4 – Detailed Savings Programme Analysis

Full 2021-22 CIP Report M09 - Final.pd

Appendix 5 – Planned Underlying Financial Position

	£m
2019/20 Outturn Deficit	**(25.28)**
Add Back Non Recurrent items	(24.96)
FYE Income Adjustments	(2.90)
2019/20 Non recurrent Savings	(2.97)
FYE 2019/20 Investments	(4.45)
2019/20 Underlying Deficit	**(60.56)**
2020/21 Indicative FRF Allocation	45.98
2019/20 Underlying Outturn Deficit incl FRF	**(14.58)**
20/21 Developments	
2020/21 Income Tariff Uplift (2%)	6.99
Inflation Expenditure (2.3% Operating Expenditure)	(9.94)
CNST Premium	(2.11)
Cost of Capital	(1.18)
Debt Regime - Interest Rate Conversion	1.53
In year Investments	(3.56)
less Non Recurrent Investments	2.52
Recurrent CIP Delivery 2020/21	6.31
Gross Loss of Non NHS Clinical Income	(0.60)
2020/21 Underlying Deficit incl FRF	**(14.63)**
21/22 Developments	
FYE of 20/21 Investments	(11.72)
CQC - Funding Support	0.00
21/22 Tariff Uplift (0.78%)	2.66
21/22 Tariff Efficiency Requirement (Estimate 0.28%)	(0.96)
21/22 Inflation Estimate (0.67% Operating Expenditure)	(3.00)
21/22 CNST Premium Increase	(0.37)
21/22 Cost of Capital & PDC	(1.50)
21/22 Efficiency Target (Estimate 2%)	8.99
Recurrent COVID-19 Expenditure	(13.52)
Recurrent COVID-19 Funding	13.52
Non Recurrent Donated Grant Funding	41.37
Headline Deficit 2021/22	**20.86**
Block Income Top Up & Deficit Support	16.15
Headline Deficit 2021/22	**37.01**
Remove Excluded Items (Donated Income)	(41.37)
Full Year Planned Deficit 2021/22 at H1	**(4.37)**
Remove Block & Deficit Support	**(16.15)**
Underlying Planned Deficit 2021/22 incl FRF	**(20.52)**

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	1 February 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 from 22 December 2021 - Finance**
Purpose of the Report and Executive Summary (to include recommendations)	• The Trust was £0.18 behind plan year to date • The Trust continued to overspend on temporary staffing • Forecast delivery of £1.0m against extra £1.5m CIP target • Capital was £46m underspent, £34.8m of which was grant funded capital for energy efficiency schemes • A new financial framework for 2022/23 was emerging • A Costing Standards Group had been set up • A deep dive into Strategic Risk SO1 1.5 was carried out
Background Information and/or Supporting Document(s) (if applicable)	Minutes of meeting
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)	
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:	1 February 2022
Report From:	Finance & Performance Committee - 22 12 21

Highlight Report:

- The Trust was £0.18m behind plan year to date. The main issue was an in month shortfall of £0.93m income due to non-receipt of ERF funding due from the Trust meeting the elective backlog recovery performance threshold. Achieving this had required additional investment to increase capacity, but the funding was dependent on the whole ICS meeting the threshold.
- High levels of spend on temporary staffing continued due to vacancies, additional activity and quality measures to improve patient safety. This presented a risk to achievement of the H2 plan, but this was offset by continued underspend on midwifery staffing.
- Concern continued about the level of non-recurrent CIP savings. The Trust expected to deliver £1.0m of the additional ICS CIP challenge of £1.5m.
- Capital was £46m underspent, £34.8m of which was grant funded capital for energy efficiency schemes. Discussions continued about legitimate ways to place contracts for work that would continue into 2022/23 to enable completion of the schemes. If no agreement could be reached, the work would have to stop and a new application for a grant would have to be made.
- The emerging financial framework for 2022/23 was considerably different. A briefing paper for F&PC would be produced to explain the key changes.
- A Costing Standards Group had been established to review Reference Cost and benchmarking data and include that in planning for 2022/23. There was a requirement to submit data more frequently, which would require additional resources or investment in Robotic Process Automation.

Confirm or Challenge of the Board Assurance Framework:

The Committee completed a deep dive into Strategic Risk SO1 1.5 'The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources'. The risk rating had reduced from 16 to 12 and further mitigating actions were in progress. The Committee were assured by the progress made, but acknowledged the difficulties the Digital team were encountering with centralising contracts and having an accurate asset register covering all devices and their owners.

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.

The Board is also asked to confirm that the highlight reports provide sufficient assurance, as obtaining confirmation of that was the final outstanding action on the Committee's Action Plan produced after the latest Self-Assessment Review.

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

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	1 February 2022
Director Lead	Lee Bond, Chief Financial Officer
Contact Officer/Author	Lee Bond
Title of the Report	**Annual Accounts 2021/22 – Delegation of Authority**
Purpose of the Report and Executive Summary (to include recommendations)	In order to ensure the timely sign off of the Trust's audited accounts by the Chief Executive and the External Auditor, prior to submission to NHSE/I on 22 June 2022, the Trust Board is requested to delegate formal authority to the Audit, Risk and Governance Committee at its meeting on the 10 June 2022 to sign off the audited accounts and reports on its behalf. The Trust Board is asked to: • Note the key dates in the final accounts process • Delegate formal authority to the Audit, Risk and Governance Committee to sign off the 2021/22 audited accounts on behalf of the Trust Board
Background Information and/or Supporting Document(s) (if applicable)	NHSE/I 2021/22 Accounts Timetable
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)	Noted in 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.

Report to Trust Board – February 2022

ANNUAL ACCOUNTS 2021/22 - DELEGATION OF AUTHORITY

Introduction

The Audit, Risk and Governance Committee, under its delegated powers, reviews the draft accounts and reports before they are submitted to NHSE/I and the Auditors on behalf of the Trust Board (SFI 3.1.3 b). This will take place at their meeting on 21 April 2022, ready for submission on 26 April 2022.

The Audit, Risk and Governance Committee also reviews the audited accounts and reports before they are submitted to the Trust Board for approval before final submission.

The key dates for the 2021/22 audited accounts, as confirmed by NHSE/I are as follows:-

Tuesday 7 June 2022	Trust Board meeting.
Friday 10 June 2022	Audit, Risk and Governance Committee meeting where the final audited accounts and reports will be reviewed in detail. The Chief Executive and Trust Chair are invited to attend this meeting.
Monday 13 June 2022	Chief Executive expected sign off date. Once signed will be passed to External Auditor for their formal sign off prior to return and submission to NHSE/I.
Wednesday 22 June 2022	Final audited accounts and reports to be formally submitted to NHSE/I by noon.

Given that the June 2022 Trust Board meeting falls early in the month, the audited accounts will not be ready for final review by that point. The Trust Board can therefore, as in previous years, delegate formal authority to the Audit, Risk and Governance Committee to approve the final accounts on its behalf before submission to the External Auditor and NHSE/I.

Recommendation

The Trust Board is asked to note the key dates in the final accounts process and is requested to delegate formal authority to the Audit, Risk and Governance Committee at its meeting on 10 June 2022 to sign off the 2021/22 audited accounts and reports on behalf of the Trust Board, prior to formal signing by the Chief Executive and the External Auditor.

Lee Bond
Chief Financial Officer
February 2022

NLG(22)017

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	1 February 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 – January 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 by the end of 2021 of a Pre- Consultation Business Case (PCBC) for the delivery of new models of care for ***(programme 2) linked to submission of a Capital EOI and Pre SOC (Programme 3) for:***

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

- We will play a full part in the development of the Humber Coast and Vale (HCV) Health & Care Partnership, including the:

    - Humber Partnership Board
    - Acute Collaborative
    - Community Collaborative
    - Integrated Care Partnerships of North and North East Lincolnshire
    - HCV Cancer Alliance and associated professional networks

- We will play a full part in other national and regional networks, including professional, service delivery and improvement (e.g. GIRFT), and operational.

Highlights	Lowlights	Risks
Overall • Joint Development Board established. Will report to Committees in Common between both NLAG and HUTH to oversee Programme 1 – Interim Clinical Plan – mobilisation and implementation from end of March 2022 • NHSE/I review of Programme December 2021 – 26 attendees (Regional/National) Teams – positive feedback and some areas to consider in finalisation of Pre-Consultation Business Case (PCBC) • The Consultation Institute Review of approach to engagement and approval of work done to date • Attendance at five Overview Scrutiny Committees (OSC) and approval of engagement process on Humber Acute Service (HAS) received from them all • Programme 2 Evaluation framework designed – support and challenge on approach from TCI, NHSE/I and DHSC • Wide ranging local authority engagement – CEO/SLT briefings **Programme 1 (P1):** • 5 of the 10 specialties have clinical leads in place • 7/10 have finalised strategies going through internal and external governance processes – which includes the three temporary change specialties (ENT/Urology/Oncology) final reports • MOU and SLA have been signed off and are in use (recently amended slightly to support COVID actions) • Activity recording been implemented within Neurology • Contracting and finance processes all mapped through for Neurology and using template for Oncology and Haematology as the next specialties to complete • Handover of Programme 1 to the operational teams is being developed, with oversight and assurance through Joint Development Board **Programme 2 (P2):** • Draft PCBC issued to Executive Oversight Group and key programme leads – process in place to collect feedback–document will be iterated and finalised for 31 March 22 • Continued programme of workshops and focus groups to support evaluation • Initiated discussions with Clinical Senate re Formal Review • Initiated discussions with DHSC equalities lead on key areas to consider in PCBC • Developing integrated options aligned to capital – identification of a Preferred Way Forward	• Complicated acute review spanning all programmes and aligning to out of hospital and community diagnostic changes • Challenges of continuous engagement and involvement / time commitments for busy operational staff (including key clinical leads during recovery phase) • Challenge of delay in timescale due to slippage of legislation for ICS approval – impact on decision making and consultation timelines • Capital funding sources not yet agreed	• Alignment of PCBC and Capital SOC – Strategic and Economic Case to ensure successful completion of NHSE/I Gateway 2 Process • Pathways in P2 look beyond hospital boundaries and require out of hospital transformation • Potential options may be subject to OSC, Public challenge resulting in Independent Review (IRP), Judicial Review (JR) or Secretary of State (SoS) review • Potential options may displace activity to neighbouring health economies

- Continued engagement with Doncaster and Lincoln health systems re potential displacement activity and EMAS/YAS in terms of potential pathway changes
- NHSE/I monthly assurance review continue with positive challenge and support
- Evaluation Criteria and Framework developed – will use small multiples – approach discussed with NHSE/I and the Consultation Institute – considering how we maximise the use of digital to support workshop delivery
- Initial draft of enablers section 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

- Aligning all out of hospitals programmes to avoid duplication
- The delivery of changed pathways will require capital investment in digital as well as wider infrastructure
- Planned care pathways must align to wider ICS Community Diagnostic Hub programme implementation
- Potential further COVID wave and ability to continue with engagement and evaluation of key stakeholders
- Potential impact on staff who have been engaged in process due to legislation delay – may lose 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

NLG(22)018

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1 February 2022	
Director Lead	Gill Ponder, NED / Chair of F&P Committee	
Contact Officer/Author	Lee Bond, Chief Financial Officer	
Title of the Report	**Finance & Performance Committee – Minutes of meetings held on 27 October & 24 November 2021**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Finance & Performance Committee held on 27 October & 24 November 2021 and approved at its meetings on 24 November and 22 December 2021 respectively.	
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.

Northern Lincolnshire and Goole NHS Foundation Trust

MINUTES

MEETING:	**Finance & Performance Committee**	
DATE:	**28 October 2021 – via Teams Meeting**	
PRESENT:	Gill Ponder	Non-Executive Director / Chair of F&P
	Simon Parkes	Non-Executive Director
	Fiona Osborne	Associate Non-Executive Director
	Lee Bond	Chief Financial Officer
	Shaun Stacey	Chief Operating Officer
	Shauna McMahon	Chief Information Officer
	Simon Tighe	Deputy Director of Estates & Facilities
	Ian Reekie	Lead Governor
IN ATTENDANCE:	Jennifer Moverley	Head of Compliance and Assurance (For item 5.2)
	Anne Sprason	Finance Admin Manager/PA to CFO (Minutes)

Item 1 10/21 Apologies for absence were noted from: Stuart Hall; Peter Reading; Linda Jackson and Jug Johal (Deputy Simon Tighe)

Item 2 10/21 **Declarations of Interest**

Simon Parkes declared an interest as he was Deputy Vice-Chancellor of the University of Lincoln, with links to the Trust in Nursing and Education, and also a Non-Executive Director at a Social Housing Partnership in Lincolnshire with links to the Trust on housing.

Item 3 10/21 **To approve the minutes from the previous meeting held on 29 September 2021**

The minutes from the meeting held on 29 September 2021 were reviewed. Fiona Osborne highlighted Page 10, 4th paragraph to add wording as follows *… 1% of the invoices that are problematic and need Trust staff attention.* Subject to the amendment the minutes were agreed as an accurate record.

Item 4 10/21 **Matters Arising**

All actions from the minutes were included either on the agenda or the action log.

4.1 Action Log

The action log was reviewed, noting there were very few items outstanding.

7.1 (28 07 21) – *Finance Report* – Pressures in medical staffing and agency costs due to vacancies and recruitment. Cross referral to Workforce Committee with update from Michael Whitworth. **Action**: Anne Sprason to check with Michael Whitworth.

All other items were either completed, on the agenda or not due until November 2021. The action log was noted.

4.2a Review of the Workplan

The workplan had been refreshed into the new format as part of the changes required in the revised TOR, as discussed at the last meeting. The workplan was reviewed and agreed.

4.2b Review of Action Plan following the self-assessment exercise

Gill Ponder highlighted that this had been reviewed and the majority of the actions were now complete including the rotation of the agenda items from this month. This would result in each section given an opportunity to appear first on the agenda and time for a more detailed discussion.

Gill Ponder had specifically highlighted the action at Item 10 i.e. *Discuss and describe how the Committee provides timely and effective direction, advice and support to Clinical and Non-Clinical Directorates in order to reduce risk to the Trust.* The evidence to support this item was noted as the Action Log and Committee Minutes. Gill Ponder asked if the alignment of NEDs to certain divisions satisfies that requirement and for any views on whether that could be improved.

Shaun Stacey noted that historically the Committee invited divisions to attend where there were financial and/or performance issues e.g. Medicine and A&E development assessment unit in the early days; Surgery and 52 weeks as well as financial issues for both divisions. This had been replaced with a rolling programme from individual divisions that Shaun Stacey presented, which he felt was the right approach and also NEDs aligned to the Divisions gave a further level of assurance.

Fiona Osborne noted that not all NEDs were members of the Committee, but the core information was quite thorough providing there was sufficient time for detailed discussions.

Lee Bond was concerned that the question asked was not the right one as it was the job of Executive Directors to provide guidance and direction to the Divisions/Directorates and the job of the Committee to gain assurance from those Executives.

Gill Ponder agreed wholeheartedly with Lee Bond's comment and suggested that the self-assessment needed an overhaul.

Simon Parkes agreed and suggested that the question should be changed as examples could not be given.

Gill Ponder proposed that when the action plan was updated an appropriate note should be added to Item 10 and that it should be closed.

Action: Gill Ponder / Anne Sprason

All other actions were agreed, and the action plan was noted.

Item 5 10/21 **Presentations for Assurance**

5.1 CQC Progress Report

Jennifer Moverley attended the meeting to present the CQC progress report and highlighted that 14 actions had been closed, with 76% of all actions either green or blue. Jennifer Moverley highlighted that the report now included the actions aligned to each Trust sub-Committee, but this was open to change if it was not correct.

There were 30 actions aligned to the F&P Committee i.e. 0 red; 10 amber; 6 green; 13 blue and 1 on hold. The Trust Wide financial strategy was amber and due at the end of October. There were 5 actions relating to waiting lists and all had mitigation plans in place; 2 delayed access to theatres with mitigations in place; Surgery ICU at SGH now had cover for weekends and were actively recruiting to vacancies including anaesthetist for delivery suite.

Fiona Osborne noted that the actions were very thorough and liked the new report but highlighted that a few areas stated, "mitigations in place" and asked if more information could be provided to give the Committee assurance. Jennifer Moverley highlighted that the actions were discussed at the PRIMs meetings and she would take the information from there to include in the report.

Action: Jennifer Moverley

Fiona Osborne referred to the finance strategy and Lee Bond explained that the H2 plan would be in place by the end of the month, the nursing establishment review was underway and he was working together with Ellie Monkhouse and Shaun Stacey to progress that. It was unlikely that any major changes could be made in the next 6 months and therefore the impact on H2 would be minimal, however it was important to have sight of it and assess the impact on the financial outlook. A longer term workforce and financial model was also required

Fiona Osborne was concerned as this had been discussed at Trust Board and NHSE/I so would be on their radar. Lee Bond confirmed that work was ongoing including consideration of Birth Rate Plus and work in the community so all areas would be covered.

Gill Ponder referred to Diagnostics (4Dai) and noted that reference was made to performance up to May and asked if there was anything more recent to indicate that improvement had continued. Jennifer Moverley confirmed that she met with Divisions on a monthly basis and gave assurance that improvements had been made, noting that a position paper had been provided to CQC which confirmed improvements.

There were no further questions and Jennifer Moverley was thanked for the clear and helpful paper provided and she left the meeting.

Item 6 10/21 **Finance Report – M06**

Lee Bond presented the paper and highlighted key issues to note:

- The Trust deficit for the month of September was £0.25m which was £0.02m adverse to plan, so no issues to highlight. This was replicated across the ICS.
- Income was £0.19m above plan in month
- ERF estimated income of £3.83m YTD which was largely used for Independent Sector capacity
- Medical Staffing & Nursing overspent by £0.87m and £1.52m respectively. Mainly around doctor costs and some related to additional activity and the number of unplanned opening of beds; also, anaesthetic costs due to adding in another tier of doctors to improve safety and not reflected in block contracts.
- Non-pay was £0.66m underspent in month due to low activity mainly around planned Independent Sector additional capacity and associated consumable costs.
- Additional Covid expenditure of £7.1m compared to £7.5m income. Forecast Covid expenditure for the year was £12m.

- Temporary staffing costs still an issue and whilst compliance with some frameworks was improving for nursing, spend was being driven by the volume of shifts being requested.
- Savings plans slightly ahead of plan however non-recurrent, so underlying position was not improving.
- Capital plans experiencing pressures due to issues with supply chain. The capital programme for the year looked likely to be £15m underspent due to problems on energy efficiency schemes. It was important to note that this was grant funded and would not count towards CDEL (Capital Departmental Expenditure Limit). The Trust were working with SALIX/BEIS to confirm funding into 2022/23, at which point the Trust would be able to place contracts.
- H2 guidance had now been received so work was ongoing with commissioners and the wider Humber patch to develop a balanced plan. Current indication was that a gap existed as a result of increased costs in the 2nd half of the year, an increased efficiency requirement and reductions in income (Covid & ERF). With regards to the ERF, current plans suggested we would achieve some but only as a result of additional in-sourced and out-sourced work with the independent sector.
- The H2 allocation also included an allocation for winter funding. The Trust were not clear yet as to how much would be made available to NLAG but the Trust had started to incur some costs at risk, notably with the introduction of an urgent care service in the emergency department.

Fiona Osborne referred to temporary staffing in particular the admin and clerical variance which was just under £1m overspent and asked if there was an education process for temporary staff. Lee Bond noted there was £429k overspend on admin and clerical staff with pressure on admin functions in organising theatres lists and clinics causing pressure.

Shaun Stacey agreed and highlighted there were some areas of expenditure that would continue i.e. swabbing and vaccinations so would impact on expenditure. There was also additional medical staff in some areas i.e. Covid and non-Covid areas in assessment unit which required staffing. More beds were open caused by seeing winter in summer and also trying to reduce potential risk of infection by managing the early part of the patient journey. The Trust were running respiratory in a similar way with additional pressure as having to extend services to meet additional demand during the winter period. He stated that whilst they could be Covid related costs, they could also be termed business as usual.

Shaun Stacey highlighted a number of training programmes in place including advanced clinical practitioners with a number of people coming off their first level of the programme but would be another couple of months before seen on the medical rota. There were a number of doctors going through the Consultant training programme, but it had been difficult to get academy learning throughout the pandemic, but they were being encouraged to complete their training, which would ultimately reduce dependency on locums. Apprentices were being considered to develop more HCAs and overseas nurses were expected to join the Trust in November which would also reduce reliance on agency. So whilst there was a training programme in train which would deliver benefits, this would take another few months.

Fiona Osborne acknowledged all that had been said but was looking for more opportunities with admin and clerical costs. Shaun Stacey highlighted that one of the reasons for the spend was some duplication of work under the current climate.

Simon Parkes referred to the SALIX grants and the two risks and asked if it was known if the grant money could be carried over, noting last month that it was stated that negotiation was still ongoing so looked like things were not moving forward. Lee Bond explained that clarity was expected by December but if not then the programme would be put on hold and SALIX and NHSE/I were aware of that. Simon Tighe stated that an FBC would be completed in January but only if confirmation was received that the grant money could be carried over to 2022/23.

Gill Ponder queried CIP under delivery in a couple of areas. Mike Smith explained that it was the unidentified schemes. A target had been set and now two areas were still under delivering, although other areas were over delivering. The two areas had plans not yet finalised which was why still showing as under delivery, however if they were not able to achieve the savings by year end, the other areas would mitigate against that

Following review and discussion the Finance report was noted.

6.2 Capital Investment Board Minutes

The Capital Investment Board Minutes had been provided for information and were noted.

6.3 Financial Special Measures (FSM) – Letter

The letter provided was from August and as no specific meeting had taken place, no further letter had been received. Lee Bond explained that a meeting would be taking place later that week to go through the financial model and he would ask for confirmation on the process and timescales for the organisation's FSM status.

6.4 Long Term Financial Model

Lee Bond explained that this was part of the exit criteria for FSM and was circulated for information. The financial model was still in draft form but he drew the Committee's attention to key issues throughout the paper.

Fiona Osborne noted that a further draft would be provided next month and asked what the process would be. Lee Bond noted that a budget was being announced that day and there would have to have assumptions to plan for 2022/23, so may have multiple years plans. He confirmed the model would change as soon as official guidance had been received.

Simon Parkes highlighted concern with inflation risks with pay inflation higher than previously anticipated. Lee Bond also highlighted that there could be capital inflation charges. The next iteration would be brought to the Committee in November.

Action: Lee Bond

6.5 Achieving the HCV System Target

Lee Bond highlighted that the system balanced at H1 and the plan was in train for H2.

6.6 Use of Resources

Mike Smith attended the meeting to present the report which was taken as read.

Gill Ponder referred to page 69 and queried the feasibility report completed in October 2019 and assumed this required updating, which Mike Smith agreed to do.

Shaun Stacey thanked Mike Smith and team for producing the report. Concern was expressed around the Weighted Activity Unit (WAU) cost and why this was so high. Lee Bond stated that fundamentally this was being driven by the Trusts reliance on variable pay and agency costs in particular but would need to look at it in more detail.

Lee Bond said that Mike Smith was going to prepare a one-page summary to explain the WAU for Peter Reading and he would circulate to NEDs as well for information.

Action: Mike Smith

Simon Tighe highlighted the accommodation around Scunthorpe and working with the Council on accommodation provision in the Town i.e. Project Anchor which was currently in the infancy stage.

Simon Parkes referred to HR costs including absence rates and overall staffing costs stating that this was a critical area for the Trust. There was also the risk around BLM and the Trust infrastructure which was well known but interesting to see it coming through the report.

Lee Bond explained that following discussions with the CEO and Director of People, approval was given to invest in HR. Christine Brereton had committed to reorganise the Directorate in the longer term but in the short term we would continue to appear as an outlier in this area.

Mike Smith explained that the document was always out of date and the best time to review the document would be January and April when the freshest model hospital information and corporate and clinical areas were available.

Following review, the report was noted.

Item 7 10/21 **Digital Strategy**

7.1 Digital Update – Including PAS Proposal

Shauna McMahon presented the report which outlined the proposals for the PAS system upgrade jointly with HUTH. There were four proposed options with option 4 the preferred option. The final confirmation would be determined subject to the finance leads at both Trusts. The majority of the costs would be covered through the digital aspirant funding with the remainder to be determined.

Simon Parkes stated that given finances were already pressured it would need to be clear that this was the right thing to do as once a joint approach was in place, it would be difficult to revert back. Whilst it may be the right thing to do now it could change in 5 years and he queried how difficult it would be to unwind from that.

Shauna McMahon explained that part of accepting the digital aspirant funding required a collaborative approach and other Trusts were doing similar. There was an ICS level Digital Board in place and there would be more reliance on collaborative working to obtain funding and deliver on the digital agenda. She added that digital was an enabler and would require more collaborative working to gain efficiencies.

Fiona Osborne asked if the investment proposal had been signed-off by HUTH.

Lee Bond stated that IT sits within his remit and he had asked for a paper on the implications for HUTH and explained that there had been some nervousness expressed around knowledge transfer and the extent to which the team at Hull would be diverted on education issues for NLAG through the process. He noted however, that HUTH had had the system for five years and hopefully could use that learning to help NLAG to avoid some of the issues they had faced.

In terms of the formality of signing contracts, there was a commercial advantage for both organisations and PAS and Patient Master Index was a core part of hospitals and he could not see that changing. He also highlighted open source technology which allows change to happen, should it be needed.

Fiona Osborne was in support of the recommendations given the information available within the report and the discussions that had taken place.

Gill Ponder asked if everyone was in agreement to approve Option 4 as the preferred option. Simon Parkes was uncomfortable to agree to a joined-up approach in case change happened further down the line. Gill Ponder stated that the open source platform would alleviate that, and Shauna McMahon stated that PAS would not be difficult to unpick if required and EPR would help with that.

It was agreed to accept Option 4 acknowledging the risk highlighted by Simon Parkes.

7.2 Business Intelligence

Shauna McMahon gave a brief verbal update to the Committee and explained that the IPR continued to be streamlined, particularly with respect to the commentary. Not included in this month's iteration was the request to include a public summary view of where the Trust sat with centiles and this would be completed for next month.

Shauna McMahon explained that the IPR would be produced and sent out for the sub-committees each month, even though only required at Trust Board every other month. Any issues that were raised where a deep dive was required could be available the following month. Gill Ponder stated that the deep dives were included on the Committee's workplan but acknowledged if there was anything additional, it could be included the following month

Item 8 10/21 Estates & Facilities

8.1 BAF Risk Review – LV/HV

Simon Tighe presented the report and highlighted issues to note, including the Premises Assurance Model (PAM) section which only had minimal and moderate improvements required which were outlined within the report. The generator sets across the sites were tested monthly with a high risk noted due to general controls which may fail, along with the age of the equipment, however in the event of a power outage, if the generator failed to start automatically the on-call engineer could manually start the generators.

Simon Tighe highlighted one red rated action on the action plan which related to the fixed wiring and test and it had been discovered that the due diligence had not been undertaken by the contractor and records had not been kept up to date. That contract had been terminated through poor performance and a new contractor was now in place. The new Contractor had undertaken a full inspection; updated drawings were currently awaited for the full site status.

Simon Tighe also highlighted the risk relating to the replacement of the generator sets which would require capital funding and would hopefully be included in the 2022/23 BLM programme which would close the risk.

It was noted that no BLM had been allocated to upgrade the LV infrastructure however a number of upgrades had been or are due to be completed as part of the ED/AAU schemes.

Simon Tighe wanted the committee to be aware that the audits on the specialist engineering fields were carried out by Authorising Engineers (AEs) and those AEs were independent to the organisation. The Authorised Persons (APs) were internal estates staff. Each member of staff normally has three AP roles e.g. HV, LV and Lifts. There were only 12 estates members of staff that hold AP functions and those staff were being asked to support the major projects on site (ED/AAU and Energy), as well as the normal schemes such as Ward 25 refurbishments. That takes the teams away from their governance roles and the annual audit reports and action plans which was why there were a number of moderate and low risk actions that had not been completed however the team would always focus on the high-risk items.

Gill Ponder queried the electrical APs covering Trust wide and Simon Tighe explained that as part of restructuring they had upskilled two of the roles to cover cross site rather than be site specific.

Following review, the report was noted.

Item 6 10/21 **Review of NLAG Monthly Performance and Activity Delivery (IPR)**

6.1 Unplanned Care

Shaun Stacey presented the IPR report and highlighted issues to note, including:

- Continued pressures being seen in urgent and emergency care due to the number of attendances as well as skill mix and workforce generally, despite increased use of agency, temporary Doctors and nurses.
- Continued challenge with flow of patients through the hospital and seeing 25% above 2018/19 levels of people who do not need to be seen in A&E and should consider alternatives. A number of those were under primary care or community services but due to feeling unwell and unable to access those services quickly, resort to A&E.
- Overnight and evenings were seeing increased numbers of ambulance deliveries after 4.00pm and because of demand resulted in a number of increased ambulance delays over 60-minute waits. A further improvement programme agreed to reduce those delays whereby ambulance teams could stream patients. Also 111 could book slots to both emergency departments, however this had caused some challenges as the given time slots could not always be accommodated due to emergencies coming in.
- Ongoing issues with discharges due to difficulties accessing care at home e.g. in North Lincs 100 beds occupied for patients who should have only been in for 3-4 days, but due to lack of domiciliary care were in for several weeks and months. Salaries and now individual Covid status were having an impact on care homes and domiciliary care. Blockages were also created due to discharges to Lincolnshire East.
- An initiative to improve the management of frailty across both sites through Single Point of Access at SGH and at DPOW, responding to falls so elderly patients could be discharged on the same day. 33% of patients were discharged on the same day which had been sustained for two months and it was hoped that this would continue through winter.

- Significant numbers of patients were being seen every day and out of 260 patients 100 were seen by urgent care service (which previously through the UTC service would only be 20 patients) so it was recognised that there was a need to move to 24 hour service. There had been a reduction in patients in A&E that had booked in and left before being seen and the initial feedback from clinicians on the new way of working was that it was more rewarding and better in managing patients.
- As part of improvements to flow out of the emergency department, a holding area would be created as part of the new IAU build but until then, they were trying to mitigate ambulance delays and majors on both sites, hopefully an improvement would be from the middle of the following week
- The primary reason for delays to flow was around domiciliary access but the introduction of discharge to assess model had in some areas returned to the original process so it was hoped to get that back on track.
- Impact of Covid - There were between 45-50 beds occupied across the two sites with 3-5 in ICU and also some early impact of flu. These affected flow and discharges with the two biggest risks being demand and workforce skill mix.

Fiona Osborne queried the ambulance service and reliance on the control room giving the right direction to crews and asked if it was getting through. Shaun Stacey believed it was and advised that they had a good relationship with the duty ops managers. The information was getting out there and ambulances were trying to reduce the numbers of attendances, but the system generally was struggling in the current climate.

Simon Parkes referred to the increase in attendances and performance deteriorating month on month and asked if Shaun Stacey thought this had peaked or if worse was to come. Shaun Stacey did not think the worst had been seen and the acuity of patients was challenging. This was being managed through the emergency department but ongoing workforce issues, including sickness absence and annual leave, had an impact and whilst they could supplement with temporary staff this did not always equate to the right quality for patients. If Covid increased and there was a flu outbreak this would have even more of an impact, noting the difficulty in that Covid positive patients cannot be sent back to care homes until two negative swabs had been seen and flu would be managed in a similar way.

9.3 Recovery of Patient Waiting Lists per Specialty

Shaun Stacey explained that the summary in IPR provided the detail and highlighted that lower performance of RTT continued due to prioritising long waiters. 52 weeks continued to be below the starting point, but had increased by 1,025 due to annual leave and fewer patients being treated in August. He confirmed there were still very clear plans in place to achieve zero by the end of March 2022. There was also the additional challenge of capacity.

Cancer – 2ww continued to be achieved with some pressure in achieving 31 day first treatment. The 62-day standard was 61.5% in September and the 62 day screening standard was 87.5% against the national standard of 90%.

Diagnostics had seen an increase in performance but again reporting limited capacity in major modalities as cancer patients were being prioritised. Some slight improvement seen in DM01.

The H2 update was provided within the papers and an outline first cut had been submitted and feedback was currently awaited.

Gill Ponder queried the 62-day standard on cancer, acknowledging the challenges and noted that it had continued for a while now and asked Shaun Stacey for a view of when they could expect to see an improvement.

Shaun Stacey commented that the challenge was the volume of patients referred into colorectal, but he hoped that improvement would be seen as early diagnostic pathways became more established as GPs were undertaking fit tests. The remainder of the cancer work was linked to services provided by HUTH on both diagnostics and treatments. Other avenues had been explored but everywhere else were having similar challenges.

Lee Bond raised the core capacity noting that the initial draft of the activity plan had suggested the Trust could achieve above the 95% threshold, whereas the organisation was just under 95% and asked Shaun Stacey what could be done to get back to those levels. Shaun Stacey highlighted theatre risk and in particular SGH theatres not being reliable but hoped an improvement would be seen through the efficiency drive. Every service were looking to add one or two additional patients on their lists. In Maxillofacial, there were problems with resource not being available and sessional commitment not available, so they were having to work with sub-contractor on that. ENT was a challenge across both sites in getting non-theatre capacity so need to work on capacity levels specialty by specialty.

Gill Ponder referred to the pilot scheme at SGH and asked how confident Shaun was that the mechanisms in place to capture learning if the pilot was successful would enable a speedy roll out to Grimsby. Shaun Stacey explained this had taken eight weeks of planning the change, but the challenge had been related to now having to report through the System 1 platform. Daily audits were undertaken which were showing positive results. There were complaints at DPOW that there were queues for minors whereas at SGH there was a waiting room for minors at peak times. Shaun Stacey agreed to bring back a further update.
Action: Shaun Stacey

Item 10 10/21 **Items for Information**

10.1 Performance Letters to Divisions following PRIMs Meetings

The letters from September 2021 had been provided for information and were noted.

Item 11 10/21 **Any Other Business**

There were no matters raised.

Item 12 06//21 **Matters to highlight to other Trust Board Assurance Committees**

There were no items to highlight to other Trust Board Assurance Committees.

Item 14 10/21 **Matters for Escalation to the Trust Board**

The following items were noted:

- Urgent Care Position and continued deterioration but recognition of the work being undertaken, including ambulance handovers.
- PAS proposal – reviewed and approved Option 4 with cautionary note from Simon Parkes

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

Gill Ponder asked the Committee if there had been any issues raised relating to the BAF risk ratings of which there were none.

Item 15 10/21 **Review of Meeting**

Shauna McMahon commented that the discussions had been helpful and very insightful and appreciated the open discussion. Fiona Osborne noted that it was good to have the time to get into more detail.

Simon Parkes noted that at the last meeting (his first) it had been difficult to get through all the papers provided but this meeting had focussed on a more detailed discussion.

Shaun Stacey agreed with all the above comments. He asked that in terms of the concerns around emergency care if the Committee were provided with sufficient information from him to provide the assurance they required to articulate to the CQC if required.

Gill Ponder commented that she could articulate the challenges. Simon Parkes agreed that he could probably paint a picture but would find it helpful and clearer joining the dots on the levels of sickness levels for example and vacancy rates etc. Whilst he could find the information, it was about drawing dots together and getting the right conclusion so would prefer key facts at his disposal.

Item 15 10/21 **Date and Time of next meeting**

Wednesday, 24 November 2021 – 9.00am-12.00pm via Teams

Attendance Record 2021/22

Name	Apr 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	March 22
Neil Gammon	✓	✓										
Gill Ponder	✓	✓	✓	✓	✓	✓	✓					
Linda Jackson	Apols	✓	✓	Apols	✓	Apols	Apols					
Stuart Hall	✓	✓	✓	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					
Ivan McConnell	Apols	✓	Apols	✓	✓	✓	-					
Shauna McMahon	✓	✓	Apols	✓	✓	✓	✓					
Helen Harris	✓	Apols	-	Apols	-	✓	-					
Brian Shipley	✓	✓	✓	✓	✓	✓	Apols					
Simon Tighe	-	-	✓	✓	✓	-	✓					
Ab Abdi	-	-	-	✓	-	-	-					
Ian Reekie	✓	Apols	✓	Apols	✓	Apols	✓					
TOTAL ATTENDEES	12	11	8	8	11	10	8					

MINUTES

MEETING:	**Finance & Performance Committee**	
DATE:	**24 November 2021 – via Teams Meeting**	
PRESENT:	Gill Ponder	Non-Executive Director / Chair of F&P
	Simon Parkes	Non-Executive Director
	Fiona Osborne	Associate Non-Executive Director
	Lee Bond	Chief Financial Officer
	Shaun Stacey	Chief Operating Officer
	Shauna McMahon	Chief Information Officer
	Brian Shipley	Deputy Director of Finance
	Simon Tighe	Deputy Director of Estates & Facilities
	Ian Reekie	Lead Governor
IN ATTENDANCE:	Jennifer Moverley	Head of Compliance and Assurance (For item 5.2)
	Anne Sprason	Finance Admin Manager/PA to CFO (Minutes)
	Lauren Short	Finance Admin Assistant (Observing)

Item 1 11/21 Apologies for absence were noted from: Stuart Hall; and Jug Johal (Deputy Simon Tighe)

Item 2 11/21 **Declarations of Interest**

There were no Declarations of Interest

Item 3 11/21 **To approve the minutes from the previous meeting held on 27 October 2021**

The minutes from the meeting held on 27 October 2021 were reviewed and agreed as an accurate record.

Item 4 11/21 **Matters Arising**

All actions from the minutes were included either on the agenda or the action log.

4.1 Action Log

The action log was reviewed.

7.1 (28 07 21) – Finance Report – Cost pressures due to vacancies and recruitment. Michael Whitworth had provided an update. **Item closed**.

7 (25 08 21) – Finance Report – Benchmarking Information. Lee Bond advised that the information would be available for January 2022 and would also include maternity.

6.2 (29 09 21) – Discussion between Lee Bond and Shaun Stacey and primary care workforce. It was agreed this was a strategic issue and should be discussed at the newly formed Strategic Development Committee. **Item closed.**

6.4 (27 10 21) – Long Term Financial Plan – a one-page summary was provided for information and circulated on 1 November. **Item closed**

All other items were included on the agenda. Following review, the action log was noted.

Item 5 11/21 **Presentations for Assurance**

5.1 CQC Progress Report

Jennifer Moverley presented the report and highlighted that 76% of actions were either green or blue with 30 actions aligned to the Finance & Performance Committee, noting none were red, but 10 were amber. An additional section of trust wide actions was now included within the report (section 5).

Gill Ponder referred to several risks aligned to the F&P Committee as follows:

3D - Compliance – Should sit with Q&S
27M - Admission rates for elective – should sit with Q&S
29M – Out of hours – Q&S from medical staffing perspective but also Workforce from safety of rotas. If rotas not safe due to cost, then this would be brought to F&P.

Simon Parkes referred to a Clinical Strategy which was in place and a Financial Strategy which could not be produced beyond March 2022 due to the lack of a financial framework from NHSE/I and asked where that left the organisation and how the Trust would be assured on a sustainable basis financially.

Lee Bond explained the difficulty of writing a financial strategy and a clinical strategy when there was no clear indication of what the Trust would look like in 3-years' time. There was no indication of the income within ICS so could only have high level intentions that buildings would not fall down, but nothing meaningful.

Fiona Osborne referred to the declining performance in Cardiology and Ultrasound and asked if it was receiving any focus. Shaun Stacey advised that additional weekend sessions were put in for Echocardiology to reduce the backlog but there had been some delays due to workforce issues, however this was improving. The item had not been updated but he confirmed that action had been taken. Shaun Stacey agreed to pick up with the team to update.

Action: Shaun Stacey

There were no further questions and Jennifer Moverley was thanked for the clear and helpful paper provided and she left the meeting.

Item 6 11/21 **Digital Strategy**

6.1 Digital Services Update including Clinical Data Improvement Programme

Shauna McMahon presented the report and highlighted that the team would be supporting improvements in the use of digital across the Trust and identifying problem areas preventing that happening. Optimising the use of digital would help to have coders working from home which in turn could have a positive impact on recruitment and improve clinical records. This would require a focus on a Trust wide digital transformation programme and was not just a data quality issue. A particular area for focus was the electronic clinical records which would help with the manual filing of medical records and ultimately help improve coding.

Shauna McMahon commented that any data collection required engagement with clinical staff and GIRFT was also about information being input into the system to ensure data was accurate and of good quality.

Shaun Stacey supported Shauna McMahon's comments that the more data that was captured in digital, the better the value of return and echoed that this was not just about digital systems but having the right people to input into those systems. A lot of paper was still produced but the Trust now had the right resource for waiting lists which had proved a massive benefit, so putting the right digital infrastructure in place was important. The quality of clinical data was improving but there was a need to close that loop by having the right administration structure.

Shauna McMahon commented that when looking at the model hospital, this organisation probably had the highest number of filers i.e. 100 compared to HUTH who had approximately 35; if those filers could be involved with data capture it would make improvements. There were still some areas in WebV to improve and it was hoped that those gaps would be picked up in the New Year, however more work was needed on culture around digital.

Fiona Osborne referred to CDIP and the success of the project noting that the staffing base needed to be reviewed. Clinical coders required involvement of stakeholders and asked if it was anticipated that an extension to the project would be required or if this would be picked up as business as usual. Shauna McMahon explained some shared management had commenced with HUTH and the coding team at NLAG. The use of the IQVIA analytics tool required support from HUTH due to the limited coding resource at NLAG. That was one of the top objectives for business as usual.

Gill Ponder commented that it was known that CDIP links to WebV and other clinical systems and asked if there was a simple architectural diagram that linked them together to help the understanding during discussions.

Shauna McMahon confirmed there was a diagram but unfortunately it would not be a simple one as the Trust's systems were more fragmented than in other organisations. Following an audit, the asset register would be reviewed to understand all those identified as being "owners" of a particular system.

Action: Shauna McMahon

Gill Ponder commented that the only way to succeed was to make using a system easier than not using it as people tend to take the easy route which could be key to unlocking the culture.

Following the discussion, the report was noted.

Item 7 11/21 **Estates & Facilities**

7.1 BAF Deep Dive – SO1 – 1.4

Simon Tighe presented the item which was contained in the full BAF document at Item 10, and highlighted specifically:

- Trust wide infrastructure with 60% falling into major repair or replacement over the next 3 years
- Sufficient number of adequately trained staff had been added to the risk register
- Expressions of interest for new hospital at SGH and new block at DPOW. If capital funding not successful it was unclear at this time what could be achieved

Lee Bond asked what Plan B would look like if some of those risks crystallised and added he was not sure if sufficient time had been spent looking from a practical perspective.

Gill Ponder reminded the Committee that the new hospital programme was a strategic issue and came under the remit of the Strategic Development Committee with the ongoing running of the hospital remaining with the Finance & Performance Committee.

Gill Ponder asked if a paper could be provided on Plan B. Simon Tighe explained that this was part of day to day work in terms of risk register and compliance but did not have sight of what was significant from a clinical perspective. A Plan B would need detailed discussions with clinical colleagues and how that mapped to service delivery. It would be quite detailed work which may not be needed should capital funding be successful. However, even if funding was awarded, there would still be a need to manage the hospital for circa 10 years until the new hospital was built.

Simon Tighe advised that the Estates Strategy was being drafted and he would discuss with Jug Johal the possibility of having narrative included for a Plan B. That would be brought to the Committee in January 2022.

Action: Simon Tighe

Lee Bond stated that he would like a three-year view of what capital would look like to enable assurance for Trust Board around continuity in that timescale. It would be taken through Capital Investment Board in the first instance and reported to Trust Board in Spring 2022.

Lee Bond asked if the risk score of 20 was the gross score and if it was still appropriate. Simon Tighe confirmed it was the gross score. He highlighted examples of the reason for 20 i.e. large parts of the roof narrowly missing staff and patients, HSE investigation of alleged legionnaire given to a patient and coronation block at SGH requiring closure. Services would still need to be maintained even with a new build on the horizon, therefore a score of 20 was still appropriate.

Gill Ponder referred to a previous conversation on some long-term risks which could not be resolved in a year and asked if annual targets should be considered to reduce the risks until the target risk score, that aligned with the risk appetite, was achieved. Lee Bond suggested a risk stratification should be produced as there were some specific areas such as roof, pipework or oxygen and there was a need to understand the granularity in order to tailor the capital around it which would ensure transparency for the Trust Board.

Gill Ponder agreed and asked if a summary of the bigger issues that were causing the risk score of 20 could be provided. Simon Tighe explained that the BAF report included the biggest risks and suggested embedding that information within the next report in January 2022.

Action: Simon Tighe

Simon Parkes commented that it was clear from the discussions that there were risks that needed to be managed and suggested highlighting to the Trust Board what Plan B would look like until the new build to ensure sustainable services.

7.2 Civils Infrastructure

Simon Tighe presented the report and highlighted areas to note.

- CCTV was a large risk for the Organisation, and this was incorporated within the car parking and security contract. The team were currently working on installing the cameras on a priority basis, which should be completed over the next 3-4 months.
- Energy performance fund scheme had been unable to roll-over into the next financial year and had been asked to complete as much as possible but that increased the fragility of the SGH site; this would also need a Plan B.
- SGH fuel storage tanks
- Clock Tower, DPOW – this was not officially a listed building but any plans to demolish it would lead to it becoming listed, so structural work had been completed over the last two-years and that risk had been removed from the risk register.
- Trust wide window replacement – windows had to be replaced on a priority basis.

Simon Tighe referred to the BAF (page 10) which included strategic risks, current controls, planned actions, future risks and gaps around funding availability and asked if that included enough detail for the Committee.

Fiona Osborne suggested that the information contained within the BAF and the E&F risk register was sufficient, acknowledging comments made by Lee Bond.

Simon Parkes found it helpful as far as it went but suggested there were significant issues to work through, not just for Estates but for the whole Trust. Hopefully, the organisation would have a good case to ensure funding, but it was difficult to see how services could be sustained, particularly at SGH, adding that it would be useful to bring together estates with operational risks for Trust Board to understand.

Shaun Stacey highlighted services were still delivered with the loss of coronation block but that could not be replicated if further capacity was lost. The issues should be escalated to Committees in Common as well as the Humber risks that need further discussion to get the strategic direction of travel. Lee Bond stated this could be picked up as part of the planning process.

Fiona Osborne supported the comments and stated that from a monitoring perspective, the papers for the F&P committee were sufficient but there would also need to be strategic sighting of the risks and review within the planning process.

Gill Ponder stated there was clearly a significant risk and the Committee were satisfied that the risk score was justified based on the conversations. As part of the planning process, estates priorities and operational impact should be reviewed, to ensure that the Trust Board were sighted on the short-term risks, whether or not funding was awarded for a new build at SGH. Clarity was required on the actions that would be possible, funding needed and the choices that the Trust would have to make when allocating funding.

Action: Simon Tighe

Following the discussion, the report was noted.

Item 8 11/21 **Integrated Performance Report (IPR)**

Shaun Stacey presented the report which was taken as read and highlighted specific issues to note:

- Emergency Departments were working under significant pressure and saw 11,000 attendees the previous month which equated to 20-25% increase on the 2019/20 position. Continued challenges with patient flow and a high proportion of DTA patients not moving to a bed in 4 or 12 hours
- A&E was 53% for 4-hour performance with slight improvement to 60% over the last few days which demonstrated that new action was being effective
- A high proportion of attendees at DPOW due to Covid, with 16% of workforce off sick due to Covid related illness. This had been discussed at the Workforce Committee but it impacts on finances and front door performance.
- Continued challenge with flow in both North and North East Lincolnshire with 59 patients with no right to reside at hospital for either 7 days or 14 days.
- Ambulance delays continued with a lot of delays exceeding 60 minutes and 16% over 30 mins, directly attributed to flow through the department and capacity
- Work at SGH affecting flow, again complicated by Covid. More beds could be opened but had limited number available with the additional challenge of staffing.
- Urgent Care Service at SGH now live with 98% performance of patients arrived, triaged and streamed within 4 hours. Better utilisation of same day community service. Ambulance also able to be streamed. This was still functioning between 8.00am-8.00pm and whilst it had been agreed with primary care to work with the Trust until midnight, shifts could not be filled. It was hoped that the 98% could be sustained which would help with the overall performance level but still had to resolve the backdoor problem.
- Continued with 111 programme and direct work through Single Point of Access and worked with ambulances on category 3-4 patients i.e. not needing blue light, but needed help. Whilst this would not help performance figures, it would reduce the number of people brought in and requiring a bed as they could be managed in the community.
- Had maintained flow albeit slow and not within the time target, continued to discharge on daily basis and slightly below the national target of 5.8% at 4.4%. Continued flow doing well as part of SDEC programme, with 30% going there, compared to 12% nationally.

Ian Reekie asked when it was envisaged that UCS would be extended to DPOW. Shaun Stacey advised that it had been discussed with NEL primary team and had been agreed to go live from the middle of December but more realistically would be January 2022.

Gill Ponder commented that the IPR was much improved and helped the Committee focus on the big issues but did not give assurance on the actions being taken and when improved performance could be expected i.e. trajectory going forward rather than looking back. That would enable the Committee to gain assurance that recovery plans were on track. Shauna McMahon confirmed that once the new IPR was established, she would expect the timescale to include trajectories but that could be Q1 of the new financial year.

Lee Bond referred to the exit block and asked for the likelihood of improvement or if LOS would increase with continued poor performance on discharges before midday. Shaun Stacey could not give assurance as he was aware of significant problems with the loss of two nursing homes in North Lincolnshire with the ability to take Covid positive patients; the Trust were working with North Lincolnshire on that. He went on to explain that work was being undertaken on bed management in the community and reviewing LOS, but the Trust may well see an increased need to open more beds and LOS increasing.

Lee Bond asked if more beds had to be opened, what quality assessment was undertaken and whether the workforce was available or would that involve using agency. Shaun Stacey explained that protocol would be followed, but currently could only get 60% fill rate and 40% in medical requests which would suggest it would not be possible to open up more beds to support the community even if available; that was also the case with nursing staff. Shaun Stacey added that if elective was stopped it would give 42 beds across the two hospitals, with only day surgery continuing, but that was not an option that he wanted to use.

Following the discussion, the IPR was noted.

8.2 Business Continuity – EPPR

Shaun Stacey explained that following self-assessment the organisation had achieved an EPPR assurance rating of Substantial i.e. 89-99% compliant with core standards; for those non-compliant core standards, the Board agreed an action plan to achieve compliance within the next 12 months.

Shaun Stacey explained that due to timings the report had already been discussed at Trust Board. NHSE/I had agreed the Trust's self-assessment rating of Substantial and the action plan which included HAZMAT training, Avian Flu Policy and Standard Operating Procedures.

Gill Ponder was content that the report continued to be brought to the F&P Committee as it was part of Shaun Stacey's remit.

Following the review, the report was noted.

8.3 Planned Care

Shaun highlighted specific areas to note:

- Continued increase in waiting list numbers which would be included in H2 planning
- 52ww reducing with an improvement seen in month
- Cancer remained steady in 2ww and breast systematic, although some concerns on 31-day treatment position. The 62-day standard had improved, but still not where it should be. All cancer data was unvalidated.
- Diagnostics – some additional capacity with MRI and it was envisaged by February 2022 waits would be 1 day, with CT waits of 4 days.
- Concern on RTT due to requirement from CAP Board to work up plan to level up waiting lists across the ICS. That would mean deterioration in NLAGs RTT position as it was assumed it would involve 52ww and 104ww, as well as significant workload of routine MRI/CT scans and endoscopy work. It would result in additional funding to deliver it, but would impact on the Trust's performance position. Shaun Stacey to include more detail in next month's IPR report.

Action: Shaun Stacey

Lee Bond stated that notwithstanding the ICS approach, it was a fabulous achievement to get to 1 day and 4 days for MRI/CT. He suggested that it should be possible to monitor the impact of the additional requirements to reduce waiting lists across the ICS as it was inevitable that long waiters would be sent to NLAG. Shaun Stacey explained that as the transfers would be electronic, the intelligence in the system was not available and it was acknowledged that the Trust's position would deteriorate.

Gill Ponder referred to Cancer and noted in the IPR there were several comments that performance would not improve without process redesign. Shaun Stacey explained that there was a comprehensive improvement programme where Q&S had oversight, a few improvements had already been implemented with benefit seen however there was a significant piece of work to be done on different cancers to determine the biggest issues. They would be prioritised with Upper GI, Colo-rectal and then Urology. Shaun Stacey suggested the report from Q&S could be provided for information which was accepted.

Action: Shaun Stacey

8.4 Monthly Deep Dive – Risk Stratification

Shaun Stacey presented the report which detailed the current risk stratification position. He explained that 89% of patients within the priority group were treated within time. However, there was a proportion not getting the required care but they were treated in the next timeline.

Fiona Osborne asked the reason for the three specialities and Shaun Stacey explained that Urology patients included cancer patients that needed annual review and regular Cystology procedures; Ophthalmology included patients with eye degenerative conditions so those were from a safety perspective; Gastroenterology included digestive disease, often in upper GI and not getting their follow-up plans done, however with improved diagnostics only cancer would cause delays.

Lee Bond referred to the total of 11,000+ patients overdue and asked how assurance could be given that no clinical risk of harm was likely. Shaun Stacey explained that through the COBRA system clinical harm assessment review was part of the next follow-up appointment, noting there was no evidence that risk stratification stopped harm occurring. Shaun Stacey added that from September 2022 no-one would be on the list without risk stratification taken place and it would include harm review assessment.

Lee Bond noted therefore that some patients may come to harm, but it would not be known until their next appointment and suggested that was a gamble. Shaun Stacey explained that there had only been one patient, which was an Ophthalmology patient, and the approach was based on science. He added that the patients had chronic conditions and would be waiting 3, 6 or 9 months for appointments but that was an historical approach and difficult to change nationally.

Shaun Stacey highlighted that Patient Initiated Follow up (PIFU) only had 21% take up due to culture of follow-up appointments and the Trust was trying to encourage more use of that, adding that virtual clinics were also useful but only 16% were using those.

Following review and discussion, the report was noted.

Item 6 11/21 **Finance Report – M07**

Lee Bond presented the paper and highlighted key issues to note:

- The Trust deficit for the month of October was £0.30m and £0.22m better than plan, with the YTD position of £0.49m deficit and £0.24m better than plan.
- Income was £1.85m above plan in month. Variances included 3% pay award funding
- Non-pay was £0.32m overspent in month mainly due to level or activity not at rate expected

- Temporary staffing was £39.5m above plan, which was circa 36-38% increase on same time in the previous year. Hugely reliant on Trust staff working on bank / agency and seeing greater use of Tier 1 and Tier 2 agencies but generally due to workforce and quality pressures
- Medical staffing – steady rate of compliance in core hour rates.
- ERF – Impact of £800k on increased activity but income not received for M07 which was affecting the financial position. Since the report was written, had worked with ICS on a proposal to secure additional elective funding amounting to circa £5m for NLAG which should improve M08 position
- Concern on costs of workforce and ability to contain, noting the potential demand outlined by Shaun Stacey on the bed situation with no staff.
- Capital – Comfortable with position as stated in terms of NHS funded. Grant funded around energy and problem of circa £23m. Discussions at national level on bridging finance from one year to the next
- Underlying position broadly similar to previous months

Fiona Osborne referred to Covid expenditure (page 5) and the urgent items for the Trust noting they had been on the report for three months and asked if progress could be provided.

Lee Bond explained that emergency department rotas was nursing rotas rather than medical and a paper would be taken to Trust Board on bed establishment for nursing. A paper had been taken to TMB the previous week outlining several gaps from a professional perspective on ward staffing and increased ward establishment to reduce safety concerns. In terms of the third item relating to virtual ward expenditure, Lee Bond agreed to investigate that issue.

Action: Lee Bond

Gill Ponder referred to Capital (page 15) and the oxygen works at DPOW noting completion should have been before winter and was now delayed to March 2022. Simon Tighe explained that a programme had been agreed with BOC but acknowledged it was still a challenge to complete the scheme by March 2022. A plan had been worked up with BOC and once money was confirmed they would come onto site, but it was still anticipated that the work could be completed by March 2022.

Fiona Osborne referred to the CIP (page 12) and the potential recurrent shortfall of £2.24m this year and the table (page 23) showed a forecast outturn of £0.5m. Lee Bond agreed to check and advise accordingly.

Action: Lee Bond

Following review and discussion, the Finance report was noted.

9.2 Capital Investment Board Minutes

No meeting had taken place since the last F&P Committee and therefore no minutes available.

9.3 Recovery Support Programme for finance (RSPf)

A report had been circulated which was in response to the work being undertaken with NHSE/I to exit special measures which involved a long-term financial model. As highlighted earlier the difficulty was writing a recovery plan when services and income were still unknown. Agreement had been reached with NHSE/I team to model around assumptions and use last known notification from the end of 2019/20 on additional income.

Lee Bond drew the Committee's attention to Appendix 2 and explained how the figure of £14.58m underlying outturn deficit was reached. The table also listed the major drivers of the financial position for 2020/21 and 2021/22.

Lee Bond suggested focussing on the table outlining the year on year bridging items (page 6) which described circumstances to return to a sustainable position over the next four years. Whilst they were a reasonable set of assumptions, they did not get the organisation back to breakeven including tariff uplift of 1% in 2022/23. A financial framework for the next financial year would be produced before Christmas 2021. Other assumptions included quality issues would need increasing; capital cost increases over next two years due to new builds would add cost of capital to the cost base. Lee Bond explained that all the assumptions made resulted in a £10m deficit and the items in the table leading to that figure were reviewed by the Committee

Lee Bond referred to the improvement target that the CEO would like to set but needed sense checking before able to commit to a final figure.

The model had been shared with colleagues at the FSM team as well as financial directors of local CCGs and the assumptions made were reasonable and prudent and should result in a level of improvement. There was a need to wait for guidance to be received and to then do a revised position.

Gill Ponder acknowledged that it was a comprehensive paper and was still in draft awaiting further guidance.

9.4 H2 Planning

Lee Bond presented the paper and explained that when H1 plan was completed the full year effect was £4.37m deficit with the organisation expected to breakeven. Since that time, several adjustments had to be made to get to £12.56m deficit pre-mitigation.

Lee Bond explained that Divisions had been asked to realise an additional £1.5m of efficiency savings over the second half of the year which needed adding to the target but left a £2.36m gap of unidentified savings, which may have to be covered from reserves. That would give a balanced target and others within the ICS had done the same to enable a balanced financial plan to be submitted. However, there were significant risks from the exceptional high demand over Winter anticipated and bed shortages.

Fiona Osborne commented that some Divisions had delivered more than their target and others fell short and noted that unless plans were developed within the next few weeks, they would not be able to deliver by end of March 2022.

Lee Bond explained that the non-recurrent effects would be stripped out to get a clear position, but it had to be a process of working with the Divisions to keep it fair for those over-achieving. It was decided therefore to share across the organisation and see how that looked, but it may not give recurrent savings. It would be helpful to get agency spend down particularly as only filling 60% of shifts.

Following review and discussion, the report was noted.

Item 10 11/21 **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 11/21 **Items for Information**

11.1 Performance Letters to Divisions following PRIMs Meetings

The letters from October 2021 had been provided for information and were noted.

Item 12 11/21 **Any Other Business**

There were no matters raised.

Item 13 06//21 **Matters to highlight to other Trust Board Assurance Committees**

Lee Bond to pick up at new Strategic Development Committee – the possibility of considering GP's in general workforce to staff the urgent care service.

Action: Lee Bond

Item 14 11/21 **Matters for Escalation to the Trust Board**

The following items were noted:

- Estates issue
- Financial plan and efficiency targets
- Recognition H2 plan submitted, and process embarked on developing 2022/23
- Exit from special measures
- Waiting Lists "levelling up" across ICS
- EPPR standards and Trust position
- A&E position and Urgent Care position

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 15 11/21 **Review of Meeting**

Gill Ponder asked Committee members for comments on the meeting:

Shaun Stacey – Good session and regular rotation of the agenda allows more debate
Fiona Osborne – Discussion was at the right level and depth even if caused a slight over-run

Item 16 11/21 **Date and Time of next meeting**

Wednesday, 22 December 2021 – 9.00am-12.00pm via Teams

Attendance Record 2021/22

Name	Apr 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	March 22
Neil Gammon	✓	✓										
Gill Ponder	✓	✓	✓	✓	✓	✓	✓	✓				
Linda Jackson	Apols	✓	✓	Apols	✓	Apols	Apols	-				
Stuart Hall	✓	✓	✓	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	-	✓	-	-				
Brian Shipley	✓	✓	✓	✓	✓	✓	Apols	✓				
Simon Tighe	-	-	✓	✓	✓	-	✓	✓				
Ab Abdi	-	-	-	✓	-	-	-	-				
Ian Reekie	✓	Apols	✓	Apols	✓	Apols	✓	✓				
TOTAL ATTENDEES	**12**	**11**	**8**	**8**	**11**	**10**	**8**	**9**				

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1 February 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 November and December 2021 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 November and December 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.

*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

QUALITY & SAFETY COMMITTEE

Meeting held on Friday, 19th November 2021 from 9am to 11.40am
Via MS Teams

Present:

Mike Proctor	Non-Executive Director **(Chair of the meeting)**
Michael Whitworth	Non-Executive Director
Maneesh Singh	Associate Non-Executive Director
Fiona Osborne	Associate Non-Executive Director

In attendance:

Dr Kate Wood	Medical Director
Dr Peter Reading	Chief Executive
Ellie Monkhouse	Chief Nurse
Abdi Abolfazi	Deputy Chief Operating Officer
Angie Legge	Associate Director of Quality Governance
Ian Reekie	Governor
Jennifer Moverley (item /21)	Head of Compliance & Assurance
Simon Buckley (item 267/21)	Head of Nursing, Medicine
Dr Anand Shirgaonkar (item /21)	
Dr Anwer Qureshi (item 267/21)	
Jenn Orton (item /21)	
Sarah-Jayne Thompson (item /21)	
Laura Coo	PA to the Medical Director **(for the minutes)**

261/21 Welcome and Apologies for Absence

Apologies for absence were received from: *Shaun Stacey (Abdi Abolfazi to represent), Helen Harris, Peter Reading to attend late, Jan Haxby*

262/21 Opening remarks

Mike Proctor asked for his thanks to be passed on as all meeting papers had been submitted on time which enabled time for members to read the papers thoroughly prior to the meeting.

263/21 Declaration of Interests

There were no declarations of interest.

264/21 To Approve the Minutes of the Previous Meeting held on 15 October 2021

Mike Proctor noted that the action mentioned under item 241/21 – Summary report of quality improvements developed through SJRs related to ED and had been brought forward onto the agenda as well as the issue about Cancer services.

Page 4 - last paragraph Extended supervision for overseas staff should read 'extended supervision for overseas staff to help them assimilate to UK practice'.
Page 5 - first paragraph 'a reduction in the overseas nurse' should read 'reduction in the number of overseas nurses leaving the Trust since using the new provider'.
Page 6 – item 251/21 the seven-day working action would be discussed at the next Workforce Committee.
Page 8 – item 255/21, Kate Wood had discussed the query about the neonatal action plan with Fiona Osborne, so the action was closed.
An attendance record was now included on the minutes as requested.

265/21 Matters Arising

266/21 Review of action log

25/21 - February 2021 meeting, Ophthalmology performance Ophthalmology – on today's agenda
158/21 – July 2021 meeting, follow up to 2019 Northumbria Medicines Management Review – item deferred to the December meeting
182/21 – August 2021 meeting, update report for Cancer Services – on today's agenda
241/21 – October 2021 meeting, Quality Improvements developed through SJRs - Kate Wood thought this action needed more time and the date would be determined through the Mortality Improvement Group (MIG).

Post meeting note: This action was covered by Medicine in the Emergency Department update and could now be closed.

267/21 Safety in ED and RSCN and Medical Cover in A&E

Simon Buckley joined the meeting at 9:09am

Simon referred to the presentation distributed which was taken as read and highlighted the key points.

The team had worked hard over the years to identify the risks and put processes in place to keep patients safe. The wait for patients to access the department and waits for beds was a risk. The ambulance services and both ED Departments worked to the same operating process to understand the risk and clinical urgency of those people in the queues. That was monitored on a regular basis by the leadership teams and several measures had been put in place to ensure the clinical needs of those attending the Emergency Departments was met.

Dr Anand Shirgaonkar joined the meeting at 9.13am

The leadership was strengthened with the introduction of the band seven Coordinators as well as other supporting processes such as ward assurance tools such as15 Steps. There was a robust safe triage training package in place which covered length of stay.

ED now had improved paediatric cover within the department and an additional twilight shift was being added which would provide cover for the early evening time which was identified as the busiest time for children coming into ED.

Dr Anwer Qureshi joined the meeting at 9:14am

Dr Qureshi added that the problem with Paediatrics was that the A&E Departments did not have enough paediatric activity to warrant full-time presence, but a Clinician had been employed to work cross-site who was linking in. They understood there had been a few incidents over the last weekend, but all were linking in with the process and the UCS. Currently ED had the PEN Nurse and had an understanding from the Paediatric teams that any child would be fast tracked if necessary.

The training put in place for the general registered nurses in the department had significantly strengthened their knowledge and skills in relation to paediatric attendances. Clinical Educators had been temporarily put into the department to support training.

Sarah-Jayne Thompson and Jenn Orton joined the meeting at 9.20am

Fiona Osborne asked about the six standards that had not been met, as she was not clear on the mitigations. In response Simon noted that some of those were relating to the medical and nursing cover which was addressed via the PEN team and Paediatrician support. A number of the standards were environmentally related based on the challenges of the sites and some would become compliant once the new building opened. Ellie Monkhouse noted that there was an acceptance that NLAG was a DGH.

Dr Qureshi added that there was a Paediatric Emergency Lead at Sheffield linked to our team for training purposes. He noted that NLaG was not big enough to employ two Paediatric Nurses 24/7, but the mitigation was that we had the specialist skill available if needed and that had been submitted in the report to CQC.

Ian Reekie asked about the Risk assessment for the patients queuing outside ED; how long were they waiting and the level of risk posed. Simon responded that the waiting time was varied as it was determined by the numbers who arrived at the department. In terms of risk assessments there was a unified process in place for both departments whereby staff walked the queue asking why people were waiting and prioritising those who were deemed to be urgent. That process commenced when the queue went beyond the ED waiting space. The requirement for the process had diminished in recent weeks with reduced attendances and the implementation of the UCS in Scunthorpe. Dr Qureshi added that the figures showed that a significant increase in walk-ins since Covid but although numbers overall had increased, this varied through the day. Maneesh Singh asked how patient confidentiality was maintained when asking the questions in the queue. Simon noted that staff ensure they are discrete with the people in the queue, which was helped by social distancing and for or more detailed conversations attendees would be temporarily pulled out of the queue.

Mike Proctor summarised that this was obviously an area of concern and accepted the position was not ideal. Mike had visited ED at Grimsby with Kate Wood during the week and it was clear that patients were managed according to clinical need rather than time of attendance and length of wait and felt patients were being managed in the safest possible way. Mike knew it was impossible to have registered children's nurses 24/7 but was confident that the mitigation was in place to give sufficient advice and help. It was a different situation but the staff on the ground were managing the situation in an appropriate way and Mike asked for Dr Qureshi and Simon to pass on this committee's gratitude and looked forward to seeing the continuing improvements being made.

Dr Anwar Qureshi and Simon Buckley left the meeting at 9.36am

268/21 Ophthalmology Report

Sarah-Jayne Thompson referred to the paper distributed which was taken as read and highlighted the key points. There had been Trustwide improvements across the majority of the waiting list with the exception for new patients converting to surgery. To mitigate that backlog the service was working with St Hugh's to transfer low level cataract patients.

There were now 590 high-risk overdue follow up patients. The report noted 127 were not booked which had significantly reduced, and todays live figure was 80 un-booked high-risk patients. Where patients could be contacted by phone they were offered mutually agreed appointments. Virtual clinics would start next year. At DPoW space had been identified on the ground floor and they were looking to mobilise that area. Accommodation for the service was on the risk register so it would be helpful once they could gain access.

Kate Wood asked if the un-booked patients were 'new' un-booked or 'old' un-booked as it was unclear. Sarah responded that the patients were manually tracked as Cobra had not yet come online as previously hoped so the Project Support Officer had been extended until March. Sarah reported back and escalated any concerns to the triumvirate every Monday.

Helen Turner and John Awuah joined the meeting at 9.40am

Kate Wood noted that Sarah had previously mentioned that they were down to 80 overdue high-risk patients but felt it was unclear whether they were un-booked from October or from a while ago. Ultimately these patients could go blind, so the timescales needed to be clearer.

Angie Legge commented that this was a concern raised at QGG as well and also commented that Jackie France had assured QGG that Cobra was live, and that divisions had concurred with that assurance.

Mike Proctor asked if there had been any harm identified for the patients who were deemed high risk and subsequently seen. Sarah confirmed there had been none identified to date.

Sarah added that she had been in Ophthalmology for seven years and this was the first time they were able to risk stratify patients so from a risk point of view they were in a much better place than they ever had been.

Maneesh Singh commented that looking at the figures appeared to be an increase overall in the waiting list. Sarah clarified the overdue follow up was coming down steadily but was still a very high number, however what they were able to say was they knew which were high risk and lots of different workstreams were being put in to address it.

Action: Kate Wood to have a conversation with Sarah-Jayne Thompson outside of this meeting to clarify the issue in relation to the implementation of the Cobra system

Although there were still risk issues for Ophthalmology they were in a better position and once this Committee had seen the report/update including the position in regard to the Cobra system then Sarah would be invited back to a future meeting to provide a further update.

Mike thanked Sarah for attending and providing the update.

Regular Reports

269/21 Clinical Support Services update (John Awuah)

John Awuah referred to the paper distributed which was taken as read. Pathlinks remained stable, although there had been a slight decline with regards to Covid testing due to staffing with Microbiology and blood services. Pathlinks had maintained its full accreditation. TMB approved a business case for additional staffing but as result of vacancies and staff absence related to Covid competency assurances were not yet available. This was going to be added to the risk register. Staff would hopefully be fully trained in the next couple of months.

Highlights summarised:

- COVID PCR and Rapid testing continued with the recent implementation of the rapid Abbott IDNow platforms.
- Averaging 160 rapid tests and 825 PCR tests per day
- Preparing for the UCAS accreditation in 2022.

Lowlights summarised;

- Staff wellbeing after lengthy continued overtime and pressures related to Covid

CQC Action Progress:

93% of junior doctors had been added to e-roster. They were working on Job planning but progress remained slow. There was a plan to have at least 75% of job plans signed off and they were hoping to meet that target.

The frequent escalation to Opel 4 had impacted on the length of stay ward rounds and reflected the challenges to patient flow. This was a concern as winter

approached in respect of Covid, Norovirus and Flu. Several agencies had been approached for staff cover.

Both sites were now JAG accredited in Endoscopy.

A new Consultant Radiologist had been recruited and another Consultant Radiologist may join NLaG in April.

It was hoped that a contract with a resourcing company should lead to a reduction in the non-obstetric ultrasound within the next couple of months.

Peter Reading joined the meeting at 9.55am

Mike Proctor thanked John for the summary of the report.

John Awuah left the meeting at 10am

270/21 Community update

Helen Turner referred to the paper distributed which was taken as read and highlighted the key points. The team continued to undertake a review for quality improvements and were making some changes which linked in with the electronic reviewing process which was positively received by the staff who were very fatigued due to high demands on the service.

There had been substantive work on EoL, they were continuing to work with the QIMP team on the use of the pain management tool across acute services.

Mike Proctor wondered how things were in terms of social care across the patch and whether the well-publicised capacity shortages in Social Care were impacting on Community services. In response Helen advised that there was a lack of care packages and they were working closely with them to support discharge and had been reviewing patients in short stay beds to try to get them discharged and provided with support where possible.

Kate Wood commented that the concern in the report was around our continence waiting list, the report was better it had been at the time of the last CQC visit and there had been significant improvements to what was always going to be a fragile process however it was unfortunate the numbers on the waiting list had increased. Helen responded to say that the team had put together a business case and suggested that this committee supported that.

Mike thanked Helen for attending and providing an update.

Helen Turner left the meeting at 10.06am

271/21 Cancer & Learning update including Breast Oncology changes

Denise Gale joined the meeting at 10.06am

Denise referred to the report distributed which was taken as read. What had become apparent through conversations with HASR was that the systems set up would be a useful mechanism to transact the changes needed to improve cancer pathways. The paper was going to the Joint Development Board to enable that work.

Mike Proctor added that he knew there were concerns about the centralisation of the Breast Service and asked if there were any issues. Denise clarified that DPoW did not have a Consultant Oncologist, so patients were being seen by a Consultant Oncologist at Hull which ensured that no patient waited longer as they were seen in chronological order. Denise was not aware of any adverse comments from patients although Denise appreciated it was not ideal as patients had to travel significant distances in some cases.

Kate Wood commented that it was really important that not only was Cancer Services discussed at this Committee, but it also needed to be monitored through the Joint Development Board and Kate wanted to ensure equity in treatment for all cancer specialties, not just breast services.

Denise added that the Transformation Programme for the services had multiple points that crossed the organisations; there were areas where there was a perception that patients were waiting longer but Denise could not provide evidence to support that. The whole purpose of the Transformation Programme was to ensure equity.

Fiona Osborne asked about the National Cancer Plan and the milestones on page two. Denise responded that nationally they were still working to the milestones, also looking at a non-site specific rapid diagnostic pathway, through a Primary / Secondary Care steering group.

Mike mentioned the change for Breast was a temporary change but knew there was a national shortage of Oncologists so suspected it could become permanent. Mike felt assured that Patients were being treated equitably across the patch and would feed that back to the Governors who had raised concerns on this issue.

Denise Gale left the meeting at 10.18am

272/21 IPR

Kate Wood referred to the paper distributed which was taken as read. She noted that with regards to VTE there had been some issues identified along the way so the denominator being used by the team was wrong and SDEC was not applicable but early signs were encouraging.

With regards to the backlog of SJRs, Kate had spoken at length to Dr Qureshi and Dr Banerjee for Medicine and was aware they very much wanted to look to the future rather than the past, but a decision had not yet been made as to whether to continue to chase older cases, given the time resource challenges.

273/21 Quality Priorities

Angie Legge referred to the paper distributed which was taken as read. The public consultation closed on the day of the meeting and work was moving to

identify the potential measurable elements within the priorities, but there was still time to add things in. Kate Wood added that the paper showed the long list and timing process, but Kate had a conversation on Tuesday about business planning to ensure they were integrated into the process and Ashy Shanker would be in touch with Angie to discuss that.

274/21 PROMS

Angie Legge referred to the report distributed which was taken as read. Angie was pleased to advise that NLaG were within the national average for all three measures of Primary Knee Replacements and above National average for the Oxford Knee Score measure. The Trusts hip scores had slipped slightly but were still within the control limits and the team were meeting to investigate that the slippage.

Mike Proctor noted that hip and knees were normally positive outcome measures as they improved quality of life but wondered if it covered other things such as hernias etc. Angie confirmed they were no longer measured as part of the PROMS programme. Kate Wood thought it was important as we move forward to capture as many of our patients experiences as possible and needed to consider how this could be done going forward.

275/21 QIA Quarterly Report

Angie Legge referred to the paper distributed which was taken as read and there were no comments or questions from members.

276/21 Key SI Update including Maternity

Angie Legge referred to the paper distributed which was taken as read and drew members attention to the appendix regarding the HSIB investigation and the learning generated from that.

277/21 Deviations from NICE

Angie Legge advised that there were no deviations from NICE.

278/21 Nursing Quality Report

Ellie Monkhouse referred to the report distributed which was taken as read. There were a couple of wards triggering on the measures, including ward 28. The Workforce matrices showed there was a completely new leadership on the ward and Ellie was confident they would start to turn things around. Amethyst ward had gone into extra support and were working to turn that area around.

The Trust continued to use our international nurses and were putting plans together with finance to recruit more. There was quite a healthy position with international nurses, Health Care support workers and Community Nursing. There had been a noticeable impact from Opel 4 increasing the number of beds and a slight increase of pressure ulcers. With regards to Fiona Osbornes earlier question that was due to the fluctuation of the bed base and acuity and increased our higher observation beds.

Mike Proctor asked about those people who had not quite achieved the required level of academic qualifications. Ellie felt that there would be some people who might not have the required qualifications who could become very good nurses. Ellie was meeting with Hull University to have that discussion as well as Lincoln and Sheffield to take on some displaced students which appeared to be working well to introduce them to healthcare.

279/21 QI Strategy

Ryan Sutton referred to the paper distributed which was taken as read. Ryan highlighted that the strategy was built to engage our QI community and those within the Trust. It was about empowering staff for the improvements they make and how they turned that into support. It was really structured in terms of how individuals could move forward but also about getting them to bring a problem that they passionately wanted to improve for a project. Improvement was a team effort and cannot be done in isolation, centrally the team were looking at how to support clinicians using quality improvement methodology.

The QI team were also looking at how the Trust ambitions could be supported and how improvements could be made on a broader level. They had been using the collaborative approach more recently to improve the safe and secure medication audit results and moved from approx. 50% compliance to over 90% in a four-week period on pilot wards.

One area for improvement was how to start engaging our patients in this work.

Ellie Monkhouse thought we had come a long way in a very short space of time and given the recent pressures of fatigue etc she felt it very heart warming. NLAG were even getting approached by other organisations to provide training which was very positive.

Peter Reading thought the work that was going on was superb and noted that he and Kate Wood had listened to some presentations from new consultants who had presented their projects, he thought it was great and of really good quality. He went on to note that Stephen Eames had been praising the improvement work around emergency care.

Kate wanted to thank Ryan for the amazing work he was doing with the rest of the team and thought the positive emails from him were good to see and that it was a very much team effort.

The committee commended the QI Strategy to the Board.

Ryan Sutton left the meeting at 10.49am

280/21 CQC Improvement plan update (Jennifer Moverley)

Jennifer Moverley referred to the report distributed which was taken as read and briefly summarised the key points. One action had been signed off and been sent to CQC. Currently at 76% of green and blue actions combined. One red action linked to Community Nursing. The only other amendment was that the report now included trust wide actions.

The Committee noted the update.

Jennifer Moverley left the meeting at 10.50am

Break

281/21 Nursing Establishment Review (Ellie Monkhouse & Jenny Hinchliffe)

Di Hughes & Jenny Hinchliffe joined the meeting at 11am

The Committee received a presentation from the Chief Nurse and her team on the Nurse Establishment Review. This was to enable Committee members to have a greater understanding of the underpinning methodology when the outcomes were presented to the Board

Mike Proctor thanked Jenny Hinchliffe and Di Hughes for joining the meeting for the presentation.

Jan Haxby joined the meeting at 11.46am

282/21 BAF

Mike Proctor asked about the Ophthalmology gap. Kate Wood noted that it was not the full BAF distributed. Helen Harris was going to be contacting Shaun Stacey and the team to see if they believed that risks in Ophthalmology had been significantly reduced and if residual risks were now manageable which would lead to a recommendation to update the BAF.

Action: Abdi Abolfazi to discuss reflecting the gap in Ophthalmology on the BAF with Shaun Stacey and Helen Harris.

Highlight reports

283/21 Mortality Improvement Group (MIG) Highlight report & Terms of Reference (ToR)

The annual review and ToR were distributed, and track changes were visible on the ToR to show the amendments. Fiona Osborne pointed out that in the ToR on the members list it said Interim Chief Nurse for Surgery and though it should say Chief Nurse for Surgery. The Committee ratified the revised ToR pending the minor amendment mentioned.

284/21 Quality Governance Group (QGG) Highlight report, Terms of Reference (ToR) & Annual Review

The annual review and ToR were distributed with the highlight report, and track changes were visible on the ToR to enable visibility of the amendments. The Committee ratified the revised ToR

285/21 Patient Safety Champions Highlight report, Terms of Reference (ToR) & Annual Review

The annual review and ToR were distributed, and track changes were visible on the ToR for visibility of the changes. The Committee ratified the revised ToR

286/21 Serious Incident Review Group (SIRG)

It was noted the annual review would be taken to the January meeting.

Items for information

287/21 Quality Governance Group (QGG) minutes

288/21 Mortality Improvement Group (MIG) minutes

Any Other Business

289/21 Health inequalities in the Trust (Dr Kate Wood)

Kate Wood advised that this was something that was going to be coming to the forefront of the NHS agenda, Jug Johal was the Board Lead in the organisation and Alex Bell, Dave Broomhead and herself had started some work that they would pass on to Jug. The statistics were saying that there was an issue within NLaG, but we were waiting for some general direction. Peter Reading updated that this was being led by the ICS and Jug attended that on the Trusts behalf The ICS work was led by Andrew Burnell and was new territory for the NHS.

290/21 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

For Trust Board

- Reflect on ED discussion and safety of patients
- Ophthalmology high risk patients
- Cancer Services and equality of treatment
- Maternity SI

291/21 Meeting review

Not discussed.

292/21 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 17 December 2021
Time: 9.30am – 12pm (tbc)
Venue: Via MS Teams

The meeting closed at 11.58am

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 Friday, 17th December 2021 from 9.30am to 11.30am
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
Shaun Stacey	Chief Operating Officer
Dr Peter Reading	Chief Executive
Jenny Hinchliffe	Deputy Chief Nurse
Angie Legge	Associate Director of Quality Governance
Diana Barnes	Governor
Debbie Bagley (item 299/21)	Associate Chief Nurse, Surgery & Critical Care
Mr Sairam Alavala (item 299/21)	Clinical Lead Trauma & Orthopaedics
Simon Priestley (item 301/21)	Chief Pharmacist
Jo Loughborough (item 305/21)	Senior Nurse Patient Experience
Mr Kishore Sasapu (item 307/21)	Deputy Medical Director
Vicky Thersby (item 308/21)	Head of Safeguarding
Jennifer Moverley (item 309/21)	Head of Compliance & Assurance
Laura Coo	PA to the Medical Director **(for the minutes)**

293/21 Welcome and Apologies for Absence

Apologies for absence were received from: *Helen Harris, Jan Haxby and Ellie Monkhouse (Jenny Hinchliffe to represent).*

294/21 Opening remarks

Mike Proctor advised that Michael Whitworth had left this committee to attend the new Strategy Committee. On behalf of the Committee Mike thanked Michael for his contribution to this committee.

295/21 Declaration of Interests

There were no declarations of interest.

296/21 To Approve the Minutes of the Previous Meeting held on 19 November 2021

The minutes were accepted as a true and accurate reflection of the previous meeting.

297/21 Matters Arising

Shaun Stacey provided an update on behalf of Jackie France following concerns expressed at the previous meeting around long waiting patients and the link to Cobra reporting.

A system and process had been developed using the PTL and Cobra, similar to that put in place to track Priority two patients on the In-Patient Waiting List. This process would enable us to monitor and track patients on the Out-Patient Waiting list, who were categorised as a Red (high risk), through Cobra, so if they were not seen within the specified risk stratification period, an escalation process would be initiated to bring this to the attention of the relevant management and clinical staff. The process was due for implementation w/c 20th December 2021.

Mike Proctor thanked Shaun for the update and clarity given.

298/21 Review of action log

158/21 Follow up to 2019 Northumbria Medicines Management Review was on the agenda today.

299/21 Surgery update

Debbie Bagley and Sairam Alavala joined the meeting.

Debbie Bagley referred to the update distributed which was taken as read.
Positive progress had been made against the CQC action plan.
With regards to sepsis the Divisions were working collaboratively to address that.
The Trust was a National outlier for Colorectal and Bowel stomas. Sairam Alavala noted that although the Trust was an outlier it did not mean that the standard of the surgery was affected, it depended on the complexity of the case but welcomed the external review. After the external review an update would be presented to the Quality Governance Group (QGG).

Manesh Singh asked if the hernia rate was a conversion rate. Debbie confirmed it was a conversion day case to admission, some of the data was not as high as initially expected however that would come through in January.

Fiona Osborne referred to page nine which mentioned areas of support and thought it would be useful to see the status of actions within the report, how they were progressing and asked if any out of the four needed support. Debbie responded that it was relating to the equipment which was being worked through with the Divisions and the Equipment Group.

There was an issue with Ophthalmology which this Committee were aware of and received regular updates, that continued to be monitored closely.
Deteriorating patient – they had noticed there was a gap in attendance at alert course training, that had been reinvigorated but they were getting a high number

of non-attendances from Medicine and Surgery which they were investigating. They were hoping to appoint a Clinical Lead. Kate Wood noted that one of the Doctors in Surgery already had some time allocated in their job plan to support this and suggested checking with Vicky Marshall or Kate would update Debbie outside of the meeting.

Mike Proctor asked about Critical Care capacity and whether there would be a review in January. Debbie confirmed that had been reviewed and ratified a few weeks ago. Debbie was due to attend the Critical Care Network meeting to discuss increased capacity as they anticipated that from January Critical Care activity would increase.

Shaun Stacey provided reassurance that following the Omicron letter from NHSE earlier in the week there were Critical Care beds available in the area within the ICS and region that were not staffed but equipped. The Trusts own plan had recently been tested but there was also the wider plan for which the Network were planning a tabletop exercise next week.

Debbie Bagley and Sairam Alavala left the meeting at 9.52am

300/21 IPC Board Assurance Framework

Maurice Madeo joined the meeting at 9.50am

Maurice Madeo referred to the documents distributed which were taken as read and provided a summary of the key points.

The latest guidance suggested to move away from the red, amber, green pathways, however the Trust had chosen not to move away from that but had kept this under constant review. Greater emphasis was on hierarchy controls, taking actions to try to reduce the risk to patients and visitors. A survey had been carried out on the ventilation and that had been adjusted where possible. The guidance had suggested a reduction in the use of PPE but given the latest Covid news that was not considered appropriate at this moment in time. The focus for the team was on ensuring there was no deviation from the gold standard in infection prevention.

Fiona Osborne found the Board Assurance Framework very interesting but from an assurance point of view it was difficult to understand the mitigation without understanding the gaps. Maurice explained that some of the gaps were big infrastructural gaps such as ventilation which could not be changed quickly, the same applied to side room and surge capacity. Several things had been introduced but Maurice could not say that mitigation would reduce this as it was based on hierarchical controls and could not pinpoint one thing that would cause a reduction.

Manesh Singh asked if they had looked at things such as heap scrubbers for ventilation; Maurice confirmed the Trust had purchased approximately 12 already.

The update to the IPC BAF were formally noted.

301/21 Medicines Optimisation report

Simon Priestley referred to the update distributed which was taken as read and provided a summary of the key points.

Simon referred to the table on page five which demonstrated the fantastic improvement in feedback from the Wards following this quality improvement approach. An appendix had been added to the Northumbria review for the one item not closed, but Simon had been through all documents and distributed them across all Divisions and the follow up was through this group which was why Simon had taken the decision not to close it.

Simon invited any comments or questions.

Kate Wood commented about the QI collaborative and the work that had been done, Kate knew it had been a sticking point and congratulated Simon and the team for that and was more confident with Simon's proposal to close the report down and continue the documentation review through documentation business as usual noting that the Pharmacy Governance Group also reported to QGG regularly.

Mike Proctor thought it was great progress in really difficult times and thought that the improvements could boost morale and would highlight that to the board.

Mike thanked Simon for the update and the Committee agreed to close the Northumbria review action.

Simon Priestley left the meeting at 10.04am

Regular Reports

302/21 IPR

Kate Wood referred to the report distributed which was taken as read.

With regards to the past structured judgement reviews it was agreed at MIG that they would not try to play catch up and would draw a line under them noting that the purpose of them was about learning and it was felt looking back over what had happened 18 months ago would not be of any benefit.

Kate also noted that there was no narrative for the caesarean section as they needed to make sure the Family Services team were looped in to be able to write that but noted they had moved a long way with the IPR over the last few months.

Kate referred to the previous updates about VTE , they were waiting for the Information team to sort out the final denominator as it was not as simple as originally thought.

Jenny Hinchliffe informed the Committee that there had been two fall SI's reported in November one was de-logged as it was a medical collapse rather than a fall.

Peter Reading left the meeting at 10.10am

303/21 Quality Priorities

Angie Legge referred to the paper distributed which was taken as read. The paper provided the findings of the consultation exercise undertaken in October/November 2021, which had resulted in three times as many responses this year than the previous year. The next step was to make recommendations for adoption as the quality priorities, which would be linked to the Darzi domains and brought back to QSC following the Execs meeting in January but any invited views or comments on the findings so far.

Fiona Osborne commented that she liked the progression of seeing how this was coming together but was surprised to see mental health featuring, Mike Proctor thought it needed more clarity as to the specific area of Mental Health which would be focussed on.

Kate Wood felt it things needed to be triangulated and that discharge was key to focus on in some way but thought that if it had a more specific focus significant improvement could be made. With regards to mental health it was such a wide-ranging topic that Kate wondered if we needed to ask the questions differently to benefit the bulk of our patients.

Jenny Hinchliffe added that with regards to discharges Di Hughes was leading on a piece of work focusing on the quality of the discharges so it might be useful to triangulate that. Hayli Garrod was working on the conversations with the experts in those areas and how would we measure it to avoid overly aspirational ideas that proved impossible to measure, ensuring measurability was an important part of this process.

Mike asked if the focus would be on Trust priorities that were within the Trusts gift to deliver on as some were not. Manesh Singh supported Mike's point that the focus needed to be on what we could control, the out of hospital SHMI for example was something we could not. With that in mind the Committee agreed the recommendations in terms of timescales, and we would look at the Quality Priorities again in January.

304/21 CLIP Report

Angie Legge referred to the report distributed which was taken as read. The report integrated and merged the intelligence received to get the themes. Themes such as documentation were fed into the learning group. Further work was planned on sharing learning in the documentation area particularly with relation to handovers. To add to that Angie now had monthly meetings with the Freedom to Speak up Guardian which had led to discussions about cultural improvements through organisational learning and leadership programmes.

Fiona Osborne referred to section three of the report and the thematic overview, the comments stated they were highly dependent on a number of systems and asked if this should be linked to the digital review in terms of how it was being fed in. Secondly having worked in the digital sphere for a long time and looking at how problems could be solved it could be improved further if the underlying business services were robust. Fiona asked if that was the case or were, we trying to plug gaps.

Kate Wood added that when electronic solutions were brought in, they often uncovered some of the poor processes that were in place and had been worked around for years so it was about picking through the processes. Kate used the example of results acknowledgement; it was for anybody who requested those tests to follow them through. One of the things that had come out of that was how the abnormal results were followed through, it made the process safer if we knew the risks and acknowledged that what Fiona had said was correct.

Angie thought the digital solution was a journey to improvement, and from experience a lot of the things currently measured would be resolved by the digital records but it started to highlight other things that needed to be looked at and prompted us to move those towards improvement. Angie was happy to send this report to any meeting to widen its accessibility. Mike Proctor suggested TMB might want to see it. Shaun Stacey would like to see the report at OMG when it was ready and agreed it should go through to TMB too. Shaun though it was easy to read and compliment Angie on that. Angie noted that most of the work for the report was done by Shafia Bibi and Kelly Burcham.

Jo Loughborough joined the meeting at 10.30am

305/21 National Inpatient Survey

Jo Loughborough referred to the presentation distributed which was taken as read. This was the headline report from the findings of the Adult Inpatient Survey 2020, and it was standard to be a year behind with the reporting.

The overall response rate was 44% which was the norm for NLaG but was disappointing.

The successes – food always came out well and patients felt there were enough nurses on duty.

Part of the survey was a section on what mattered to the patients the most, out of 20, nine were predominately made of information given and discharge issues. From those responses an overarching action plan had been created which linked together all the surveys. The Divisions each provided their updates, Jo also met with the divisions where patient experience issues were picked up and things were also taken through the Patient Experience Group (PEG).

Manesh Singh was curious to see what could be done about the information given to patients as a high percentage seemed to go back through A&E. Jo advised this would fall into part of the work which Di Hughes was doing on the quality of the discharge, it was about embedding those processes and about making the improvements to the patient information leaflets.

Fiona Osborne asked about the timing of this as although it said it took 13 months the presentation was dated in May. Mike Proctor clarified that he had seen the presentation at Governors in May and thought that was an error as there was a huge amount of work needed to analyse the data. It had been through the Patient Experience Group and to Governors and apologised it had been out of process, but the time was needed to refine the raw data before it could be presented to this Committee.

Jo Loughborough left the meeting at 10.40am

306/21 Nursing Quality Report (including Patient Experience Group)

Jenny Hinchliffe referred to the report distributed which was taken as read and summarised the key points.

The combined fill rate of registered nurses against the current establishment had increased. The Trust had welcomed another cohort of international nurses, but it was worth noting the vacancies in general were a concern and they had been increasing in for Community and Midwifery. The Health Care Support Worker vacancy had increased again and were doing a deep dive looking into the reasons why. Amongst other things a career clinic was being put on to look at how to maintain the support workers.

The red flag for staffing incidents was reflective of the vacancies as well as the increased sickness rates.

The number of complaints in October was 37 which was an increase and Jenny noted that the complexity of the complaints was increasing.

Mike Proctor asked about the international recruitment and whether, as the net was cast further afield, it was becoming more difficult to overcome cultural differences with onboarding.

Jenny responded that the team would be doing their homework so if they did proceed with that would ensure it was safely.

Fiona Osborne asked in terms of retention of staff what was being done to prevent people leaving. Jenny confirmed that there was a lot of work on retention, they had a recruit who was speaking to HCA's to find out why they were leaving NLaG. They were finding they were choosing to leave in the first year so were looking at why. A lot were not filling out exit questionnaires. They were now looking at putting career opportunities in place so staff could progress from a support worker to a registered nurse if they had those ambitions. Fiona asked if there was capacity in HR to do 1:1 interviews with leavers. Kate Wood suggested that Fiona might raise that question at the Workforce Committee.

307/21 Risk Stratification & Clinical Harm

Kishore Sasapu joined the meeting at 10.50am

Kishore Sasapu referred to the presentation distributed which was taken as read. This was looking at people who were on the waiting list for something and assessing the risk to enable clinical prioritisation. The Pandemic had cast a spotlight on the issue, so we had a risk assessed and risk stratification with a clinical view to ensure we responded appropriately. Everybody on the waiting list had been risk stratified. When it came to out-patients, because of the size of the PTL, the risk was greater which was always the case when the risk was invisible. If everybody could be seen on time, there would not be a risk however as that was not the case there would be those that could be at risk and would be targeted for risk stratification. They were rated red, amber, or green. Reds were seen, ambers

were a concern for Kishore as the numbers were huge and those were the ones where capacity needed to be created to see these patients. As we had seen recently a few patients had come to potential harm in Ophthalmology where a patient had sight affected due to a delay in being seen, although this was a process error rather than a lack of risk stratification.

Mike Proctor invited any questions or comments

Fiona Osborne was assured that the framework was being reviewed and that the weak links were being looked at.

Mike thanked Kishore for the update but in terms of reports to this committee he needed to get some idea of numbers in the actual report so that the Committee could monitor what was happening to those patients and identify those concerns.

Maneesh Singh added that his concern was the growing waiting list and our capacity to continue to provide services across the board.

Following up on what Mike had said Fiona thought it would be useful to see trends i.e. 5 greatest improvements and 5 areas for improvements

With regards to Mike's comment about the numbers, Shaun Stacey informed the committee that was already reported and suggested for Mike to contact Gillian as the report to Finance & Performance also included trends. As to when we were likely to get back to a level of normal due to the Pandemic, we were 18 months behind where we expected to be. We still had a trajectory to work towards and Shaun's ambition was to hit the 2022 target in 2023. We already knew about the challenges and infrastructure, but the impact of the Pandemic had been huge, there were currently 400 staff not available for work. That would give a predicted timeline in terms of follow ups. Managing follow ups was very difficult and the Trust had a culture for driving follow up reductions and it was not cost effective as it took clinicians away from seeing new referrals. We had improved with most aspects of care in our region, but the 62-day Cancer waits still needed to be improved. This was an issue shared with HUTH and we had limited influence upon that.

In the same way this Committee had a CQC assurance report, Kate Wood wondered whether we needed to have the assurance report brought into the numbers report and vice versa so that both Committees had the same information, but conversations could be directed to the relevant part of the report.

Action: Kate Wood to pick up with Kishore Sasapu and Shaun Stacey outside of this meeting

Mike Proctor thanked Kishore for the update.

Kishore Sasapu left the meeting at 11.10am

308/21 DoLs & Safeguarding

Vicky Thersby joined the meeting at 11am

Vicky Thersby referred to the update distributed which was taken as read and highlighted the key points.

There had been a couple of inspections recently; An Inspection of Special Educational Needs and Disability (SEND) in North Lincolnshire commenced on the 6th December for one week.

The second inspection had key colleagues and practitioners involved in focus groups across some of our NLaG services; Paediatric Community Nursing Teams, Therapy Services and the Looked After Children team were amongst the teams across health services and they were awaiting the outcome of that inspection.

Ofsted carried out an inspection of N E Lincolnshire Council Local Authority Children's Services between 4th to 15th October and were rated inadequate in all four domains. NLAG was providing support for social care in a lot of areas and were supporting them in fulfilling their statutory duties.

There had been a Deep Dive for children with mental health problems which concluded with a list of actions to be worked through.

On a positive note, training for level three and DoLs training had increased. The teams were working hard to improve things and ensuring the patients were safe. Mike Proctor mentioned the two stories in the national media about children and found it dreadful to hear that whilst out of our control the Local Authority Children's Services were found to be inadequate. Mike asked if externally the agencies believed that our organisation was doing all we could to support them.

Vicky agreed that they were dreadful cases and they were at the time of the pandemic where children were not at school and how much more difficult it was to identify children at risk. From a partnership perspective we had a statutory responsibility to work with our colleagues' police and social care and were happy to work with them and would take anything from here if anybody felt necessary.

Mike took assurance from the report and that Vicky was leading on it.

Vicky Thersby left the meeting at 11.19am

309/21 CQC Improvement plan update Key

Jennifer Moverley joined the meeting at 11.10am

Jennifer Moverley referred to the update distributed which was taken as read and highlighted the key points.

Eight actions were closed and uploaded to the CQC portal. An extra three actions had been added due to the inclusion of the three-standalone Trust-wide actions and four actions had moved from red to amber

A new section had been included in the report, highlighting what had changed. Community nursing had moved from red to amber as the block contracts had been finalised. These would progress to green once the staff had commenced in post.

In End of Life the bluebell model had started, last days of life care was implemented and being monitored. Actions had been taken to improve the standards.

Mike Proctor thanked Jennifer for the update.

Jennifer Moverley left the meeting at 11.24am

310/21 SI Update including Maternity

Angie Legge referred to the report distributed which was taken as read and noted that there were no new SI's in Maternity to report. There had been one new never event which centred on the failure to comply with the WHO checklist and an email reminder had gone out to all clinicians as well as posters in key areas to focus attention in this area.

Kate Wood expressed huge disappointed about the never event, which was a wrong site injection of the wrong part of the ankle and the only person that knew that was the surgeon who put his hand up straight away and admitted that they had not done the WHO checklist. Although disappointed, Kate was really pleased with the culture within the organisation and the fact that people felt they should and could admit their error immediately.

311/21 Potential Deviations from National Guidance

There were not any deviations.

Highlight reports

312/21 312/21 Quality Governance Group (QGG)

Angie Legge referred to the highlight report distributed which was taken as read and noted that the group did discuss Ophthalmology again and the high-risk patients.

Shaun Stacey drew the Committees attention to the significant risks for Oncology in the region and would like to see more focus on the risks within the organisation related to extended cancer waiting times.

Angie noted that the QGG frequently and regularly reviews Cancer risks and report on the issues to QSC.

Mike Proctor agreed and emphasised that the risks related to Cancer were regularly reviewed by the QSC.

313/21 Mortality Improvement Group (MIG)

The report was distributed and taken as read.

314/21 Patient Safety Champions

Angie Legge referred to the report distributed which was take as read. Angie had strengthening ties with the Freedom to Speak up Guardian and an SPC chart had been included to show the impact.

Items for information

315/21 Quality Governance Group (QGG) minutes

316/21 Mortality Improvement Group (MIG) minutes

317/21 Any Other Business

Nothing raised

318/21 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

To be agreed outside of the meeting.

319/21 Meeting review

Not discussed.

320/21 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 25 January
Time: 1pm – 4pm
Venue: Virtual via MS Teams

The meeting closed at 11.58am

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	✓		✓								

NLG(22)020

Name of the Meeting	**Trust Board of Directors – Public or Private**	
Date of the Meeting	1/2/2022	
Director Lead	Adrian Beddow, Associate Director of Communications	
Contact Officer/Author	Charlie Grinhaff, Communications Manager	
Title of the Report	**Communications Round up – Feb 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	This report covers key developments from the communications Team and highlights some of the projects the team are working on as well as providing updates on media and social media activity. It covers the period 13 November 2021 to 14 January 2022.	
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:

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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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NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

February 2022

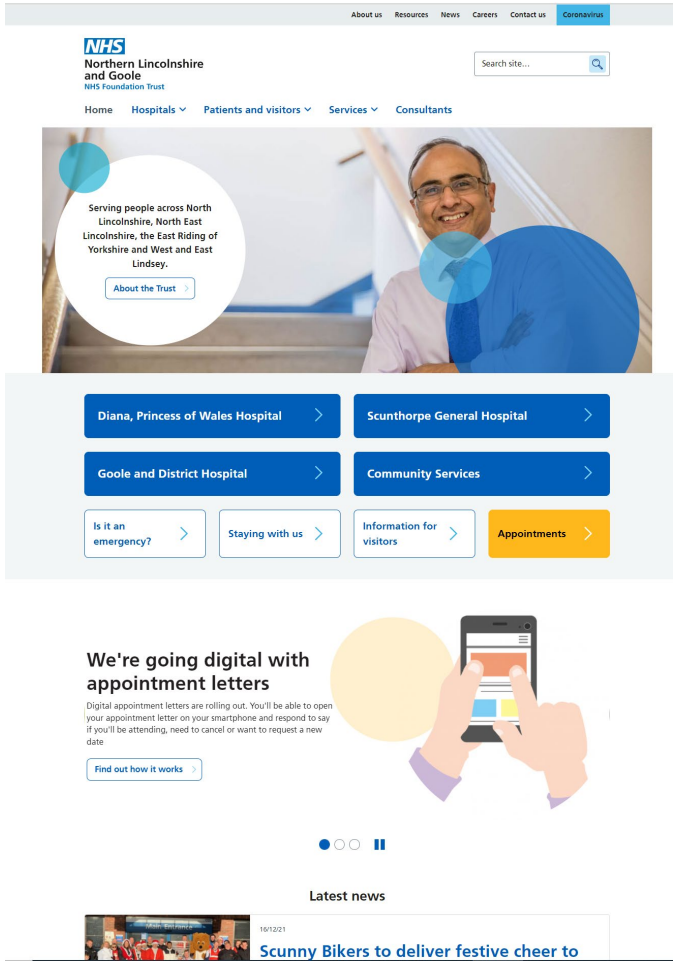
Kindness • Courage • Respect

February update 2022 – covering 13 Nov 2021 to 14 Jan 2022

Key developments

Website: The new Trust website launched at the end of December. It was the culmination of many months work and has vastly improved the accessibility of the site.

Thank You system: In January the team launched a new mechanism for staff to thank each other. Hosted on the Hub, staff go on and send a message to a colleague – which generates a thank you email. They have the option of copying in the staff member's line manager and also the Communications team so compliments can be shared more widely.
In the first week alone more than 50 compliments were shared with the Communications Team and the page itself has had more than 750 hits.



Campaigns

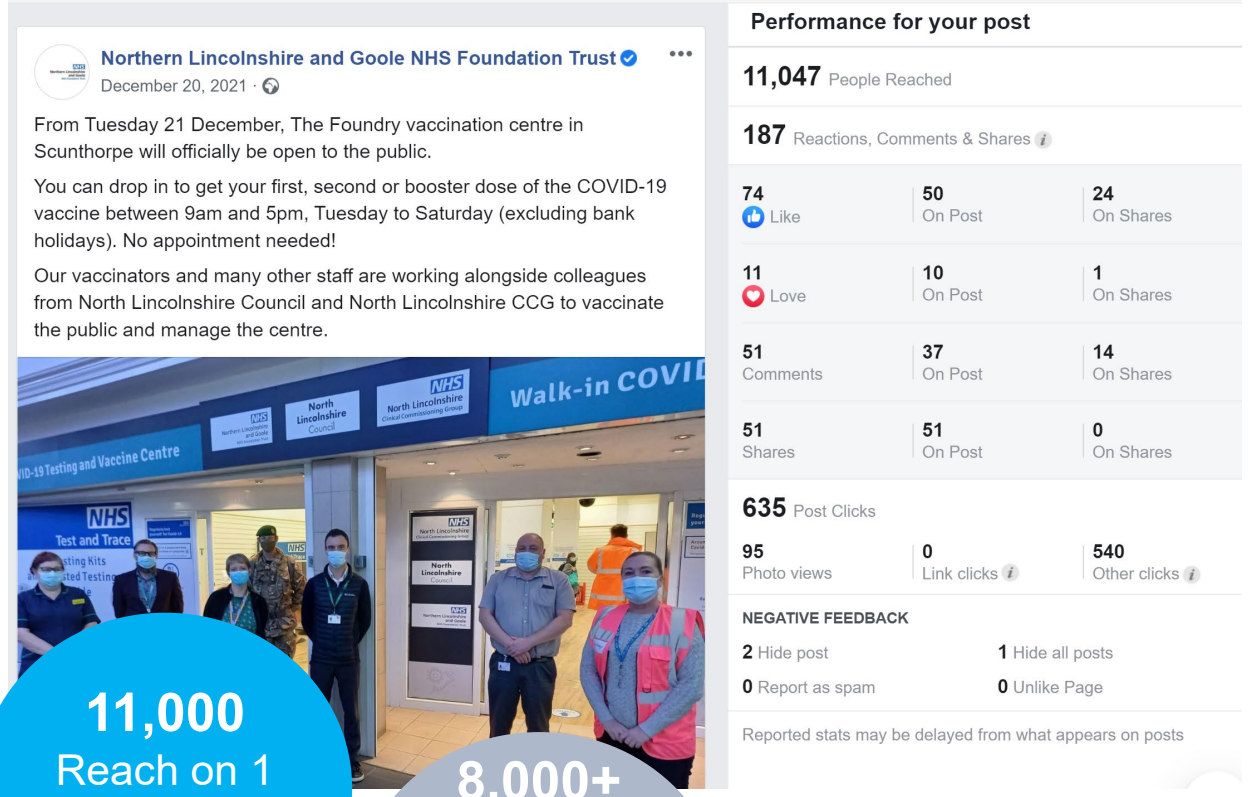
Key campaigns

The main campaign the team are currently supporting is encouraging uptake of the COVID-19 vaccine, which includes communicating information about mandatory vaccines for staff. This work has involved drafting letters and other communications to staff who meet the criteria where their vaccination status is unknown, as well as generic messaging for all staff.

The team has also supplied supporting materials such as the Hub site, an FAQs document, a support guide and more.

42 Ask Peter questions have been responded to on this Subject alone and there have been more than 8,000 hits on The staff vaccination page on the external website (which only launched at the end of December)

A Facebook post advertising the vaccination centre at The Foundry was the 2nd most popular post in this period with more than 11,000 reach (the number of people to have seen the content)



Other projects and supporting the Trust's priorities

Other projects

We are supporting much work happening across the Trust including:

- **People's Pulse Survey:** Launched 31 December and runs until 31 January. It takes just 5 mins to complete and, unlike the National Staff Survey, bank staff can complete this one.
- **Pandemic response:** We continue with COVID-19 updates to all staff when needed (12 in this period) and attend Gold and Silver meetings as well as the daily operational meetings. Since the pandemic began there have been around 60,000 hits on the Trust's Coronavirus Hub page.
- **Green agenda**: The Trust received trees from the NHS Forest Scheme, which were planted at Grimsby and Goole hospitals. This was our top tweet in December
- **Health Tree Foundation:** We launched the ED Christmas appeal at the end of November, which led to TV, radio, print and online coverage. The Scunny Bikers visited SGH in December and donated toys to the children on Disney Ward. The charity also provided special blankets for inpatients over Christmas
- **Promotion of awareness weeks and months:** In the time period covered by this report these included disability history month, National Tree Week, Cervical Cancer Prevention Week, and Fraud Awareness Month.

Top Tweet earned 1,181 impressions

Trees have been planted at Goole hospital this week. We recently received 16 trees from NHS Forest, a project which aims to improve health and wellbeing by increasing access to green space on or near to NHS land. Read more on our Facebook page: ow.ly/isPh50H85CZ pic.twitter.com/YRTQzKo5LI

3 13

View Tweet activity

View all Tweet activity

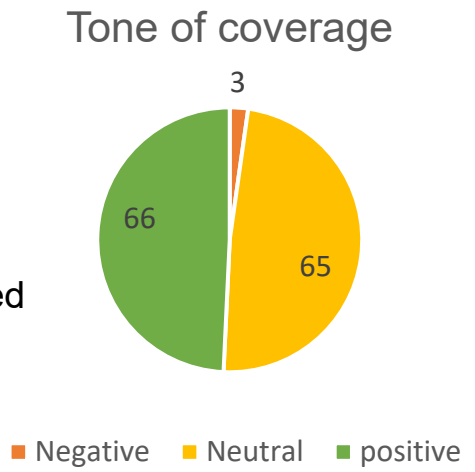
Improving reputation through external communications

Media coverage

There were 139 stories about the Trust in the media during this period. 94% of media coverage was positive or neutral in tone. The team works hard to balance negative stories about the Trust: only 6% were classed as negative. Coronavirus continues to be the top theme on media coverage, with 53 stories on this.

National media coverage of note:

- There was positive coverage for our maternity services, in particular NICU, in The Sun and The Mirror
- Peter Reading was interviewed as part of a HSJ piece on ending discrimination against disabled staff
- Negative coverage included coverage of a whistleblowing report in the HSJ and the case of a man who suffered with complications after having his tonsils removed, which was covered in the Sun, The Daily Star and The Mirror.



Media enquiries

65 media enquiries were handled in this time – 31 were in the first two weeks of January alone.

98% of media enquiries were dealt with within the requested timescale

Top theme for media enquiries was winter pressures, followed by Coronavirus. 12 came in on the back of proactive news releases. The main reason journalists got in touch was to put in an interview request.

10 news releases

7 media statements

65 media enquiries

Improving reputation through external communications

275,000 Page views on our website

17,382 followers on our corporate accounts

60,000+ Tweet impressions in Dec/Jan

Social media

We currently have 17,382 followers:
- 12,423 on the Trust's Facebook page
- 4,959 followers on Twitter

There were 5,500 profile visits on our Twitter profile in Dec
We are rated 4.6 out of 5 stars on reviews on Facebook

Twitter: @NHSNLaG
Facebook.com/NHSNLaG

Website
- 122,596 visits and 274,972 page views.
- 75% of visitors were new users
- 94% of users were in the UK
- 70% of users accessed the site via a mobile or tablet.

The top news release on the website was about the Hospital at Home service in Grimsby which led to TV, print, radio and online coverage.

Top Facebook post – 12,715 reach

Top Tweet – 1,125 impressions

Improving staff morale and engagement

Ask Peter .
261 Ask Peter's were received in this period (up 114 from last year's 147) Hot topics included: mandatory vaccines; staff incentives; parking in the pit; motorcycles; wheelchairs and staffing and morale.
In this period we redacted three questions and removed two.

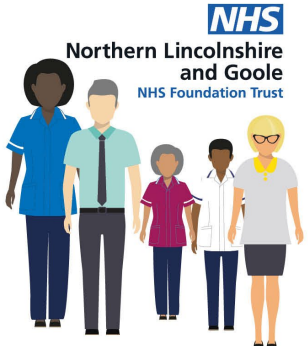
Senior Leadership Community (SLC) briefing
99 senior leaders attended the December SLC briefing.
Updates included: mandatory vaccines, information governance and quality improvement

Staff closed Facebook group stats
3,032 active members
1,072 posts
6,143 comments
18,827 reactions

Improving staff morale and engagement

Wednesday Weekly News
We are unable to track how many people read this the all staff email, but we are able to access link clicks.

Key stats on vaccinations and testing in this period:
More than 2,200 clicks on links for people to report lateral flow test results
More than 1,300 click throughs to the COVID-19 vaccination form



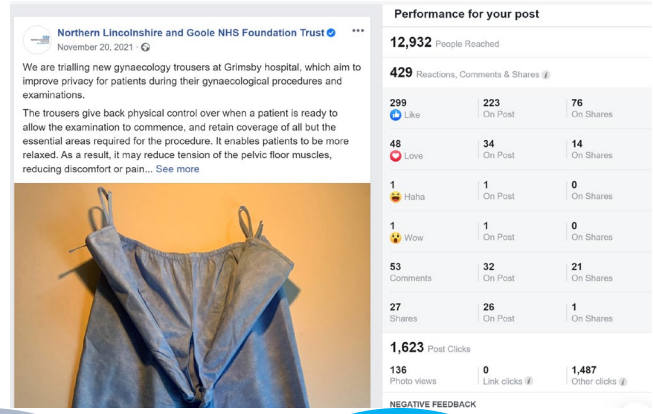
Monday Message
Topics have included:
- 15-steps
- Culture work
- Peter's personal story
- Update on all things digital
- Launch of the Thank You system
- Update following the Trust Board meeting.

Celebrating staff

Thumbs up Friday and #ThankYouTuesday
We have posted more than 60 Thumbs Up Fridays and Thank You Tuesdays in this period. The division with the most Thumbs Up Fridays is Family Services. The division with the most Thank You Tuesdays is Surgery and Critical Care.

Working with divisions
Currently this financial year the Chief Nurse division has generated the most press releases and Family services have had the most positive coverage.

This post on Facebook celebrating an innovation by staff in gynaecology services was one of our most popular during this period. It had nearly 13,000 reach on Facebook and 429 comments, reactions and shares.



30 #Thumbs UpFriday posts

30 #ThankYou Tuesday's received

Family Services most positive coverage

Communications relating to service and capital investment

Building Our Future update

Between November 1 and January 14, we have:
Shared 35 external social media posts
Responded to seven direct questions from the public
Had 5,747 visitors to the website pages giving updates on our capital works (Including the latest parking information).

Internally, over the same period we:
Had 247 visitors to our internal Hub pages
Shared 32 staff Facebook posts
Sent out 13 all staff emails
Answered 9 Ask Peter queries
Provided five direct staff briefings

692,751
Combined campaign reach so far

The combined reach of the campaign to date is well in excess of 692,751. 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 more than 20,681,106.

NLG(22)021

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1 February 2022	
Director Lead	Helen Harris, Director of Corporate Governance	
Contact Officer/Author	As Above	
Title of the Report	**Documents Signed Under Seal**	
Purpose of the Report and Executive Summary (to include recommendations)	The report below provides details of documents signed under Seal since the date of the last report (August 2021 – NLG(21)185).	
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
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Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal has been used on the following occasions:

Seal Register Ref No.	**Description of Document Sealed**	**Date of Sealing**
-	-	-

Action Required

The Trust Board is asked to note the report.

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1 February 2022	
Director Lead	Helen Harris, Director of Corporate Governance	
Contact Officer/Author	As Above	
Title of the Report	**Trust Board Development 2021/22 and 2022/23**	
Purpose of the Report and Executive Summary (to include recommendations)	To receive, for information, the Trust Board Programme of Meetings, briefings and Development Sessions for 2021/22 and 2022/23	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
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Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Meeting and Development Timetable – 2021-22

Month	Meeting	Topic (where applicable)
6 April 2021	Formal Board Meeting and Board Briefing	**AM:** Formal Board (Public and Private) **PM:** Board Briefing: Governance
4 May 2021	Board Briefing and Board Development Activity	**AM:** CQC Briefing
1 June 2021	Formal Board Meeting / Briefing and / or Board Development Activity	**AM and PM:** Formal Board (Public and Private)
6 July 2021	Board Briefing and Board Development Activity	**AM:** Board Briefings: Freedom to Speak Up (Part 1), Making Data Count **PM:** Well-Led
3 August 2021	Formal Board Meeting / Briefing and / or Board Development Activity	**AM:** Formal Board (Public and Private) **PM:** Board Briefing: Priorities and Risk Discussion
7 September 2021	Board Briefing and Board Development Activity	**AM:** Board Development: National Patient Safety, HASR Programme **PM:** Board Briefing: Insights
5 October 2021	Formal Board Meeting / Briefing and / or Board Development Activity	**AM:** Formal Board (Public and Private)
2 November 2021	Board Briefing and Board Development Activity	**AM:** Strategy Session: Strategy and Vision. ICP and ICS Development **PM:** Board Briefing: Freedom to Speak Up (Part 2), People Strategy - Culture Theme and Equality, Diversity and Inclusion
7 December 2021	Formal Board Meeting	**AM:** Formal Board (Public and Private)
1 February 2022	Formal Board Meeting	**AM:** Formal Board (Public and Private) **PM:** Listening Event (ICB Chair and ICB Chief Executive) Health Inequalities Briefing
1 March 2022	Board Development Activity	**AM:** Equality, Diversity and Inclusion (Eden Charles) **PM:** Acute Collaborative Briefing and Digital Transformation (NHS Providers)

Trust Board Meeting and Development Timetable 2022-23

Date	Meeting	Topic (where applicable)
5 April 2022	Formal Board Meeting and Board Briefing	**AM:** Formal Board (Public and Private) **PM:** Board Briefing: Mortality, ICS Development and Stakeholder Mapping, PCBC and Capital
3 May 2022	Board Development	**AM:** Review of Vision, Values and Strategic Framework **PM:** CQC Well Led – Self Assessment
7 June 2022	Formal Board Meeting and Board Briefing	**AM:** Formal Board (Public and Private) **PM:** Board Briefing: Mental Health and Liberty Protection Safeguards
5 July 2022	Board Development	**AM:** Culture and Leadership, Building Relationships, Team Work **PM:** Managing Conflict
2 August 2022	Formal Board Meeting and Briefing	**AM:** Formal Board (Public and Private) **PM:** Board Briefing: Humber Acute Services
6 September 2022	Board Development	**AM / PM:**
4 October 2022	Formal Board Meeting	**AM:** Formal Board (Public and Private)
1 November 2022	Board Development	**AM / PM:**
6 December 2022	Formal Board Meeting	**AM:** Formal Board (Public and Private)
7 February 2023	Formal Board Meeting	**AM:** Formal Board (Public and Private)
7 March 2023	Board Development	**AM / PM:**

For Future Consideration
Cyber Development (September or November 2022)
Performance and Information (KL5 / 8)
Learning and Improvement (KL8)
Board to Board Partnership (NLAG/HUTH)
Digital Transformation, part 2 (March 2023)