Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 5 October 2021, Sands Venue Stadium, Glanford Park, Scunthorpe, DN15 8TD
9.00 am – 12.30pm

For the purpose of transacting the business set out below

		Note / Approve	Time	Ref
1.	**Patients' Story and Reflection** Melanie Sharp, Deputy Chief Nurse	Note	09:00 hrs	Verbal
2.	**Business Items**			
2.1	**Chair's Opening Remarks** Linda Jackson, Acting Chair	Note	09:10 hrs	Verbal
2.2	**Apologies for Absence** Linda Jackson, Acting Chair	Note		Verbal
2.3	**Declarations of Interest** Linda Jackson, Acting Chair	Note		Verbal
2.4	**To approve the minutes of the previous Public meeting held on Tuesday, 3 August 2021** Linda Jackson, Acting Chair	Approve		NLG(21)194 Attached
2.5	**Urgent Matters Arising** Linda Jackson, Acting Chair	Note		Verbal
2.6	**Trust Board Action Log - Public** Linda Jackson, Acting Chair	Note		NLG(21)195 Attached
2.7	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note	09:20 hrs	NLG(21)196 Attached
2.8	**Integrated Performance Report (IPR)**	Note		NLG(21)197 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	09:25 hrs	NLG(21)198 Attached
3.2	**Quality & Safety Committee Highlight Report and Board Challenge** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	Note	09:35 hrs	NLG(21)199 Attached
3.3	**Quality & Safety Committee Self-Assessment:** • **Committee Effectiveness Reviews** • **Terms of Reference** • **Workplans** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	Note		NLG(21)200 Attached
3.4	**Executive Report – Performance** Shaun Stacey, Chief Operating Officer	Note	09:45 hrs	NLG(21)201 Attached

3.5	**Winter Plan & Potential COVID 19 Third Wave 2021-22 (DCM567)** Shaun Stacey, Chief Operating Officer	Note	09:50 hrs	NLG(21)202 Attached
3.6	**Finance & Performance Committee Highlight Report and Board Challenge – August & September 2021 (Performance only)** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	10:05 hrs	NLG(21)203 Attached
3.7	**Infection Control Annual Report** Maurice Madeo, Assistant Chief Nurse / Deputy Director of Infection Prevention & Control	Note	10:10 hrs	NLG(21)204 Attached
3.8	**Safeguarding Annual Report** Lynn Benefer, Deputy Head of Safeguarding	Note	10:20 hrs	NLG(21)205 Attached
BREAK – 10:30 hrs – 10:45 hrs				
4.	**Strategic Objective 2 – To Be a Good Employer**			
4.1	**Executive Report – Workforce** Christine Brereton, Director of People	Note	10:45 hrs	NLG(21)206 Attached
4.2	**Workforce Race Equality Standard Report** Christine Brereton, Director of People	Note		NLG(21)207 Attached
4.3	**Workforce Disability Equality Standards Report** Christine Brereton, Director of People	Note		NLG(21)208 Attached
4.4	**Workforce Committee Highlight Report and Board Challenge** Michael Whitworth, Non-Executive Director & Chair of the Workforce Committee	Note	10:55 hrs	NLG(21)209 Attached
4.5	**Workforce Committee Self-Assessment:** • **Committee Effectiveness Reviews** • **Terms of Reference** • **Workplans** Michael Whitworth, Non-Executive Director & Chair of the Workforce Committee	Note		NLG(21)210 Attached
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Executive Report – Finance – Month 05** Lee Bond, Chief Financial Officer	Note	11:05 hrs	NLG(21)211 Attached
5.2	**Executive Report – Estates & Facilities** Jug Johal, Director of Estates & Facilities	Note	11:10 hrs	NLG(21)212 Attached
5.3	**Finance & Performance Committee Highlight – August & September 2021 (Finance)** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:15 hrs	NLG(21)213 Attached
5.4	**Finance & Performance Committee Self-Assessment:** • **Committee Effectiveness Reviews** • **Terms of Reference** • **Workplans** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note		NLG(21)214 Attached
5.5	**Business Planning / CIP Timetable** Lee Bond, Chief Financial Officer	Note	11:25 hrs	NLG(21)215 Attached
BREAK – 11:30 hrs – 11:40 hrs				

6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Executive Report – Strategic & Transformation** Ivan McConnell, Director of Strategic Development	Note	11:40 hrs	NLG(21)216 Attached
6.2	**Submission of Humber Hospitals £720 million Expression of Interest in the DHSC Health Infrastructure (Future Hospitals) Plan** Ivan McConnell, Director of Strategic Development	Note	11:45 hrs	NLG(21)217 Attached
6.3	**Health Tree Foundation Trustees' Committee (HTFTC) Highlight Report & Board Challenge – September 2021** Gill Ponder, Non-Executive Director	Note	11:50 hrs	NLG(21)218 Attached
6.4	**Committees in Common Highlight Report & Board Challenge – August 2021** Linda Jackson, Acting Chair	Note	11:55 hrs	NLG(21)219 Attached
7.	**Strategic Objective 5 – To Provide Good Leadership**			
7.1	**Board Development Timetable** Helen Harris, Director of Corporate Governance	Note	12:00 hrs	NLG(21)220 Attached
8.	**Governance**			
8.1	**Audit Risk & Governance Committee – Extra-Ordinary Meeting (AR&GC) Highlight Report & Board Challenge – September 2021** Michael Whitworth, Non-Executive Director & Deputy Chair of the Audit, Risk & Governance Committee	Note	12:05 hrs	NLG(21)221 Attached
8.2	**Emergency Preparedness, Resilience & Response Core Standards 2020/2021 - Assurance process Statement of Compliance 2021-22** Shaun Stacey, Chief Operating Officer	Note	12:15 hrs	NLG(21)222 Attached
9.	**Approval (Other)**			
9.1	No items			
10.	**Items for Information / To Note (please refer to Appendix A)** Linda Jackson, Acting Chair	Note	12:20 hrs	
11.	**Any Other Urgent Business** Linda Jackson, Acting Chair	Note		Verbal
12.	**Questions from the Public**	Note		Verbal
13.	**Date and Time of Next meeting** **Board Development** Tuesday, 2 November 2021, Time TBC **Public & Private Meeting** Tuesday, 7 December 2021, Time TBC	Note		Verbal

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

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

APPENDIX A

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

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

10.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
10.1	**Finance & Performance Committee Minutes – June & July 2021** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(21)223 Attached
	Quality & Safety Committee	
10.2	**Quality & Safety Committee Minutes – July & August 2021** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(21)224 Attached
10.3	**Nursing Assurance Report** Ellie Monkhouse, Chief Nurse	NLG(21)225 Attached
	Workforce Committee	
10.4	**Workforce Committee Minutes – July 2021** Michael Withworth, Non-Executive Director & Chair of the Workforce Committee	NLG(21)226 Attached
	Audit, Risk & Governance Committee	
10.5	**Audit, Risk & Governance Committee Minutes – June 2021** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(21)227 Attached
	Health Tree Foundation Trustees' Committee	
10.6	Health Tree Foundation Trustees' Committee Minutes – May 2021 Neil Gammon, Chair of the Health Tree Foundation Trustees' Committee	NLG(21)228 Attached
	Other	
10.7	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(21)229 Attached

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 3 August 2021 at 10.00 am
Via Video Conference

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
Ellie Monkhouse	Chief Nurse
Shaun Stacey	Chief Operating Officer
Dr Kate Wood	Medical Director
Gillian Ponder	Non-Executive Director
Michael Proctor	Non-Executive Director
Michael Whitworth	Non-Executive Director

In Attendance:

Adrian Beddow	Associate Director of Communications
Christine Brereton	Director of People
Chris Evans	Associate Director of Information Services
Dr Liz Evans	Guardian of Safe Working Hours (for item 4.3)
Stuart Hall	Associate Non-Executive Director
Helen Harris	Director of Corporate Governance
Liz Houchin	Freedom to Speak up Guardian (for item 4.4)
Jug Johal	Director of Estates & Facilities
Jo Loughborough	Lead Nurse – Patient Experience (for item 1)
Ivan McConnell	Director of Strategic Development
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 10.00 am.

1. Patients' Story and Reflection

Jo Loughborough presented a story from Ann-Marie Westerman whose mother had been admitted to hospital during the pandemic. The patient experience team had been very helpful in particular Rachel during the inpatient stay. After this a role was advertised within the Patient Experience Team and as Ann-Marie had been so impressed by the impact the role had on patients and families Ann-Marie applied for the role and was successful. The team received such positive feedback from patients and families which highlighted how the role was appreciated. Part of the

role was to support patients on the wards by playing games and to be there to assist during video calls with family members. It had been recognised that this helped with the well-being of patients to keep in touch with families. Patients were also able to recommend changes and improvements required in ward areas through this role which had enabled the suggestions to be put in place.

Linda Jackson thanked Jo Loughborough for the story as it had highlighted what it meant to patients. Mike Proctor was pleased to see how the role freed up time for staff on the wards and asked if this could be highlighted at the Quality & Safety Committee (Q&SC) to see how it supported in other areas. Ellie Monkhouse explained the role had been put in place as a response to the pandemic but it had gone above and beyond the initial thoughts of how well received it would be. There was a feeling this would also support the Trust in the journey of coming out of quality special measures as it showed different level of care in the organisation. Prestigious Trusts had now started to use the model as it had been seen how successful it was. Shaun Stacey advised that from a patient welfare perspective it had been an important initiative and had demonstrated success in care. It had also provided support for staff on the wards when they had been under immense pressure. Linda Jackson asked if thanks could be passed to Ann-Marie for sharing the story.

2. Business Items

2.1 Chair's Opening Remarks

As Terry Moran had now left the Trust, Linda Jackson wanted to note collectively the appreciation for everything that Terry Moran had put into the role as Chair and that he would be sorely missed. The Board were advised that Linda Jackson had been appointed as Acting Chair and this had been approved by the Council of Governors (CoG) the previous week.

A meeting was due to take place later that week with Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) colleagues and NHS England / Improvement (NHSE/I) colleagues on the way forward to appoint a new Joint Chair for NLAG and Hull University Teaching Hospital (HUTH). An Extra-ordinary CoG meeting would take place on the 12 August to approve the process to be used to appoint the new Chair.

Stuart Hall had been appointed as Acting Chair at HUTH and it had been agreed that both Acting Chair's would attend the other Trusts Board meetings but the sub-committees would not be attended for the time being due to other commitments.

Andrew Smith, Non-Executive Director (NED) was due to leave the Trust at the end of August 2021, thanks were noted for the input and experience that had been brought to the role during the time at the Trust. The role had been recruited to but relevant employment checks were being completed.

2.2 Apologies for Absence

Apologies for absence were received from Andrew Smith, Shauna McMahon (represented by Chris Evans) and Elaine Criddle.

2.3 Declarations of Interest

No declarations of interests were declared.

2.4 To approve the minutes of the Public Meeting held on Tuesday, 1 June 2021 – NLG(21)147

The minutes of the meeting held on the 1 June 2021 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made.

- Lee Bond referred to page 4, the word underline should be changed to underlined in the third paragraph.
- Dr Kate Wood referred to page 7, section 3.3. The wording needed to be changed to say the report received had revealed there was no effective system of risk stratification which had meant the committee was not assured of the process in place.
- Lee Bond referred to page 8, final paragraph and asked for an “a” to be added to the name Shaun.

2.5 To approve the minutes of the Trust Board Self-Certification Event held on Tuesday, 25 May 2021 – NLG(21)148

The minutes of the meeting held on the 25 May 2021 were accepted as a true and accurate record and would be duly signed by the Chair.

2.6 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.

2.7 Trust Board Action Log – Public by exception NLG(21)149

Linda Jackson invited Board members to raise any further updates by exception in relation to the Trust Board Action Log, none were received.

2.8 Chief Executive’s Briefing

Dr Peter Reading advised of further development of the Humber Coast & Vale (HCV) Health & Care Partnership, posts had been advertised to lead the organisation at the Integrated Care System (ICS). Further development of partnership arrangements in North East Lincolnshire, North Lincolnshire and East Riding of Yorkshire, had started to develop separately but NLAG had been part of the discussion.

There were currently substantial pressures on emergency care and an update would be provided later in the meeting. This had also impacted on the rest of the country and included issues with children with Relationships and Sex Education (RSE) and mental health problems in the community as patients were unable to gain access to support in those areas.

2.9 Quarter 1 – Trust Priorities and Integrated Performance Report (IPR) – NLG(21)150

Helen Harris advised the report shared was the first report for this year and included the Trust Priorities. The report had been reviewed by the Executive Team (ET) and each sub-committee during July. Helen Harris advised Sam Riley from NHSE/I had worked with the Trust on further development of the report and this would evolve even more going forward. More consideration would be required on what further information the Trust Board would want to receive going forward.

Key highlights included some references between the IPR and trust priorities in reference to cancer, referral to treatment (RTT), Accident and Emergency (A&E) performance, venous thromboembolism (VTE) performance and sepsis assurance, they were also highlighted through the Trust priorities for quarter one. There were areas of concern for the A&E performance and this was linked to the Trust priorities report at page 61, discharge to assess had some areas of concern on page 62. Areas of cancer concerns were on page 64, data and assurance on this were linked through to page 81 of the report.

Linda Jackson felt the report had been reviewed well this month in sub-committees but this had highlighted there was some duplication at Trust Board so further work would be required on what should be shared throughout the various meetings moving forward.

3. Strategic Objective 1 – To Give Great Care

3.1 Executive Report – Quality & Safety - NLG(21)151

Dr Kate Wood referred to the report and advised the front sheet highlighted key concerns that had impacted on providing consistent care. Complaints had maintained the management of responses within timescales and this was currently at 84%. Safe staffing had now been a concern for several months but more so in the last few weeks due to staff absences due to Covid-19. Linda Jackson queried how the night shift safe staffing highlighted in the report would be addressed going forward. Ellie Monkhouse explained this was an ongoing concern as the number of staff available from 7.00 pm at night did decrease. A full establishment review had been undertaken and a request for full staffing on night shifts was to be requested to mitigate risks. Agency staff in some areas were being seen more like substantive staff due to the amount of time spent on NLAG wards, however, they did not want substantive roles when they had been offered liking the flexibility agency working afforded. A review of staff was being undertaken every day to ensure the appropriate skills mix was on every ward.

Linda Jackson queried the mortality out of hospital SHMI and whether Dr Kate Wood felt comfortable that there was sufficient traction provided within North Lincolnshire. Dr Kate Wood advised this would continue to be highlighted over the next few months and that the system End of Life Group were also meeting regularly and monitoring this. A proposal had been put together for end of life care which required some investment into the provision of this and palliative care through

additional specialised palliative care medical workforce, particularly at the NE Lincs end of the patch. It had been identified that patients were dying within 24 hours of hospital admission whose care delivery could potentially have been in a different place at the End of Life. This is being tracked as a quality priority. Any issues going forward would be highlighted.

Stuart Hall queried how the Trust had dealt with the issues around staff who had had to isolate and how the advice the Trust were giving had worked, also how the Trust had coped due to staff being pinged through the NHS app. Ellie Monkhouse advised this had caused major problems but it had improved this week. The Trust had had over 400 staff off work in isolation in any given day and the majority of staff had been clinical. This had meant patients being moved around wards with the consolidation of wards at times. The Trust had safe care live which supported the process. Ellie Monkhouse wanted to note that staff had been amazing at trying to continue and had come back to work when they were able to. The platform had worked well and staff had used this. Support had also been provided from the infection control team.

Gill Ponder referred to the report as it stated pressure ulcers remained consistent, however, there was no way of knowing whether this meant it was good or bad and queried whether there was a variance between the sites. A request was made to highlight to board members the red flags so this could be sighted in the future. Ellie Monkhouse confirmed this was highlighted when required and it would also be raised through the Q&SC Highlight Report if there was any concern. Other reports were also available to show assurance.

Maneesh Singh queried whether data of staff isolating could show those who had been pinged and then tested positive. Shaun Stacey advised this was available and was regularly reviewed and then shared regionally by the infection control nurses, this was completed for regional workforce support.

Mike Proctor referred to the point raised by Gill Ponder and advised the Q&SC were focussed on the areas required, and advised Gill Ponder was welcome to attend the meeting to gain assurance.

3.2 Quality & Safety Committee Highlight Report and Board Challenge – NLG(21)152

Mike Proctor advised the Quality Account had been reviewed over two meetings of the Q&SC and had been shared at the board that day for approval. The committee had signed off the Clinical Negligence Scheme for Trusts (CNST) which had firstly been reviewed at confirm and challenge meetings to ensure a robust process was in place. The committee had been confident all 10 standards were met which had been a great achievement.

3.3 Executive Report – Performance – NLG(21)153

Shaun Stacey referred to the key highlights within the report. One key point was the significant high numbers that had attended A&E, the department continued to care for patients that had no other places to go to in the community for care. Staff sickness had also impacted on other areas such as cancer. Linda Jackson referred

to the discharge to assess page and highlighted the good work that had been undertaken.

Lee Bond referred to the A&E attendance numbers in respect of the increase to pre-pandemic numbers and what the system response was to this to stem the demand. Shaun Stacey advised there had been an increase of 9% but this was in fact an increase of 24% with ambulance arrivals. The Trust still only had on average a 20 / 25% ratio conversion to admission which was a great accolade for staff. The A&E attendance was made up of 80% of activity that could be managed by an alternative provision. The community had undertaken work on alternative pathways to try and support this, NHS111 was well established and had taken some activity away from the Trust. Pathways had been established to move urgent care requests for primary care back to primary care by the request of appointments with General Practitioners (GPs). This had been working in North East Lincolnshire but had not yet gone live in North Lincolnshire. Through the A&E Delivery Board a working group had been established to look at alternative pathways. East Midlands Ambulance Service had also put a GP and paramedic on the front line to respond to patients who may not require hospital care.

Stuart Hall referred to the issues around patients with mental health issues as this was concerning. One issue had been raised recently that some patients with mental health issues that did not require hospital care were still referred to the hospital as it was seen as a place of safety. Shaun Stacey advised this was the case and would become worse as under normal circumstances the police would call social services and refer the person to them. However, the police no longer responded to such calls and only referred people to the ambulance service. The paramedic would then make the decision that the patient was vulnerable and needed to be in a safe place. Currently in the Trust system call 24 would be the mental health route of access but this was not fully functioning which had meant access to services did remain with the emergency department. Some measures had been put in place to manage the flow of those patients. In North East Lincolnshire, NAVIGO offered a service for vulnerable people and RDASH had been working on this with commissioners for a similar service to be offered in North Lincolnshire.

3.4 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(21)154

Gill Ponder explained progress with the new CQC process had been noted as a fantastic step forward. The committee had endorsed £1.7 million per year for the next two years due to cost pressures with the new A&E / Acute Assessment Units (AAU) facilities. If agreed by the Board, the amount of £1.2 million would be moved over to the next two years, with contingencies within the case if it was not all used.

Lee Bond advised there had been a forecast overspend in respect of A&E / AAU due to increased costs. Due to the timing of the spend the Trust were able to top slice the internal capital programme by £1.7 million each year in order to meet the shortfall. This did mean there would be a £2 million contingency, which would then be released back if it was not required. Jug Johal added this would be the first call on the major capital programme for the next two years as it was just finishing off schemes that had already started.

The Trust Board agreed to move the money over the next two years.

3.5 Annual Quality Account – NLG(21)155

Dr Kate Wood advised the required work had been undertaken to review the report through the Q&SC. The report would normally be submitted earlier in the year but as no guidance was provided in time it had been taken off the normal cycle. This had also been reviewed by stakeholders and governors.

The Trust Board agreed to approve the Annual Quality Account.

3.6 Annual Complaints Report – NLG(21)176

Jo Loughborough confirmed the report had been presented to the Q&SC. Work was still required in terms of the Patient Advice & Liaison Service (PALS) which would be progressed over the next year with a focus on the medicine division. The process had achieved the KPI of 87% that week for complaints received and responded to within the correct timescale. The report highlighted key themes and learning. The team had also had to adapt to changes in procedures with the Parliamentary Health Service Ombudsman (PHSO).

Dr Peter Reading congratulated Jo Loughborough, the team and divisions on the achievement along with Ellie Monkhouse's leadership, this had been a phenomenal achievement. Ellie Monkhouse wanted to acknowledge the culture change through the pandemic as this had been difficult. The Boards' attention was drawn to Appendix 1 as this showed how quality improvement processes were embedded. Christine Brereton referred to the themes that had been identified and felt this could also be triangulated to other areas to highlight staff behaviours. It was agreed this would be discussed further outside of the meeting.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Executive Report - Workforce – NLG(21)157

Christine Brereton confirmed the workforce data was now being included within the IPR. There were five key indicators a present, but work would be continuing on further indicators that would then be shared with the Workforce Committee. Two deep dives had been undertaken at the Workforce Committee, one being the People Strategy and the other the NHS People Plan. There were some risks to highlight in respect of medical and nurse vacancies, with further work being required in those areas.

Christine Brereton had been approached by NHSE/I to undertake some work around retention. Lee Bond queried if future reports could detail the number of vacancies and whether this could identify any areas of concern. Lee Bond queried whether the target of the zero non-registered vacancies had been met and whether that was why it was not detailed in the report. Christine Brereton advised this was detailed within the IPR, the target had been met by the 31 March 2021 and was now at a fluid position due to issues with retention. Some of the vacancies had originally been

filled by people who had not worked in a care setting previously and due to it not being what was expected there had been some drop-out rates. Ellie Monkhouse advised there had been some issues with the newly recruited Healthcare Support workers as the pay was not as high as it was in the hospitality business, so staff had left to work in those areas. This was currently a national problem so the Trust would need to be mindful of this.

4.2 Workforce Committee Highlight Report and Board Challenge – NLG(21)158

Michael Whitworth advised that the committee had received the Annual Organisation Audit – Annual Medical Workforce Revalidation Report, and were asking for the Board to endorse the Accountable Officer to sign the Statement of Compliance of the report.

Two important reports had been discussed at the committee around race and disability, these would be scrutinised before they were shared with the Board. A deep dive into recruitment and retention had been undertaken to determine how work with the divisions could be undertaken differently. Linda Jackson had attended the meeting and wanted to note the impressive Revalidation Report as it highlighted the level of grip the team had, thanks were noted for the team in the work undertaken. Dr Kate Wood advised the Annual Organisation Audit – Annual Medical Workforce Revalidation Report required sign off by the board so requested if Michael Whitworth's recommendation could be approved.

The Trust Board approved the Annual Organisation Audit – Annual Medical Workforce Revalidation Report.

4.3 Guardian of Safe Working Hours Annual Report – NLG(21)180

Dr Kate Wood introduced Dr Liz Evans who had recently been appointed as the Guardian of Safe Working hours in addition to a role in anaesthetics at Diana, Princess of Wales Hospital (DPOWH). Dr Kate Wood advised the report shared was mandatory.

Dr Liz Evans explained some issues had been raised within the medicine division so further work would be required, however, this did not necessarily mean staff in this area were not happy. Work was being undertaken with new doctors to identify why concerns were not being highlighted. The quarterly report had been shared with the Trust Management Board (TMB) to ensure any actions were reported. Stuart Hall queried whether the main six areas could be published to identify what they were. Dr Liz Evans agreed to share the detail in the report going forward. Linda Jackson thanked Dr Liz Evans for attending the board and giving a comprehensive update.

4.4 Freedom to Speak Up Guardian Update – Quarter 1 - NLG(21)159

Liz Houchin highlighted there were some issues to note within the quarter one report. The number of concerns raised was slightly below the quarterly average for the previous year. The report showed there had been no anonymous concerns reported. The main themes were around behaviour and worker safety. The data provided from the report had been shared with Human Resources Business Partners

to enable them to identify hot spots. The report was shared at the Workforce Committee meeting in July and there had been good debate around the patient safety elements. More context would be added to the report to provide assurance.

Linda Jackson thanked Liz Houchin for sharing the report which was very comprehensive.

5. Strategic Objective 3 – To Live Within our Means

5.1 Executive Report - Finance – Month 03 - NLG(21)160

Lee Bond advised that the finances for the first quarter had been looked at in more detail at the F&PC. In month two and three the Trust had been below plan on the elective recovery fund (ERF) due to the amount of electives that had been carried out, this was due to the pressures highlighted earlier in the meeting. A major change to note with elective recovery was the change in thresholds, the eligibility in order to achieve this had moved from 85% to 95%, which would affect any margin achievable through the elective recovery fund.

Stuart Hall referred to the changes in thresholds for ERF and queried if this was in relation to a shortage of funds. Lee Bond advised it related to the billion pound fund that was spent in the first three months of the year. The Centre did not believe they had seen the required amount of activity carried out for this period.

5.2 Executive Report – Digital Strategy 6 Month Update – NLG(21)161

Chris Evans advised the Trust were currently behind spend on the financial plan. There was due to be some significant milestones later in the year so it was expected this position would be recovered in the third quarter. Dr Kate Wood questioned the coding element on page seven, it referred to a Memorandum of Understanding (MoU) for the shared management model with information governance and coding with HUTH. Work had previously been undertaken with clinical coding and focussing on clinical engagement had been key to the improvements seen at NLaG. There would be some nervousness that engagement would be lost due to teams being moved around. This had not been discussed as to what mitigation would be put in place along with the difference in Summary Hospital Mortality Index (SHMI) from HUTH to NLAG which would cause some concern if NLAG deteriorated. Linda Jackson felt this was a valid point and asked if Dr Kate Wood could be provided with assurance outside of the meeting.

Ellie Monkhouse queried where the patient safety stop was and whether this was the Digital Strategy Board, if so was this where the Quality Impact Assessment (QIA) was discussed. There had been some occasions where patient safety concerns had not been flagged correctly. Chris Evans advised this element was now covered by the Digital Solutions Group. Subject to approval there was a further detailed forum where teams would work with stakeholders which included the Clinical Safety Officer. Chris Evans agreed to share the governance model with Ellie Monkhouse.

Stuart Hall referred to page 20 and queried how this had progressed with Lorenzo and Web V sharing views of records as it stated this would be by the end of

August. Chris Evans advised this was approached in two ways, Lorenzo was now completed so the same approach would be put in place in respect of WebV. The replacement of the Patient Administration System (PAS) would be carried out in a number of different ways. A paper was due to be shared with the Executive Team for the appropriate governance channels for approval.

5.3 Finance & Performance Committee Highlight Report and Board Challenge – June & July 2021 – Finance & Digital - NLG(21)162

Gill Ponder advised the Covid-19 expenditure had increased and the vast majority of funding would be due to run out in H2. Due to delays beyond our control with the overseas recruitment there would be a risk to delivery of the improvement plans. A letter had been received in respect of what would be required to emerge from financial special measures by the end of September.

Ellie Monkhouse wanted the Board to recognise that the Covid-19 expenditure had been for patient facing. It was noted Covid-19 continued to cause issues operationally and was concerned that the additional funds would not continue. The issues with the completion of the use of resources assessment had been raised a number of times at the Q&SC as this had arisen due to the demographics of staff that had to work in other areas. The Trust needed to be sighted that this information would not necessarily fit into national benchmarking as all Trusts had worked differently

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Executive Report – Strategic & Transformation – NLG(21)164

Ivan McConnell advised that a visit had been undertaken by Amanda Pritchard, Chief Executive, NHSE/I and Richard Barker, North East and Yorkshire Regional Director, NHSE/I to look at the collaborative working, with feedback from the visit being very positive. There had been a relaunch of programme two which had been successful. Engagement events had continued to ensure statutory duties had been achieved.

Dr Kate Wood noted the UCE review had been undertaken by colleagues across the system and queried where this would be presented along with where the oversight of this would be. Ivan McConnell explained the UCE review had been undertaken through the senate and they had been asked to undertake rolling desktop and formal reviews. The reviews had been sent to the Clinical Design Group. A formal set of reviews would be received before a formal senate sign off.

6.2 Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – July 2021 – NLG(21)165

Ellie Monkhouse wanted to note disappointment at the decision of trustees in respect of Dementia Friendly Wards not being approved. More was support was required in respect of dementia patients going forward. A request was made for this to be reviewed again in the future. It was noted this decision had not been discussed with Ellie Monkhouse as Dementia lead.

6.3 Committees in Common Highlight Report and Board Challenge (CIC) – NLG(21)166

Michael Whitworth advised the first meeting had been held in June. Linda Jackson referred to item five, where it explained the Committee had reviewed the development of a Governance Service Level Agreement for joint working arrangements which would jointly access and monitor improvements in quality and safety. It had been recognised the process would involve building on existing governance, Linda Jackson queried how this would work. Michael Whitworth advised it would be included within the existing committees at both Trusts. Dr Kate Wood felt a discussion would be required outside of the meeting to provide appropriate oversight of this request. Linda Jackson agreed with this suggestion.

7. Strategic Objective 5 – To Provide Good Leadership

7.1 Board Development Timetable – NLG(21)167

Helen Harris shared the paper and advised the timetable was subject to change should anything further arise.

Mike Proctor queried if consideration could be taken on trying to meet in person at some point going forward. Linda Jackson advised a discussion had taken place with Dr Peter Reading and due to the high number of positive cases in the area it had been agreed to continue with virtual meetings this would be reviewed at the end of August 2021.

8. Governance

8.1 Audit, Risk & Governance Committee (AR&GC) Highlight Report & Board Challenge – May and June 2021 - NLG(21)168

Michael Whitworth advised a number of business items had been discussed over the two meetings. The areas of concern had been noted within the highlight report.

8.2 Board Assurance Framework (BAF) - NLG(21)169

Helen Harris wanted to thank the Executive Team for the time spent going through the strategic risks. The BAF had then been reviewed by each sub-committee for the quarter. Particular attention was drawn to the number of high level risks on page four. Helen Harris felt some triangulation should be undertaken between all strategic risks to ensure this was strengthened. Two items were brought to the Boards' attention in respect of the recommendations to reduce the score of some risks as detailed on the first page of the report.

Christine Brereton felt the debate for the BAF should be undertaken at the board collectively. Although recommendations could be made through the sub-committees it should also be jointly owned by other executive team members. It was asked if this opportunity could be undertaken through board development sessions where in

depth discussion could take place to join some of the risks together.

Michael Whitworth felt some of the work undertaken in respect of recruitment, retention and wellbeing meant the risk could be reduced from 20 to 15. The risks around recruitment had been raised at other sub-committees due to the financial implications included within this. It was felt as workforce impacted on all of the risks this would provide more assurance. Ellie Monkhouse did not support the reduction of the risk. The way the risk was written was a professional risk in respect of safe staffing. The Workforce Committee mitigated the operational aspects but this also related to safety, adequacy and skills mix. Therefore, this risk should be owned by the Chief Nurse, Medical Director and Director of People or the wording should be changed to make this more clear. Christine Brereton agreed there was some issues in respect of safe staffing so further work would be required to ensure the right score level was agreed.

Dr Peter Reading felt there was some misunderstanding as the BAF was owned by the Trust Board. The detailed discussion was undertaken in the sub-committees but this was then shared at board for assurance and sign off. Linda Jackson felt a further discussion should be undertaken outside of the meeting with Helen Harris, Christine Brereton and Ellie Monkhouse to review strategic objective two to ensure this was broken down more. The risk would remain at 20 as it had not been agreed to reduce this until further discussion had taken place. It was agreed to reduce Strategic Objective One to change this from international to national.

Action: Helen Harris, Christine Brereton, Ellie Monkhouse to meet outside of the meeting to discuss Strategic Objective Two.

8.3 Fire Annual Report – NLG(21)170

Jug Johal explained the report had been approved through the relevant sub-committee. This year had seen a major capital investment into the fire alarm system at the DPOWH site. The Trust Board agreed to the supporting of the report.

8.4 Local Security Management Specialist (LSMS) Annual Report & Workplan including Security Annual Report - NLG(21)171

Jug Johal shared the report with the board and highlighted key points.

The Trust Board approved the report.

8.5 Emergency Preparedness Resilience & Response Annual Report – NLG(21)172

Shaun Stacey advised the report summary provided key highlights for the past year. Linda Jackson noted the excellent work undertaken by the team over the last year.

9. Approval (Other)

9.1 North East Lincolnshire Health & Care – Memorandum of Understanding – NLG(21)173

Dr Peter Reading advised the report was a follow up to the North East Lincolnshire Care Partnership proposal discussed at the June Private Board meeting. The paper had been shared to ask for endorsement by the Trust Board.

The Trust Board endorsed the paper.

10. Items for Information

11. Any Other Urgent Business

Mike Proctor referred to the changes of the F&PC Terms of Reference in respect of allowing Deputies to attend sub-committees and queried whether all sub-committees should follow the same process. Linda Jackson agreed with this and advised Helen Harris would be taking this forward for all sub-committees. Dr Peter Reading agreed there was some inconsistency and felt they needed to be consistent across all the sub-committees. A standard template would be agreed by the Trust Board along with any sub-committee changes. Gill Ponder advised the F&PC had put in place an interim point whilst the review of the Terms of Reference took place. The Trust Board agreed to support the interim change of the Terms of Reference.

Action: Helen Harris

Dr Peter Reading made a request for Dr Kate Wood's title to be changed to Chief Medical Officer. The Trust Board agreed to the change of Dr Kate Wood's title with immediate effect.

12. Questions from the Public

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

13. Date and Time of the next meeting

Board Development
Tuesday, 7 September 2021, Time TBC

Formal Trust Board Meeting
Tuesday, 5 October 2021, Time: TBC
Via video conference

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

Linda Jackson closed the meeting at 12:45 hours.

Northern Lincolnshire and Goole NHS Foundation Trust

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

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

NLG(21)195

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?
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				

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?

Key:

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

NLG(21)196

DATE OF MEETING	Tuesday, 5 October 2021
REPORT FOR	Trust Board - Public
REPORT FROM	Dr Peter Reading, Chief Executive
CONTACT OFFICER	Dr Peter Reading, Chief Executive
SUBJECT	Chief Executive's Briefing
BACKGROUND DOCUMENT (if any)	Not applicable.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Not applicable.
EXECUTIVE SUMMARY	The report provides an overview of the following: • 6 Month Progress Report on 2021-22 Trust Priorities • Development of Humber Coast and Vale Health and Care Partnership

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	1.1, 1.2, 1.4, 1.5, 1.6, 2, 3.1, 3.2, 4 and 5.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Chief Executives Overview

1. 6 Month Progress Report on 2021-22 Trust Priorities

Attached to this paper as an Appendix is the 6-month (April to September 2021) Progress Report on the 2021-22 Trust's Priorities.

2. Development of Humber Coast and Vale Health and Care Partnership

The development of the local Integrated Care System (ICS) – Humber Coast and Vale Health and Care Partnership (HCV) - continues at pace, with full participation in all relevant aspects of its development of Trust Executive Directors, managers and clinicians. Subject to the passing of enabling legislation by Parliament, HCV will go 'live' on 1 April 2022. ICSs will assume the statutory responsibilities of Clinical Commissioning Groups, which, again subject to legislation, will be abolished on 31 March 2022.

Recent national guidance has identified the two governing bodies of ICSs as an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP). The former will govern the NHS side of an ICS with statutory powers and be the overarching financial and managerial body for services and organisations within the ICS. Each ICB will have a Non Executive Chair appointed by the Secretary of State, and a number of mandatory Board posts, including a Chief Executive, a Finance Director, a Medical Director, a Chief Nurse and at least two Non Executive Directors. The ICB will have discretion to appoint other executive and non-executive directors. The ICP will have a key role in determining the strategy of the ICS and will include representatives of all relevant local authorities, together with other local stakeholders. In HCV, following an open recruitment process, a recommendation for the post of Chair-designate has been made to the Secretary of State, with an announcement of the appointment expected shortly. Recruitment to the Chief Executive-designate post is now under way, with an appointment expected within a few weeks.

Within HCV, there has been intensive activity over recent months to establish the key components of the new ICS structure. Partnership Boards have been established for York and North Yorkshire and for the Humber. The NLaG CEO is a member of the latter Partnership Board. Four Provider Collaboratives have been established – one each for Acute providers, Community providers, Mental Health, Learning Disability and Autism providers, and Primary Care. NLaG is a member of the first two of these. The Collaborative of Acute Providers is developing its work programme and it is keen to play a leading role in Cancer, Elective Care, Diagnostics, Maternity and Paediatrics and Urgent and Emergency Care, together with enabling collaborations in relevant aspects of Digital, Workforce and clinical service planning and development. The Community Collaborative is focusing on developing and sharing good practice, for example, in Discharge to Assess.

At Place (defined by local authority boundaries), work is proceeding at pace to establish structures and ambitions to ensure that local needs are adequately addressed in the new system and also that the new objectives of the NHS and its partners, including population health management and reducing health inequalities, are addressed adequately and at pace. Local authorities are a playing key role in these developments, with relevant CCGs, providers, primary care networks, and independent and voluntary sector organisations. The work is most advanced in North East Lincolnshire, where local organisations (including NLaG) have signed a Memorandum of Understanding and have a draft Partnership Agreement ready for signing.

Work remains at an early stage in determining where money flows from the ICS, and which organisation has the lead role in specific areas, ie the ICS, collaboratives and Place-based partnerships. This work is expected to accelerate once the ICB Chair-designate and Chief Executive-designate are in post, creating a matrix for collaboration, service transformation, service delivery, financial flows, and the delivery of the objectives of the NHS, alongside the new objectives for health (eg population health management, reducing health inequalities).

Peter Reading
Chief Executive

Trust Priority 1 – Pandemic Response

- We will play a full part (both acute and community) in the NHS's **response to the Covid-19 pandemic**, offering the best and safest service possible to patients, staff and public, including maintaining the highest standards of infection prevention and control.

  The Trust has continued with the red, yellow and green wards throughout this year in order to segregate the COVID positive, COVID negative and those awaiting swab results for the suspected and not suspected patients. The segregation has also continued within the EDs where the COVID suspected patients are within the red area. On all wards, within ED and in Outpatients, social distancing has continued and the deep cleans, where required, are still happening. Staff are still donning/doffing masks, aprons and gloves as per Infection Control guidelines, in order to limit cross contamination. Visiting on the Wards has been limited to one named family member/friend and if a patient can attend ED alone then this is advised; where a patient is unable to attend alone due to age, ability to communicate, then one family member/friend has been allowed to stay. The Trust has implemented a policy on staff absence for staff who test positive for COVID or where a household member has tested positive. The Trust is also continuing to remind all staff to undertake twice weekly lateral flows in order to identify any staff who are COVID positive but are not symptomatic. Infection Control is still contacted where any questions around COVID may arise.

- We will maintain and deliver as full an **urgent and elective service** as resources allow during and after the pandemic, including:

  - delivery of our agreed recovery plans (currently Wave 3);

    As of 14 September, the Trust had achieved 91% of the H1 activity plan, this can be broken down to:

Outpatient New	102%
Outpatient Review	87%
Elective Inpatients	80%
Day Case	89%

    The Trust did not achieve the plan for 3 of the 4 categories of activity but this can be explained through the extra work carried out for Risk Stratification, limited elective capacity, COVID patients 'over-flowing' into theatres and workforce absence.

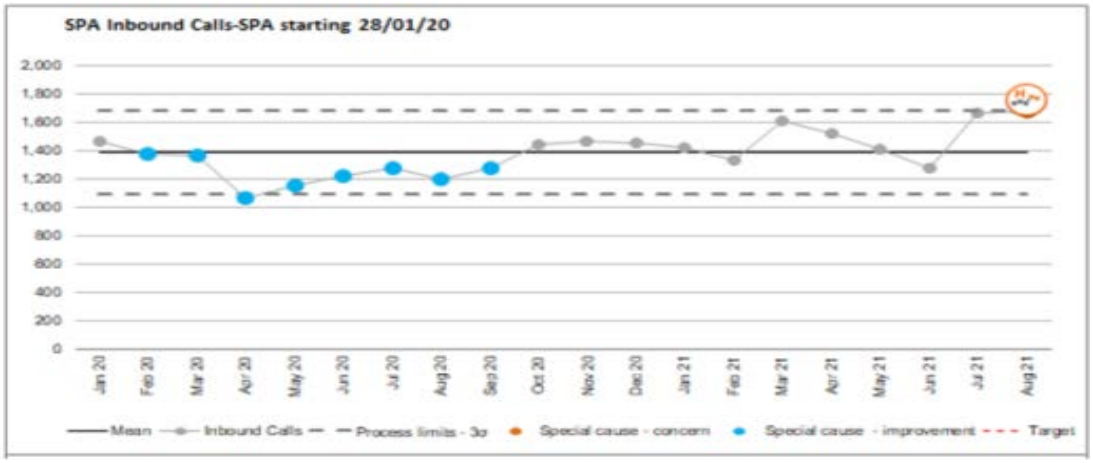
  - an emergency response through our Emergency Departments of 80% of patients managed within 4 hours;

    The Trust's ED performance has dropped and we are not achieving the 80% of patients managed within 4 hours, however there are a number of schemes being put in place to attempt to raise the performance back to the required levels. The programmes of work include but are not limited to: Integrated Urgent and Emergency Care, Patient Flow and Acute Assessment Unit Capital Scheme. The Integrated Urgent and Emergency Care programmes

involve looking at the ED Front Door, ED Streaming, ED Roles and Responsibilities, Trust Wide Roles and Responsibilities, Portering in ED, Paediatric Urgent Care Pathways and the Medical and Nursing workforce. The Patient Flow programme is aiming to reduce the number of long stay patients and therefore free up acute hospital beds and therefore increase the flow of patients from the Eds. This programme of working includes the already operational Hospital Discharge Service. Finally, the Acute Assessment Unit Capital Scheme is concentrating on the establishment of the current IAAUs and the integration of the Wards into the new build EDs

- community Single Point of Access (SPA) with 70% of patients receiving a crisis response within 2 hours;

The Single Point of Access (SPA) has seen an increasing number of incoming calls since its introduction in January 2020 and will now form part of the business case outlining a major reconfiguration of unplanned care.



The Community and Therapies Division is currently working towards the required milestones to deliver 2 Hour Urgent Community Response in line with the NHS Operational Planning Guidance 2021/22. The initial milestone was to submit the required information to the Community Services Data Set (CSDS) which has been achieved. The next steps are to work with the Information Team to establish internal reporting against this measure along with developing the operating model and recruiting additional staffing capacity. Work on these stages commences in October 2021, with a deadline for delivery of March 2022.

- a reduction to zero by 31.3.22 of patients waiting over 52 weeks for elective treatment, and those waiting over 104 days for cancer treatment;

The 52 week position has been steadily decreasing month on month since February 2021 and it is currently below the target required to be at by March 2022.

The 104 day waiters have also been decreasing and are currently at 26 (as at 29 September 2021). Some of the long waits for patients are outside our control, as treatment is due to take place at HUTH, therefore when HUTH make the decision to stand down theatre sessions due to COVID this can have a knock-on effect to the NLaG waiting position which effectively we cannot control. This means that although the trajectory would suggest a decrease in the 104 day waiters, there remains some risk to achieving this by the end of the financial year.

- full risk stratification of those whose elective or out-patient care is delayed.

  Risk stratification of the Live Inpatient Elective waiting list stands at 99.8% and the Planned Inpatient Elective Waiting list stands at 66.7% (as at 29 September 2021). The Planned Elective waiting list compliance is gradually increasing and should be close to 100% by the end of the financial year. The Outpatient New waiting list has 44.9% Risk Stratification compliance and the follow up waiting list is showing as 54.1% compliance. The Outpatient follow up has a large number of outstanding risk stratifications to complete but the Divisions have put plans in place to have all of these complete by the end of the financial year.

Trust Priority 2 – Workforce and Leadership

- We will strengthen **Recruitment and Retention** of key groups of clinical staff, specifically focussing on filling vacancies for health care support workers and registered nursing and taking account of Workforce Safeguards (2018) standards

  Recruitment continues across all staff groups within medical and nursing vacancies. 73 Newly Qualified Nurses are due to start shortly following completion of training. International nurse recruitment is ongoing, with the project led by and overseen by the Chief Nurse's Directorate. 5 nurses are scheduled to start in October 2021, with 21 planned for November 2021, 21 for December 2021, and 20 for January 2022.

  Recruitment of Health Care Support Workers (HCSWs) is ongoing, with 161.87WTE HCSW recruited between January 2021 and September 2021. The HCSW pipeline continues to be utilised responding to increased turnover. From previous recruitment in September, all appointments were allocated immediately, subsequent recruitment has resulted in 15.97 WTE awaiting start in October and

November. A recruitment process is currently underway and is at the shortlisting stage with interviews scheduled.

For Medical and Dental the last report position in August 2021:

- Consultants – 18.73% (target 16%)
- Specialty Doctors – 14.87%
- Junior Doctors (training) – 14.65%
- Junior Doctors (non-training) – 16.12%

Current pipeline of individuals awaiting start stands at 6 Consultants, 29 SAS and 17 juniors, with further recruitment ongoing. Rotation fill for August was 80.10%. Increases in establishment have impacted against targets, with budgeted establishment for M&D increasing by 19.60 WTE between June and August 2021.

- We will **Improve Culture** by developing overall plans to further implement and embed our values, improve working practices, and support new ways of working

  Proposals have now been developed for a **Culture Transformational Group** which will co-ordinate activities and objectives to improve culture at NLAG. This will bring together under one infrastructure all information, data and intelligence and work areas so that it can be appropriately governed and focus on key priorities and measure output. This will include Equality, Diversity and Inclusion, Freedom To Speak Up, HR case work, staff survey, health and wellbeing and OD. This has been socialised at Executives and Workforce Committee and will be presented further to TMB and Board in October/November.

  To further support this agenda we have:

  - Appointed an Associate Director for Culture and OD who will support the People Director
  - Relaunched our staff network groups for BAME, Disability and LGTBQ+
  - WRES / DES and gender pay gap data submitted
  - Introduced a Board Development Programme for 2021/22 alongside Executive leadership development
  - Shaping a Just Culture framework to deal with B&H complaints and disciplinary – to embed a learning culture
  - Focus on staff engagement initially through staff survey to be launched on 4 October
  - Considering next steps for Pride and Respect and embedding our values

- We will design and implement a **Health and Wellbeing plan** which sets out our offer for all staff the next two years.

  To identify the objectives for our Health and Wellbeing (HWB) plan we are going to undertake a diagnostic of our current culture and approach to Health and Wellbeing across. This will be done by completing a self-assessment NHSI/E tool kit. Given Covid, the NHSI/E HWB tool kit has been further updated and enhanced to include:

  - Leadership and Management

- Data
- Environment
- Professional Wellbeing support
- Relationships at work

The HWB self-assessment tool kit is completed with a range of stakeholders, including HWB specialists, senior leaders, managers, trade unions and staff. NLaG has been successful in being one of the pilot Trusts to support this enhanced tool kit and a meeting to discuss its implementation will take place with NHSI/E in early October. Once the self-assessment has been completed, this will identify hotspot areas for the Trust to focus its attention on, either working locally or across the ICS to improve HWB for our staff. A HWB plan will then be drafted, implemented and communicated. Delivery of the objectives of the HWB will be governed through the HWB group and Workforce Committee on behalf of the Board.

To further support this agenda we have:

- Appointed a Health and Wellbeing Guardian to our Board. This is governed through the Workforce Committee.
- Appointed a HWB Co-ordinator role who commenced in post at the end of August and is currently gathering all information on our HWB "offers" across the Trust to inform the self-assessment process.
- Health and Wellbeing Group has now been re-established chaired by the Director of People.
- Implementing PTSD support for our staff to ensure easier access
- Continuing to promote available support and resource to our staff via our web. Facebook and communications.

- We will scope our **Leadership Development** Framework to enhance the capabilities of clinical and non-clinical leaders at all levels.

An exercise will be undertaken to design a Leadership programme for all Leaders within the Trust and will encompass HWB, Diversity and Inclusion and conflict management. Work will be undertaken to gain valuable insights from leaders across the organisation so that the programme is co-designed. In addition, we will also review current leadership development models underway to establish "what works".

In line with the Culture work, we are also considering how to encompass Pride and Respect/our Values into a leadership development programme and to link in with leadership development within the wider NHS.

Initial proposals will be drafted by end of December for discussion at Executives in early 2022, which will be costed, and if approved, for delivery within the next financial year.

To further support this agenda we have:

- Introduced a stand-alone leadership programme for new consultants to support their induction

- Continuing where possible to support individuals to develop in leadership roles, ie nursing

- We will enhance and invest in the **People Directorate capability** to support the Trust to deliver the NHS People Plan and Trust People Strategy

  A business case was submitted to the Executive Team in March 2021, to support changes and enhancements for the People Directorate, this was supported in part to enhance investment for OD given the priorities for the Trust and function around Leadership, Culture and OD. As a result, three senior posts have been appointed to roles in August.

  A formal consultation exercise with staff and trade unions commenced in early July and ended at the end of August. Consultation within the HR team has continued and will end in early October. A number of vacancies have arisen as a result of the restructure and recruitment is underway for these posts, mainly within in the OD team. This presents some immediate risks to the delivery of the Culture and Leadership objectives whilst we recruit.

  Objectives for the People Directorate for 21/22 have been devised which focus on delivery of the People Strategy which was signed off by the Board in June 2020. Full benefits realisation will be measurable from 2022 onwards.

Trust Priority 3 – Quality and Safety

- We will redesign the **Quality Improvement (QI)** offer, programme and culture across the Trust; investing in our QI team and empowering our staff to contribute to and champion our emerging QI community.
- We will continue to learn and improve following external agency reports, with clear action to resolve or mitigate risk, particularly related to patient safety, including the **response to the 2020 CQC report** and other major national reviews e.g. Ockenden

- The Team has now been fully recruited to, with all postholders in post by the beginning of December.
- There is a nursing and medical lead, with an AHP lead expected in the near future, these are sessional posts and unfunded past March 2022 but essential for clinical support and promotion of QI methods.
- There is a QI Trust wide methodology and the QI platform ‘Life QI’ is now in use for current QI projects.
- The Trust QI Strategy will be shared with TMB in mid-October and then to the next Trust Board.
- We continue to develop our Trust QI brand and are ‘Turning NLaG Orange’.
- We have started our first Trust wide QI Collaborative Programme in Medicines Management, with six smaller projects underway. Our first Collaborative was within Maternity, demonstrating a significant change.
- We held our first QI Council in September 2021.
- We continue to develop our training academy which includes virtual training and project implementation for our staff, but also across the HCV for Junior Doctors.

- We will focus on the following five **quality priorities:**

  - End of Life care and related mortality indicators

    The out-of-hospital SHMI has reduced, mainly as a result of improvement in SGH OOH SHMI; collaborative review work with partners of recent cases has commenced and MIG will receive a paper in October focussing on the data relating to out-of-hospital mortality indicators. Good progress.

  - The Deteriorating Patient and sepsis

    Manual audit data is now available to support understanding performance with Deteriorating patients and sepsis. This has identified gaps in recording. Electronic data relating to sepsis remains a challenge. This is being escalated to the MIG in November. An improvement campaign is planned to focus on both areas based on the audit findings. There is concern in progress here hence the improvement campaign planned for November.

  - Reduction of medication errors
  - Diabetes Mellitus management

    Medication safety in relation to omitted doses and insulin administered on time perform well from EPMA data. A focus on weighing patients is currently being targeted from the audit data now available. Good progress here for both of these quality priorities

  - Safety of discharge

    Safety of discharge is tracked through the Access & Flow data on the IPR and is centred on time of discharge (before or after 12 noon) and the time spent in hospital, and also timeliness of discharge letters.

Trust Priority 4 – Strategic Service Development and Improvement

- With Hull University Teaching Hospitals, we will complete the **Interim Clinical Plan**, including:

  - the delivery of a revised leadership and clinical delivery approach for oncology, haematology and dermatology by May 2021;
  - the joining together of the clinical services of ENT, ophthalmology, cardiology and urology under a single service leadership by March 2o22;
  - improved access and treatment pathways, including a redesigned community approach by March 2022.

- Interim Clinical Plan (ICP) – twelve month plan in place and governed through Committees in Common (HUTH and NLaG) and Joint Development Board (Chair Ellen Ryabov COO HUTH)
- Single leadership in place for haematology, dermatology, cardiology and oncology
- MOU and SLA drafted for cross organisational working
- JD drafted for joint clinical directors – first post to go to advert for Ophthalmology
- Service strategies complete

- Connected Health Network cardiology – running well and some very good learning that can be applied across other specialties
- Wide ranging engagement with out of hospital programmes and primary care – but more to be done – need to recognise the challenges of different business/contracting models and also potential issues of capital investment

Good progress – but given challenges of elective recovery we need to shift focus from planning to delivery and implementation more quickly than planned.

- With partners in the Humber Acute Services Review, we will engage fully in leading and supporting the development by the end of 2021 of a **Pre-Consultation Business Case (PCBC) for the delivery of new models of care** for Urgent & Emergency Care, Maternity

- Pre Consultation Business Case planned for publication Q4
- UEC, Maternity, Paediatrics and Neonatal and Planned Care pathways being developed – options for change

    - Data analysis underway
    - Potential options for change mapped
    - Evaluation framework developed
    - NHSE/I assurance reviews underway – monthly
    - Clinical Senate Engagement and reviews underway
    - College and Peer reviews underway
    - Wide ranging engagement – 3,883 public survey, 569 staff survey, 1,133 maternity voices partnership, 72 local councillors focus groups, citizens panel, 750 clinical staff engaged in pathways

- Approach reviewed by Consultation Institute and recognised as example of good practice
- Pre Consultation Business Case is linked to Capital EOI – review process for Gateway Review will link both PCBC and Capital investment

Trust Priority 5 – Estates, Equipment and Capital Investment

- We will invest **c£130 million (subject to approvals) in estates and equipment**, including:

    - back-to-back MRI suite at DPOW: this has successfully opened. Total MRI waiters at peak was over 6,000. From March 2021, this has reduced from 5,262 to 2,362**;** Number of patients waiting longer than 6 weeks has reduced from over 3,000 at its peak to 215; the % of patients breaching the 6 week constitutional target has reduced from >50% to 9.1%.
    - new MRI at SGH: the new MRI at SGH is under construction.
    - new Emergency Departments, Same Day Emergency Care and Acute Assessment Units at both DPOW and SGH: full Planning Permission has been granted. With the exception of the multi-storey car park at DPoW, all key enabling works are completed including the relocation of c200 staff, enabling existing services to be maintained. ED super structure built, with work on internals commencing at DPoW. Car parking at SGH completed. AAU FBC submitted. All key M&E infrastructure upgrades underway.

- o £40.3 million on major **energy schemes** across all three hospital sites including a new energy centre at Goole & District Hospital: the new energy centre at Goole and District Hospital is under construction.

- We will continue to work with North and North East Lincolnshire Councils and NHSE/I on the long term development of a **new hospital for Scunthorpe and redevelopment of DPOW:** this work continues. The Trust (jointly with HUTH) submitted an Expression of Interest to the DHSC New Hospitals Programme in September 2021 for £720 million investment in the Humber's hospitals, including a proposal for a £350 million new hospital for Scunthorpe and £120 million for redevelopment of DPOW.

Trust Priority 6 – Digital

- We will deliver the **first phase of the Trust's Digital Strategy**, including investment of £2.5 million Digital Aspirant capital plus £2.5 million Trust 'matched' capital on:

  - o Improved access to patient information by linking WebV and HUTH Lorenzo EPR, & Yorkshire and Humber Care record and other sources;
  - o Upgrading the Trust data warehouse to improve business intelligence and data management;
  - o Upgrading versions of current inhouse systems to support paper-lite/paperless working;
  - o Investing in solutions & devices to enable real time clinical data entry and single sign on;
  - o Piloting a scalable automation platform (Robotic Processing Automation – RPA) to reduce the burdens of repetitive data entry.

The Digital Transformation Programme that support the Digital Strategy is tracked across its various projects via a programme tracker which provides a RAG rating framework for the schemes. National reporting rated the programme at Amber+.

Delivery target is Fiscal 21/22. Some of the initiatives will be started, not completed in Yr. (i.e. Doc mgmt., Command Centre).

Workstream	Target Completion Date	RAG Status	Update
Digital Aspirant award	March 2022	Amber +	Submission of NHSX funding report in September 2021, rating programme at Amber+. Successful delivery appears viable however this will be monitored through the Digital Programme Management Group to ensure risks/issues do not escalate into major threat affecting programme delivery.
Governance/Resourcing	October 2021	Amber+	Digital PMO Office developed, temporary Programme Manager and Office 365/ITSM Project Manager in post until Oct 2021. Successful recruitment to permanent Digital Programme Manager starting Nov 2021. Governance processes implemented for approvals for new projects through the Digital Programme Management Group and Digital Solutions Delivery group.
Funding for 2021/22	September 2021	Green	Completed and submitted Funding Evidence Report (FER) to NHSX in September 2021 to support £2.27m for 2021/22 capital and £196k for 2021/22 revenue.
Funding for 2021/22	March 2021	Green	2020/21 funding for devices and infrastructure was spent successfully before 31st March 2021. Kit deliveries were received and are continuing to be rolled out across all areas.
HUTH/NLG Lorenzo/WebV	August 2021	Completed	Development and testing of Lorenzo >WebV viewer is complete, roll out underway scheduled to complete by end of September 2021.

Kindness • Courage • Respect

The Digital Transformation Programme that support the Digital Strategy is tracked across its various projects via a programme tracker which provides a RAG rating framework for the schemes. National reporting rated the programme at Amber+.

Delivery target is Fiscal 21/22. Some of the initiatives will be started, not completed in Yr. (i.e. Doc mgmt., Command Centre).

Workstream	Target Completion Date	RAG Status	Update
Lorenzo PAS	August2021	In Progress	Lorenzo PAS technical proposal currently being assessed by both Trusts for preferred model of implementation. Lorenzo PAS Business Case/options paper to be provided to ET/TMB in Sept/Oct 2021
Data Warehouse	July 2022	Amber/Green	Data Warehouse project outline understood, and procurement options assessed. Discussion underway with HUTH DW supplier around shared proposal that would link into support the preferred PAS option. Otherwise a separate procurement exercise would be undertaken in September/October.
Clinical Systems Upgrade	Dec 2021	Amber/Green	Clinical system upgrades have been purchased from suppliers and form part of the schedule of planned work across the Digital Teams. Priorities around CTG archiving, Cardiology and Obstetric ultrasound systems. New PM starting to progress this piece of work.
RPA	October 2021	Amber/Green	RPA 'envision' workshop held with Patient Admin teams at both Trust and Northampton General (Automation Accelerator). Feedback on priority processes by end of July. Productive discussion with NHSEI to support shared RPA infrastructure for initial pilots.

Kindness • Courage • Respect

Trust Priority 7 - Finance

- We will achieve the **Trust's 21/22 Financial Plan**.

  Whilst the H1 (month 06) results are not yet known, the Chief Financial Officer is confident the Trust will have met the plan that was set for the first half of the financial year. The H2 planning guidance was released on 30 September and the Trust is now working through what that means, not only for this organisation but also for the overall Humber system. A proposed plan for H2 will be presented as soon as possible.

- We will achieve the 21/22 Humber Coast and Vale HCP **system financial control total**.

  As above, it is fully expected that the HC&V control total will have been met in the H1 period. The H2 plan is now being developed and will be made available as soon as possible.

- We will leave **Financial Special Measures**.

  A letter from the Regional Director of Finance received in late 2020, laid out a number of specific criteria needed to enable the Trust to leave FSM. Achievement of the H1 targets and agreement of an achievable H2 plan were two of those criteria. An assessment of the Trust's financial governance was also included. To that end NHSE/I representatives have recently been in attendance at a number of governance meetings and informal feedback received from that process has been favourable. The final element relates to the development of a long term financial model which we are currently in the process of completing. It is expected that a discussion with the FSM team relating to the Trust's exit from the FSM process will take place by the end of November.

Trust Priority 8 – The NHS Green Agenda

- We will promote, develop and embed the **NHS Green agenda** into the Trust, specifically, procurement policies, staff energy champions, travel, waste and energy reduction: our Board level approved **Green Plan** supports the **NHS Green agenda** and is focused on reducing our carbon impact. It targets our direct, indirect and external scopes, such as energy reduction, waste, travel, use of resources, medicines, food and construction. Our Waste teams are increasing facilities to recycle at every level of the organisation, these efforts were recognised by the judges in the **Zero Waste Awards** having achieved zero waste to landfill. We are reviewing our lease car policy, shifting our staff fleet to ULEV and ZEV vehicles and increasing electric fleet pool cars, whilst increasing charging capacity.

- We will invest £40.3 million from the **Public Sector Decarbonisation Fund** (joint DHSC and BEIS) in Green schemes across all three hospitals, including replacing the coal fired boiler at Goole: so far we have used the £40.3 million from the **Public Sector Decarbonisation Fund** (joint DHSC and BEIS) to remove the coal boiler at Goole, creating an energy centre. More widely, we continue to review the heating at SGH and investigate ground source heat pumps, alongside a wide range of energy saving innovations.

Trust Priority 9 – Partnership and System Working

- We will play a full part in the **development of the Humber Coast and Vale (HCV) Health & Care Partnership**, including the Humber Partnership Board, the Acute Collaborative, the Community Collaborative, the ICPs (Integrated Care Partnerships) of North and North East Lincolnshire, the HCV Cancer Alliance and associated professional networks

  The Trust has played a full part in the multiple work streams which are developing the Humber Coast and Vale (HCV) Health and Care Partnership. This has included: membership of the Board of the Collaborative of Acute Providers (CAP) and the Trust's Chief Operating Officer chairing the CAP Chief Operating Officers Group; Board level membership of the Community Collaborative; supporting the development of and signing the Memorandum of Agreement for the North East Lincolnshire Integrated Care Partnership (ICP); participation in development workshops for the emerging ICPs for North Lincolnshire and East Riding of Yorkshire; membership of the Humber Partnership Board; and multiple supporting committees and development workshops.

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

  The Trust continues to play a full part in multiple GIRFT (Getting It Right First Time) programmes, has joined the Faculty of Medical Leadership and Management (FMLM), is involved in a variety of support programmes arrangde through the NHSE/I Intensive Support Team, has established Committees in Common with Hull University Teaching Hospitals, and plays a full part in HCV and Regional Clinical Networks.

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)197

DATE OF MEETING	05 October 2021
REPORT FOR	Trust Board - Public
REPORT FROM	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Medical Director Christine Brereton, Director of People
CONTACT OFFICER	Shauna McMahon, Chief Information Officer
SUBJECT	Integrated Performance Report (IPR)
BACKGROUND DOCUMENT (if any)	Access and Flow – IPR (August Data) Quality and Safety – IPR (July Data) Workforce – IPR (August Data)
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Quality and Safety Committee (September 2021)
EXECUTIVE SUMMARY	**1. Introduction** The IPR aims to provide the Board with a detailed assessment of the performance against the agreed indicators and measures, and describes the specific actions that are under way to deliver the required standards. **2. Access and Flow – New Version** 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 – New Version** The executive summary of the Workforce section is provided over on page 6. **5. The Trust Board is requested to:** a) Receive the IPR for assurance. b) Note the performance against the agreed indicators and measures. c) Note the report describes the specific actions which are under way to deliver the required standards.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)

1. To give great care	2. To be a good employer	3. To live within our means	4. To work more collaboratively	5. To provide good leadership
✓	✓			✓

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	**Strategic Objective 1: To Give Great Care** **a) Description of Strategic Objective 1 - 1.1:** To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. **Risk to Strategic Objective 1 - 1.1:** The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience. **b) Description of Strategic Objective 1 - 1.2:** To provide treatment, care and support which is as safe, clinically effective, and timely as possible. **Risk to Strategic Objective 1 - 1.2:** The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care. **c) Description of Strategic Objective 2:** To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviors, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. **Risk to Strategic Objective 2:** The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.

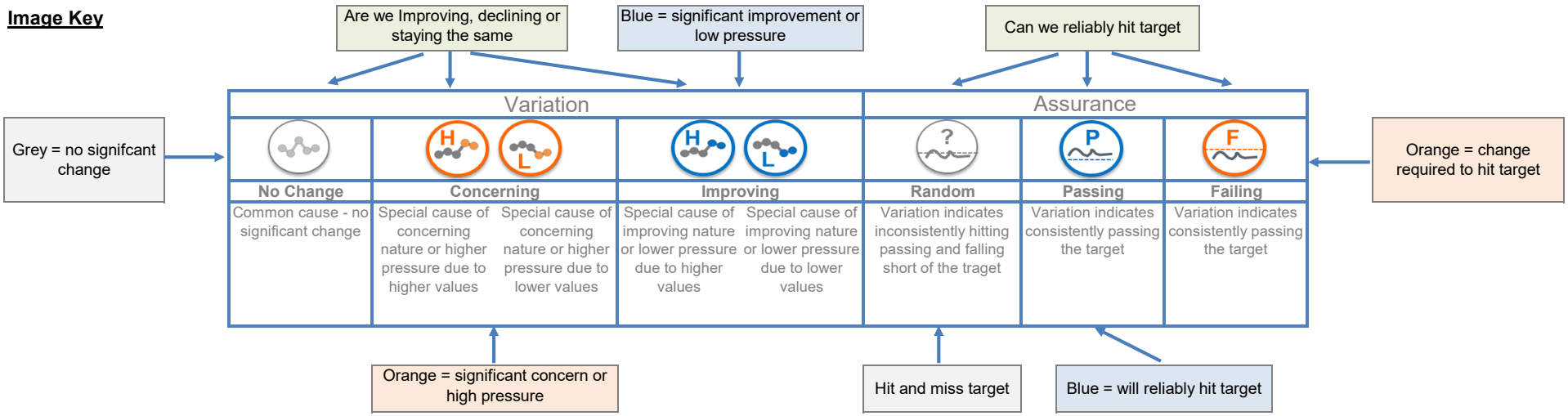
	d) **Description of Strategic Objective 5:** To ensure that the Trust has leadership at all levels with the skills, behaviors and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. **Risk to Strategic Objective 5:** The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Access and Flow
Objective: To give great care
The Emergency Departments (ED) are currently seeing increased levels of attendances and the department is facing pressure in moving patients through the system as well as challenges with the workforce in terms of number and skill mix across the Trust which has impacted upon delivery of the patient flow, Emergency Department waits and ambulance handover delay target. The Trust is already being challenged by the Wave three COVID19 with increasingly more numbers at Grimsby Hospital (DPoW) compared to Scunthorpe Hospital (SGH). The workforce challenges particularly medics and nursing due to sickness and self-isolation yet again has created a serious challenge which is being managed by the teams as proactively as possible. The Department has recently implemented a new East Midlands ambulance service (EMAS) direct streaming to same day emergency care (SDEC) service at both sites and the trust is an early adopter in the region and went live with direct bookable arrival slots in ED at Grimsby for the single point of access (SPA) as part of the "NHS111 First" initiative programme to try and increase performance. Also in conjunction with the system partners three audits at the front door have been undertaken and the identified opportunities are being progressed through the newly established Patient Flow Improvement Group led by the Trust's Chief Operating Officer. A frailty service pilot at DPoW commenced on 12 May 2021 for four weeks providing improved patient experience for frail patients on SDEC instead of ED with 93% of patients being discharged from SDEC. This service has been continued beyond the pilot. Pathways for EMAS to access advice and guidance through SPA to avoid acute attendances where possible have been implemented.B10 All wards now have senior consultant presence at board rounds before 10am to aid discharge and are able to report if and when a patient no longer meets the criteria to reside in an acute hospital bed, by completing webV. Referral to treatment (RTT) continues to see an increasing number of patients waiting, resulting in an unvalidated performance of 68.2% for August 2021; (unvalidated 66.46% for September 2021 as of 20th September 2021). There were 1,285 patients that have waited in excess of 52 weeks at our peak at the end of February 2021, this has since reduced to an unvalidated 469 in August 2021; (unvalidated 508 for September 2021 as of 20th September 2021). The performance is as a direct result of the reduced elective operating capacity due to the theatre and anaesthetic response to supporting the high acuity of COVID19 patients and the social distancing and patient choice. Significant progress has been made in creating additional capacity which includes both the use of Goole District Hospital and the Independent sector where the initial focus is on the treatment of urgent and cancer patients. Cancer two week wait (2ww) standard continues to be achieved at 97.7% 2ww/100% breast symptomatic in August 2021; though there have been some pressures in achieving the 31 day first treatment standard (May) but the target of 96.0% has been met since; the 62 day standard was 59.8% for August 2021; the 62 day screening standard was 77.8% against national standard of 90% in June and 55.6% in July 2021 again this is as a result of capacity, primarily within the diagnostic modalities, however in August 2021 90.9% was achieved. The Trust remains below the 28 day Faster Diagnosis standard (75%) at 58.2% for August 2021. Diagnostic services has seen an increase in performance but was limited due to treating patients on urgent and cancer pathways and reduced capacity in some modalities, which has been partially addressed through the opening of the new scanning facilities at DPoW recently and the further opening of additional capacity in May 2021. The service continues to explore additional capacity options which include use of the independent sector and community diagnostic hubs. Performance against H1 ERF currently demonstrates 91% achievement with over achievement in first attendances and under achievement in other PODs including ordinary electives.

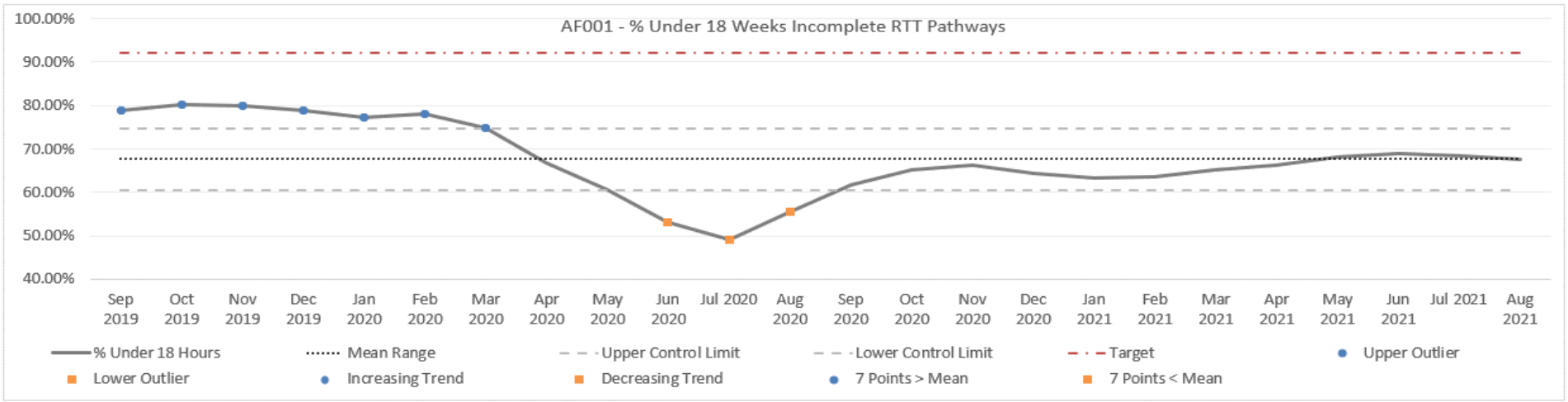
Quality & Safety
Objective: To give great care
• Venous Thromboembolism (VTE) risk assessments have been under target, impacted upon adversely in response to an increasing demand of Covid-related (or Covid-suspected) acute admissions. Progress has been made during the month of September to launch an e-risk assessment tool linked to the Trust's Electronic Prescribing and Medicines Administration (EPMA) system. Work continues to update the Trust's policy and patient information in line with the latest NICE guidance. • During July 2021 the Trust reported a further Never Event. This related to a retained swab in Theatres at SGH. • An increase of 3.28 is noted in the latest month's SHMI release. This relates to the annual rebasing exercise undertaken by NHS Digital which resulted in a number of deaths during 2020 being retrospectively removed from the SHMI calculation as they related to Covid-19, an exclusion criterion. The Trust recording and capture of Covid-19 related diagnoses was good, as part of the coding improvement project that was underway during 2020. This means that the number of observed deaths remained largely the same following the rebasing, but the number of 'expected' deaths, the denominator on which the SHMI calculation is based, reduced, resulting in the SHMI increase, which is higher than would have been expected under normal reporting circumstances. Whilst the SHMI value has increased, the SHMI trend is still one of improvement and remains within the 'as expected' range. The Hospital Standardised Mortality Ratio (HSMR) is also within the as expected threshold and remains under 100. • One of the Trust's priorities is to further improve the mortality position by reducing the out of hospital (OOH) SHMI, through collaborative working with community partners. The OOH SHMI shows early signs of a positive reduction, although too early to determine if this is a trend. • There remains a backlog of priority SJRs that require completion. NHSE/I SJR training has been provided to 50 staff within Medicine which will support an increase in reviewers available and support improved quality of reviews to support the learning from deaths focussed work. Those cases overdue are actively being followed up with nominated reviewers. • Patient observations recorded in line with timescales (with 30mins grace period) has remained above the raised target of 90%. Further work is underway to gain assurances on the action taken in escalation to national early warning score (NEWS) observations, in line with the Trust's policy and in relation to sepsis screening. • The performance with blood glucose being recorded in the Emergency Department if paediatric early warning score (PEWS) is more than one is 83%. The average performance is also 83% since January 2020. The standard operating procedure (SOP) has been amended where the Paediatric Emergency Team will determine if BM testing is clinically appropriate and if not, this will be reflected in the snapshot audit.

Workforce
Objective: To give great care
Trustwide Vacancies Trustwide vacancies have increased in month by 37.61 WTE, due to the trainee rotation fill rate and a small increase in unregistered nurse vacancies . Recruitment activity, across various workstreams including regular recruitment and projects for international nursing and HCAs, is ongoing at an increased rate. In the last 12 months recruitment activity has increased by 19.88%. Travel difficulties are delaying starts for new employees for overseas, with regular engagement taking place to facilitate starts as quickly as possible. Registered Nurse Vacancies The vacancy rate in month has remained stable. Recruitment activity is ongoing across projects, including sourcing candidates from overseas via the Trust's Talent Acquisition Team, Yeovil NHS Trust's international nurse recruitment programme, and newly qualified nurse recruitment which has resulted in 73 NQNs sourced so far to commence. 20 nurses sourced from overseas are due to commence in October, with a further 26 planned for December. This activity is overseen by the project group led by the Deputy Chief Nurse. Medical Vacancies Medical vacancies are outside of target, this is largely due to an increase in establishment in April 2021 combined with a fill rate of 80.10% for trainees in August. July showed a decreased vacancy position due to F1 trainees commencing shadowing while current F1s were in post. Recruitment activity is ongoing, with a pipeline of 65 doctors appointed awaiting start who the recruitment team are engaging with regularly and supporting to facilitate starts as quickly as possible. Travel difficulties are causing some issues with delaying start dates. Alongside regular recruitment activity, including MTI scheme recruitment, the Talent Acquisition Team are now attempting to source senior medical staff for particularly hard to fill roles. Unregistered Nurse Vacancies Overall vacancies have reduced significantly since the implementation of a recruitment project focussing on this staff group, however have increased in month due to leavers. This project continues through regular recruitment to recruit to a pool of staff who are appointed and ready for allocation to roles to cover vacancies and ongoing turnover. Retention of unregistered nurses is a potential risk, with turnover increasing in newly appointed staff recently. This will be mitigated by effective use of information to inform candidates who are new to healthcare what the role entails and the environment they will be working in. This activity is overseen by a project group led by the Deputy Chief Nurse. Turnover During August 2019 to April 2020 the Turnover Rate significantly improved. This has gradually deteriorated over time since the start of the pandemic in April 2020 to present. The latest turnover data point (9.84%) is over the Trust target of 9.4% which indicates that the turnover position is not improving or seeing signs of recovery in relation to pre-pandemic levels of turnover of 9%. . 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. Sickness The recent variation seen is common variation which shows no significant change and is within the control limits. Following the last covid wave and sickness peak in November 2020, sickness had been in decline and entered a period of plateau during the early part of 2021. The last couple of months has seen a slight increase in sickness but still within the control limits. PADR The Trust wide non medical PADR compliance position currently stands at 81% this is below the Trust target of 90% The Training and Development Department will continue targeting Managers with low compliance by sending out reminders, and guidance for completion. We will continue to target and consider an escalation process for those areas not complying. Mandatory Training The Core Mandatory Training position currently stands at 92%. This cntinues to be above the Trust target of 90%, historically the trend data shows that the Core Mandatory Training compliance is around the same for this time of year, as of May 2020 the Core Mandatory Training Position was also at 90%. The Role Specific Mandatory Training position currently stands at 82% (August 2021). This is within the Trust target of 80%, historically the trend data shows that the Role Specific Mandatory Training compliance is around the same for this time of year, as of August 2020 the Role Specific Mandatory Training Position was also at 83%. The Training and Development Department will continue targeting employees with low compliance by sending out reminders, guidance and workbooks for completion. We will continue to target and consider an escalation process for those areas not complying. The Training and Development Department will ensure all data is processed and support class administrators are supported with data collections. Auto enrolment has now been switched on in ESR making this easier for staff to complete eLearning modules and work continues with the power BI dashboard which id due to go live shortly.

Image Key



SPC Key - example SPC chart



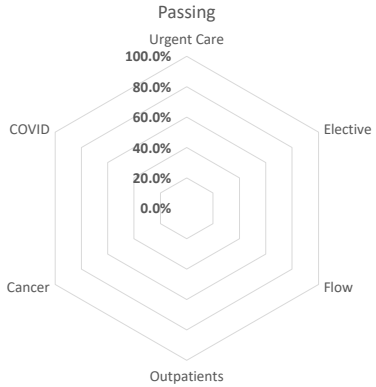
Orange Squares = significant concern or high pressure / change required to hit target

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

Northern Lincolnshire and Goole NHS Foundation Trust

Consistently Passing

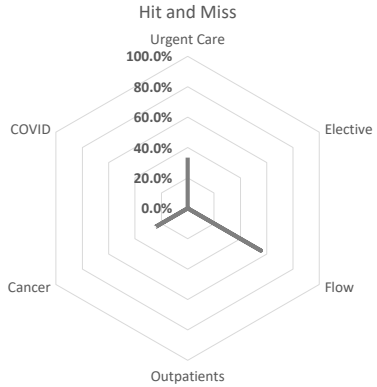
Total: **0**
Rate: **0.00%**



Urgent Care

Hit and Miss

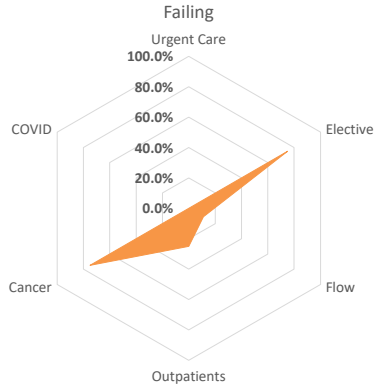
Total: **7**
Rate: **25.93%**



Cancer	Cancer Waiting Times - 62 Day GP Referral
Flow	Discharge Letters Completed Within 24 Hours Post Discharge
	Inpatient Averge Length Of Stay
	Inpatient Elective Averge Length Of Stay
	Inpatient Non Elective Averge Length Of Stay
	Patients Discharged On The Same Day As Admission
Urgent Care	Ambulance Handover Delays 60+ Minutes

Consistently Failing

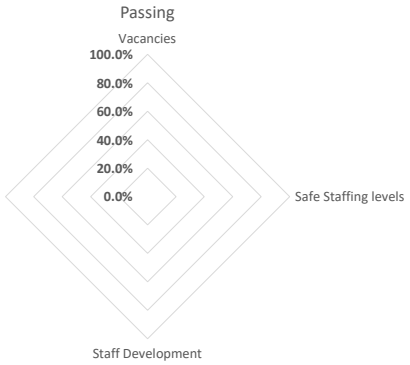
Total: **8**
Rate: **29.63%**



Cancer	Cancer Request To Test In 14 Days
	Cancer Waiting Times - 104+ Days Backlog
	Patients With Confirmed Diagnosis Transferred By Day 38
Elective	% Under 18 Weeks Incomplete RTT Pathways
	6-week wait for diagnostic procedures (DM01)
	Number of incomplete RTT pathways 52 weeks
Flow	Inpatient Discharges Before 12:00 (Golden Discharges)
Outpatients	RTT Outpatient Follow Up Waiting List

Consistently Passing

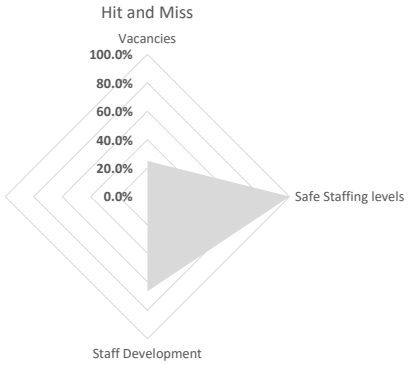
Total: **0**
Rate: **0.00%**



There are no indicators consistently passing the target

Hit and Miss

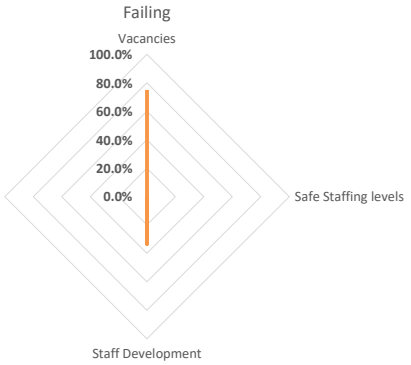
Total: **5**
Rate: **55.56%**



Safe Staffing levels	Sickness
	Turnover Rate
Staff Development	Core Mandatory Training Compliance
	Role Specific Mandatory Training Compliance
Vacancies	Medical Vacancy Rate

Consistently Failing

Total: **4**
Rate: **44.44%**



Staff Development	PADR Rate
Vacancies	Unregistered Nurse Vacancy Rate
	Registered Nurse Vacancy Rate
	Trustwide Vacancy Rate

Aug 2021		Assurance: Pass (P)	Assurance: Hit and Miss (?)	Assurance: Fail (F)	Hit and Miss / Common Cause
Variance: Special Cause Improvement	H / L		Patients Discharged On The Same Day As Admission		Discharge Letters Completed Within 24 Hours Post Discharge Inpatient Averge Length Of Stay Inpatient Elective Averge Length Of Stay Inpatient Non Elective Averge Length Of Stay Cancer Waiting Times - 62 Day GP Referral
Variance: Common Cause			**See Hit and Miss / Common Cause Box (right)**	Inpatient Discharges Before 12:00 (Golden Discharges) % Under 18 Weeks Incomplete RTT Pathways 6-week wait for diagnostic procedures (DM01) Cancer Waiting Times - 104+ Days Backlog Patients With Confirmed Diagnosis Transferred By Day 38 Cancer Request To Test In 14 Days RTT Outpatient Follow Up Waiting List	
Variance: Special Cause Concern	H / L		Ambulance Handover Delays 60+ Minutes	Number of incomplete RTT pathways 52 weeks	

Aug 2021			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement	H		Core Mandatory Training Compliance Role Specific Mandatory Training Compliance	
		L			
	Common Cause			Medical Vacancy Rate Sickness	Unregistered Nurse Vacancy Rate Registered Nurse Vacancy Rate PADR Rate
	Special Cause Concern	H		Turnover Rate	Trustwide Vacancy Rate
		L			

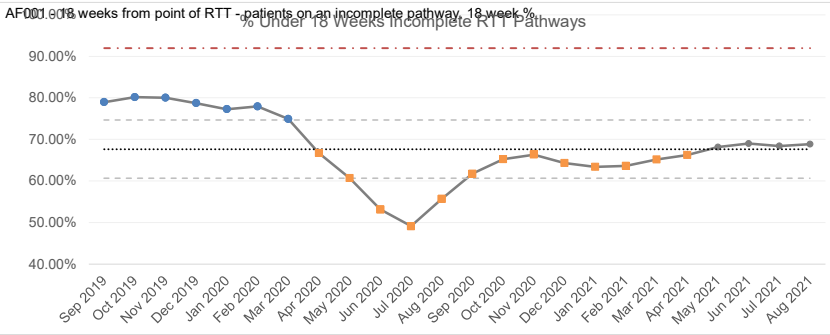
Planned	% Under 18 Weeks Incomplete RTT Pathways	Aug 2021	69%	92%	No Action Required		F
Planned	Number of incomplete RTT pathways 52 weeks	Aug 2021	456	0	**Action Required**	H	F
Planned	Total inpatient waiting list	Aug 2021	9,906	11,563	No Action Required	L	?
Planned	6-week wait for diagnostic procedures (DM01)	Aug 2021	36%	1%	No Action Required	L	F
Cancer	Cancer Waiting Times - 62 Day GP Referral	Aug 2021	58%	85%	**Action Required**		?
Cancer	Cancer Waiting Times - 104+ Days Backlog	Aug 2021	32	0	**Action Required**	L	F
Cancer	Patients With Confirmed Diagnosis Transferred By Day 38	Aug 2021	38%	75%	No Action Required		F
Cancer	Cancer Request To Test In 14 Days	Aug 2021	82%	100%	**Action Required**		F
Urgent Care	ED 4 Hour Performance	Aug 2021	60%	95%	**Action Required**	L	F
Urgent Care	Number Of ED Attendances	Aug 2021	12,511	No target	No Action Required		No target
Urgent Care	Ambulance Handover Delays 60+ Minutes	Aug 2021	466	0	**Action Required**	H	?
Urgent Care	Decision to Addmit 12 Hour Waits	Aug 2021	73	0	**Action Required**	H	?
Flow	Patients Discharged On The Same Day As Admission	Aug 2021	41%	92%	**Action Required**	H	?
Flow	Inpatient Discharge for Extended Stay 21+ Days	Aug 2021	2%	No target	**Action Required**		No target
Flow	Inpatient Elective Averge Length Of Stay	Aug 2021	2	2.40	No Action Required		?
Flow	Inpatient Non Elective Averge Length Of Stay	Aug 2021	4	4.10	No Action Required		?
Flow	Ward Medical Outliers	Aug 2021	2,428	No target	**Action Required**	H	No target
Flow	Discharge Letters Completed Within 24 Hours Post Discharge	Aug 2021	85%	85%	No Action Required		?
Flow	Inpatient Discharges Before 12:00 (Golden Discharges)	Aug 2021	16%	35%	**Action Required**		F
Flow	Bed Occupancy	Aug 2021	93%	92%	**Action Required**	H	?
Outpatients	Outpatient Overdue Follow Up	Aug 2021	30,040	9,000	**Action Required**		F
Outpatients	Outpatient DNA Rate	Aug 2021	10%	No target	**Action Required**	H	No target
Outpatients	Outpatient Non Face To Face Attendances	Aug 2021	34%	No target	**Action Required**	H	No target
COVID	COVID patients in ICU beds	Aug 2021	14	No target	**Action Required**	H	No target
COVID	COVID patients in other beds	Aug 2021	46	No target	**Action Required**		No target
COVID	COVID staff absences	Aug 2021	0	No target	No Action Required	L	No target

Ref	Metrics	Jul 2021 unless otherwise stated	Target / Trajectory	Variation	Assurance
	National Requirements				
QS001	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0		
QS003	Escherichia coli (E.coli) bacteraemia bloodstream infection (BSI)	5	0		
QS004	Trust attributed C-Diff	1	No target		No target
QS006	Venous Thromboembolism (VTE) risk assessment	76.33%	95.00%		
QS007	Duty of candour	100.00%	No target		No target
QS008	Emergency C-section rate	18.50%	15.20%		
QS009	Patient Safety Alerts to be actioned by specified deadlines	100.00%	No target		No target
QS010	Serious incidents - Raised in month	6	No target		No target
QS011	Occurrence of any Never Event	1	0.00		
QS012	Hospital Standardised Mortality Ratio (HSMR) **- Data is for June 2021**	79	As Expected		As expected
QS013	Summary Hospital level Mortality Indicator (SHMI) **- Data is for March 2021**	109	As expected		As expected
QS014	Formal Complaints per 1000 WTE	5.5	No Target	Not an SPC	Not an SPC
QS022	Inpatient scores from Friends and Family Test - % positive	92.87%	No target	Not an SPC	Not an SPC
QS023	A&E scores from Friends and Family Test - % positive	77.09%	No target	Not an SPC	Not an SPC
QS024	Maternity Scores from Friends and Family Test - Antenatal positive responses	0 out of 0	No target	Not an SPC	Not an SPC
QS024	Maternity Scores from Friends and Family Test - Birth positive responses	68 out of 68	No target	Not an SPC	Not an SPC
QS024	Maternity Scores from Friends and Family Test - Postnatal positive responses	1 out of 1	No target	Not an SPC	Not an SPC
QS024	Maternity Scores from Friends and Family Test - Ward positive responses	66 out of 70	No target	Not an SPC	Not an SPC
QS025	Community Services Score from Friends and Family Test - % positive	92.86%	No target	Not an SPC	Not an SPC
	Quality Priorities				
	End of Life and Related Mortality				
QS027	Reduction in the number of patients dying within 24 hours of admission to hospital	14	Reducing		N/A
QS028	Reduction in the number of discharges in relation to emergency admissions for people in the last 3 months of life	107	No target		N/A
QS029	Reduction in the out of hospital SHMI to 110 by March 2022 - **Data is for March 2021**	128.65	110.00		
QS030	Structured Judgement Reviews	31.00%	100.00%		
	Deteriorating Patient and Sepsis				
QS031	90% of adult observations are recorded (with a 30 min grace)	91.00%	90.00%		
QS032	90% of child observations are recorded (with a 30 min grace)	83.33%	90.00%		
QS033	Escalation of NEWS in line with Policy - **Data is for May 2021**	8.00%	No target	Not an SPC	Not an SPC
QS034a	Sepsis screen in 90% of patients with a sepsis 6 indicator - Sepsis screening Manual audit figure - **Data is for May 2021**	56.00%	90.00%	Not an SPC	Not an SPC
QS034b	Sepsis screen in 90% of patients with a sepsis 6 indicator - Sepsis Six completed for those with a red flag - Manual audit figure - **Data is for May 2021**	63.00%	90.00%	Not an SPC	Not an SPC
	Reduction of Medication errors				

		Jul 2021	Target		
QS035a	Improvements in recording patient weights in relation to weight based medication prescribing on the integrated admissions ward: % with actual, patient reported or estimated weight recorded on EPMA or WebV. Manual audit figure. **Data is for July 2021**	65.00%	No target	Not an SPC	Not an SPC
QS035b	Improvements in recording patient weights in relation to weight based medication prescribing on the integrated admissions ward: % with the patient's actual weight recorded on EPMA or WebV. Manual audit figure. **Data is for July 2021**	34.00%	No target	Not an SPC	Not an SPC
QS035c	Improvements in recording patient weights in relation to weight based medication prescribing on the integrated admissions ward: % of patients whose weight was 50kg (+/- 6kg) and who were on specific medications requiring weight adjustment. Manual audit figure. **Data is for July 2021**	No data this month	No target	Not an SPC	Not an SPC
QS036	Insulin administered on time in 85% within wards using EPMA	99.42%	85.00%	Not an SPC	Not an SPC
QS037	Reduction in medication omissions without a valid reason for ward areas using EPMA	No data this month	No target	Not an SPC	Not an SPC
	Safety of Discharge to be reported through access and flow				
QS038	Improve the proportion of patients discharged before 12 noon	17.29%	30.00%		
QS039	Improve the proportion of patients discharged before 5pm	67.59%	70.00%		
QS040	Improving trend showing a reduction in length of hospital stay above 7 days	258	No target		N/A
QS041	Improving trend showing a reduction in length of hospital stay above 14 days	113	No target		N/A
QS042	Improving trend showing a reduction in length of hospital stay above 21 days	55	No target		N/A
QS043	Improve the timeliness of discharge letters within Orthopaedics	97.98%	95.00%		
QS044	Improve the timeliness of discharge letters within Ophthalmology	35.71%	95.00%		
	Diabetes Management				
QS045	Diabetes Audit finding	81.21%	80.00%	Not an SPC	Not an SPC
QS046	100% of BM taken in ECC in adults when NEWs of >1	95.0%	100.00%		
QS047	100% of BM taken in ECC in paediatrics when PEWs of >1	82.50%	100.00%		
QS048	90% Relevant staff have completed mandatory diabetes training	87.97%	90.00%		

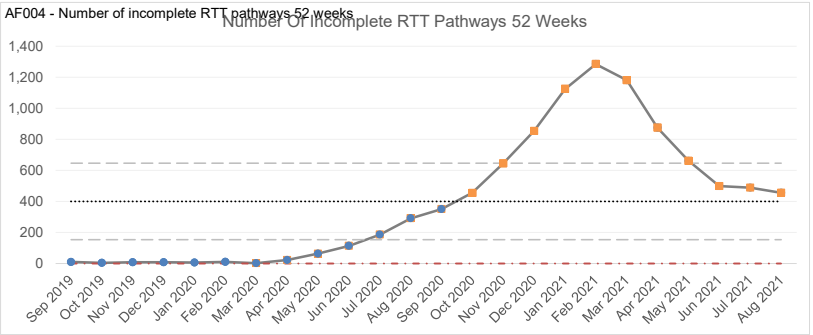
Domain	Ref	Metrics	Period	Actual	Target	Action	Variation	Assurance
Vacancies	W001	Unregistered Nurse Vacancy Rate	Aug 2021	6.92%	2.00%	**Action Required**		F
Vacancies	W002	Registered Nurse Vacancy Rate	Aug 2021	10.70%	8.00%	**Action Required**		F
Vacancies	W003	Medical Vacancy Rate	Aug 2021	11.31%	15.00%	No Action Required		?
Vacancies	W004	Trustwide Vacancy Rate	Aug 2021	9.24%	7.00%	**Action Required**	H	F
Safe Staffing levels	W005	Turnover Rate	Aug 2021	9.74%	9.40%	**Action Required**	H	?
Safe Staffing levels	W006	Sickness	Jul 2021	5.14%	4.10%	No Action Required		?
Staff Development	W007	PADR Rate	Aug 2021	79.00%	85.00%	**Action Required**		F
Staff Development	W008	Core Mandatory Training Compliance	Aug 2021	92.00%	90.00%	No Action Required	H	?
Staff Development	W009	Role Specific Mandatory Training Compliance	Aug 2021	81.00%	80.00%	No Action Required	H	?

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



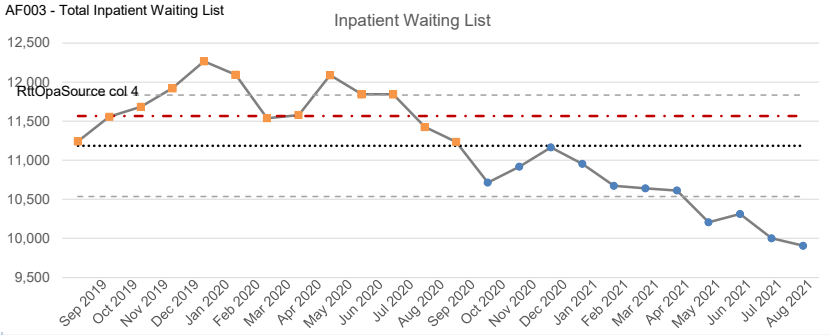
Aug 2021	Target	Variance	Assurance
68.85%	92%	Common cause - no significant change	Variation indicates consistently failing short of the target

AF004 - Number of incomplete RTT pathways 52 weeks



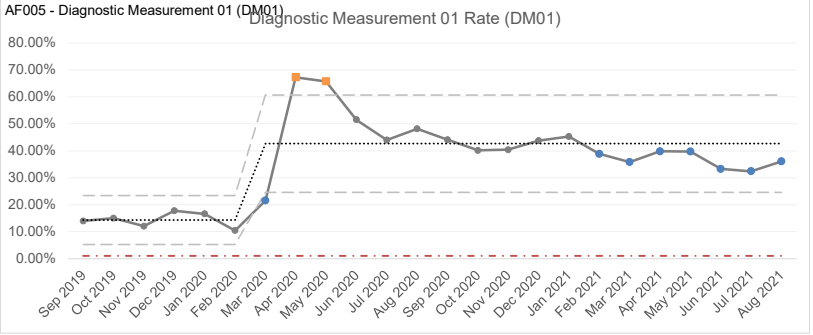
Aug 2021	Target	Variance	Assurance
456	0	Special cause of concerning nature or higher pressure due to higher values	Variation indicates consistently failing short of the target

AF003 - Total Inpatient Waiting List



Aug 2021	Target	Variance	Assurance
9,906	11,563	Special cause of improving nature or lower pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the traget

AF005 - Diagnostic Measurement 01 (DM01)



Aug 2021	Target	Variance	Assurance
36.07%	1%	Special cause of improving nature or lower pressure due to lower values	Variation indicates consistently failing short of the target

Data Analysis:

Under 18 weeks: Common cause variation, no significant change. This system is not reliably capable. It will FAIL the target without system change.

52 weeks: Special cause of concerning nature where the measure is significantly higher than the average value. This occurs where there is higher pressure in the system or detriorating performance. This system is not capable. It will FAIL without system change.

Inpatient waiting list: Special cause of improving nature where the measure is significantly lower than the average value. This occurs where there is improving performance. This system will not consistently hit or miss the target. (This occurs when the target lies between the process limits).

DM01: Special cause of improving nature where the measure is significantly lower than the average value. This occurs where there is improving performance. It will FAIL the target without system change.

RTT 18 Weeks

The latest month figure is currently unvalidated. Medicine division performance is currently 75.85% with a recent week on week improvement. The division has 7/11 specialties above 92% threshold with the remaining specialties showing improvements in RTTperformance week on week. Family Services at 76.71% for Sept as of 17th Sept. For August, the finalised position was 79.59%. Breast, Paediatrics & Community Paediatrics are currently achieving 85% target, however the overall divisional percentage is reduced due to gynae being at 74.31% for August. Surgical Division performance currently 61.3%. **Issues/Risks:** Across most medicine specialties, there remains some capacity risks in the coming weeks due to the summer months and 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 as demand is greater than capacity in Radiology and other diagnostic services. The Division have identified risk for delivery with OP nursing support, theatre teams, independant sector being fully mobilised and diagnostic capacity to support the movement through the patient pathways. Reduced theatre capacity for gynaecology compared to pre-covid. Winter pressures may further reduce theatre capacity. Diagnostic capacity within CSS is also delaying gynae pathways and subsequently causing 18 week breaches. **Actions:** Medicine Division Activity Recovery Plans for 2021-22 for every specialty are in place. External Providers sourced for Gastroenterology, Respiratory, Cardiology, Endocrinology. Additional sessions being delivered by internal consultants also. To improve the RTT position for gynaecology, we are looking to utilise SHH capacity as much as possible to reduce our long waiter and breach patients. Weekly RTT meetings are now also in place to ensure validation is up to date and all clock stops are actioned. The Surgical Division have recovery plans in place for 2021-22 for each speciality. Independent sector support is in place for Opthalmology, General Surgery, Colorectal and Orthopaedics. The Division is waiting for further mobilsiation of independant sector support for ENT. **Mitigations:** Medicine Division continue with recovery with additional sessions by NLaG clinicians. Working with various external providers to provide additional clinic capacity and reduce the time patients wait to receive treatment. Working with SHH and also looking at other external providers (?Trent Cliff) to provide additional capacity. The Division are working closely with CSS, communicating the recovery plans to enable CSS Division to plan and support the additional activity.

RTT 52 Weeks

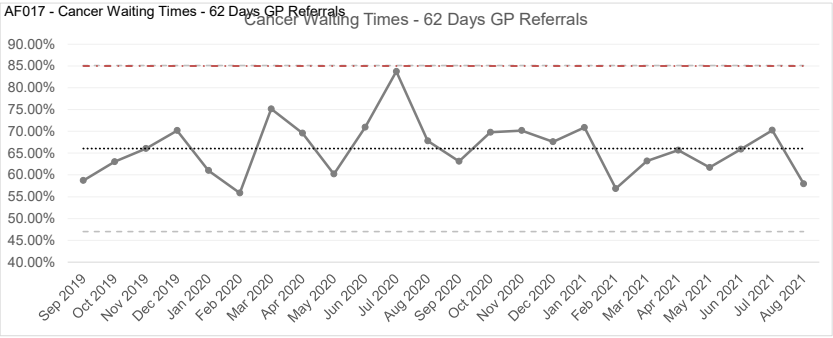
Medicine have seen a similar number of patients waiting more than 52 weeks for treatment over the recent months. Patients are being seen and treated over 52 weeks, however high numbers of patients are tipping over 52 weeks. Surgery & Critical Care (S&CC) have a decreasing number of patients waiting more than 52 weeks within the division. Many patients waiting over the 52 weeks are those who are difficult to work-up requiring multiple diagnostic treatments, input from different specialties, high risk assessments and require a critical care level bed post op. Family Services currently have a total of 63 52 week breach patients, 59 of which are for gynaecology. We are looking to utilise capacity from external providers where possible to reduce our 52 week breaches. **Issues/Risks:** Potential further COVID waves. Carry over of annual leave - clinician availability. Inability to resource additional sessions as lockdown lifts. Winter pressures.

Actions: Medicine have secured external provider for New Referral to Treatment (RTT) patients which has seen a further reduction in the number of 40+wks patients. In addition the focus is also on the >40 weeks to fill lists with these patients if 52 week patients are unable to attend to reduce the number of patients tipping over to 52 weeks. S&CC apply close scrutiny to the over 52 week patients and ensure all patients have a valid preassessment 12 weeks prior to come in (TCI) for all routine patients. In addition the focus is also on the >40 weeks to fill lists with these patients if 52 week patients are unable to attend to reduce the number of patients tipping over to 52 weeks. Family Services holding weekly RTT meetings being held to prevent breaches where possible. We are also reviewing 40week plus patients to prevent them tipping over to 52w. Mitigations: Medicine are progressing with securing additional external provider sessions. Locum staff in place. Blocking booking of agency and bank. Theatre productivity programme has commenced. Reviewing inpatient waiting list to ensure where possible IPT to SHH.

DM01

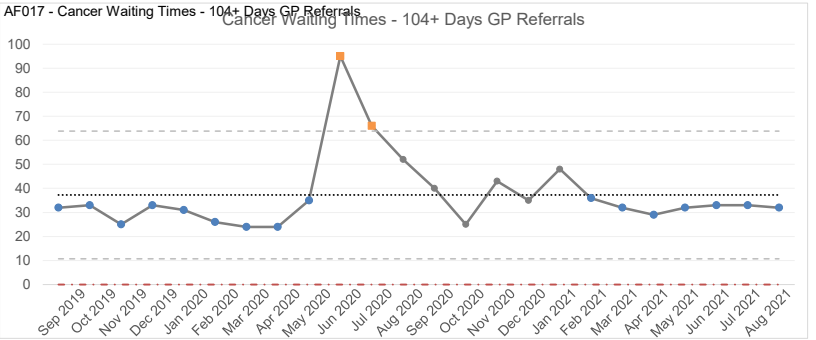
From Mar 21 to May 21, the modalities with the poorest DM01 rate were Audiology, Ultrasound, Echocardiograms (Echos) and to some extent MRI. Echos have seen a deterioration since May and has been escalated within the Trust Planning forum. Audiology had experienced an expected deterioration, however is now on track to achieve the recovery plan. MRI - seeing an ongoing improving position as a result of new scanner coing on line and continuation of vans/IS support. Non-Obstetric Ultrasound is a low performing area. Improvements were expected due to directly contracting with another independent sector (IS) provider; however improvement has not been seen. Conversations are happening with NLCCG and another two IS providers. There is a meeting planned to review the classifying of Audiology assessments that are counted in the DM01. There could be a risk if a sudden change in the counting has to be adopted - this is dependent on the outcome of the review. Endoscopy is recovering well against plan, however currently experiencing issues around patient choice and also switching focus to ensure overdue planned patients (not counted in DM01) are pulled back on track. **Issues/Risks:** The impact of Non Obstetric Ultrasound performance. Consultant Radiologists: 50% vacancy rate. Endoscopy: 7-day diagnostics turnaround for suspected cancer patients to meet 28-day faster diagnosis target. Staffing levels becoming a concern in all modalities due to covid related absence (sickness and contact / isolation) and annual leave. **Mitigations:** Ongoing recruitment of Consultant Radiologists (UK and abroad). New Consultant Radiologist has been recruited (starting Sept 21). The Trust has increased radiographer reporting and implemented insourcing and outsourcing of reporting. Endoscopy mitigation – Funding approved to support additional activity (endoscopy recovery programme). Funding for the Ultrasound recovery programme approved by the Trust and programme is underway to clear the waiting list backlog – ongoing focus in this area is required. Business cases are being written to appoint more substantive staff in these departments to bridge the gap between demand and capacity. Staffing - working with Emergency Preparedness Resilience & Response team (EPRR) to ensure guidance is followed in order to protect staff and patients. Backfilling gaps with bank / agency as required and available.

AF017 - Cancer Waiting Times - 62 Days GP Referrals



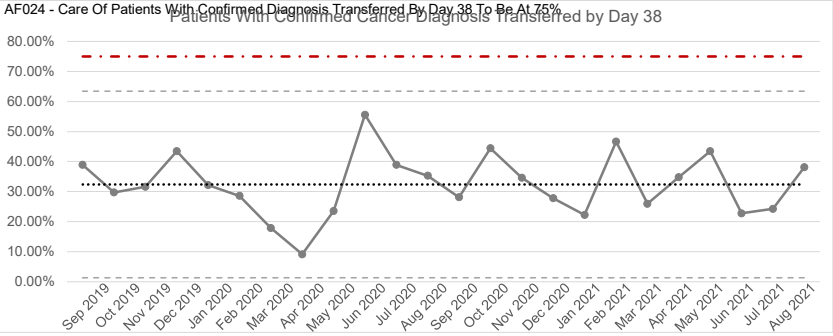
Aug 2021
57.97%
Target
85.00%
Variance
Common cause - no significant change
Assurance
Variation indicates inconsistently hitting passing and falling short of the traget

AF017 - Cancer Waiting Times - 104+ Days GP Referrals



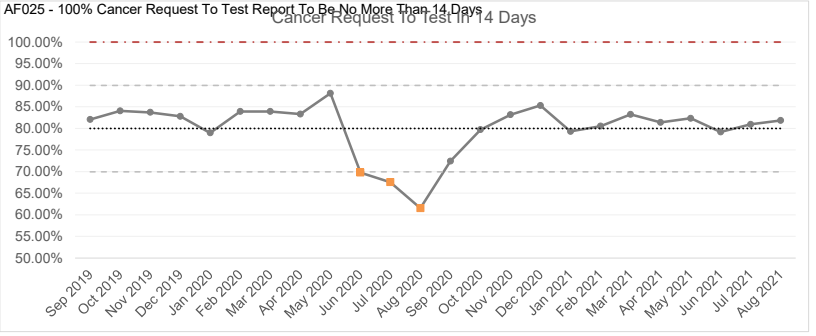
Aug 2021
32
Target
0
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Variation indicates consistently failing short of the target

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



Aug 2021
38.10%
Target
75.00%
Variance
Common cause - no significant change
Assurance
Variation indicates consistently failing short of the target

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



Aug 2021
81.86%
Target
100.00%
Variance
Common cause - no significant change
Assurance
Variation indicates consistently failing short of the target

Data Analysis:

62 days GP referral: Common cause variation, no significant change. This system will not consistently hit or miss the target. (This occurs when the target lies between the process limits).

104+ days GP referrals: Special cause of improving nature where the measure is significantly lower than the average value. This occurs where there is improving performance. It will FAIL the target without system change.

Transferred by day 38: Common cause variation, no significant change. This system is not reliably capable. It will FAIL the target without system change.

Request to test 14 days: Common cause variation, no significant change. This system is not reliably capable. It will FAIL the target without system change.

Cancer Waiting Times - 62 Days GP Referrals: The Trust continues to fail the 62 day standard.

Issues/Risks: Impact of another surge in COVID and the inability to deliver agreed interventions within a timely manner - diagnostics, surgery, oncology

Actions: Colorectal: significant improvement in delivery of this standard currrenlty at 65% - drop in performance in August due to number of patients already breached but now requiring treatment; there is an increase in the number oncology breaches which has impacted on performance. September perormance currently at 66.7%.
H&N, UGI and Urology historically struggle to achieve this standard due to complex diagnostic pathways and referral to HUTH for treatment. UGI Currently averaging about 50% achievement with Urology currently averaging about 60% achievement.
Weekly cancer PTL meetings go through every 62d+ patient pathway to ensure the next step is in place and pathways are progressing. Weekly cancer meetings with Cancer Manager where concerns are escalated and fed back to Oncology. Weekly tracking meetings with Consultants to ensure there are no preventable delays in patients pathways.

Mitigations: Improving achievements of 28 day faster diagnosis standard.
* Implementing national optimal pathways in Lower GI, Lung, Prostate and Upper GI.
* Implementing Rapid Diagnostic pathway for iron deficiency anaemia patients in both Upper & Lower GI.
* Implementing cancer transformation programme within NLAG to complement Humber and HASR programmes (to include RDC, MDT streamlining, pathway transformation, and the Living With and Beyond Cancer implementation).
* Breast 62 day standard a concern due to delays with diagnostics and oncology following the service moving to Hull.

Cancer Waiting Times - 104+ Days GP Referrals: The volume of patient pathways over 104+ days has remained static since May 21 but is significantly lower than the peak at June 2020 (95 patients) which represented 4.0% of the total 62 day PTL. The current level of patients over 104 days has returned to pre-covid levels (33) representing 2.0% of the total 62 day PTL (including GP referral, screening and con upgrade). The largest cohort of patients remains 'suspected' cancer patients (i.e. those without diagnosis). The position has remained static since May 21.
Family Services currently have no 104+ confirmed cancer patients. Gynae do have 1 suspected cancer over 104 days but the patients has had surgery and we are awaiting histology.

Issues/Risks: Longer waiting times for diagnostic/staging (including tertiary centres) and oncology 1st appointments risks increasing volumes over 104+ days.

Actions: Trajectories in place to reduce 104+ pathways to 0.9% of PTL (being presented to Divisional Boards).
At 16/09/21, S&CC curently have 13 patients waiting over 104 days - 5 suspected and 8 confirmed;

Mitigations: Weekly cancer PTL meetings go through every 104+ patient pathway to ensure the next step is in place and pathways are progressing.
Escalation to tertiary centre if pathway appears stalled (for those patients awaiting treatment and/or staging at tertiary centre).

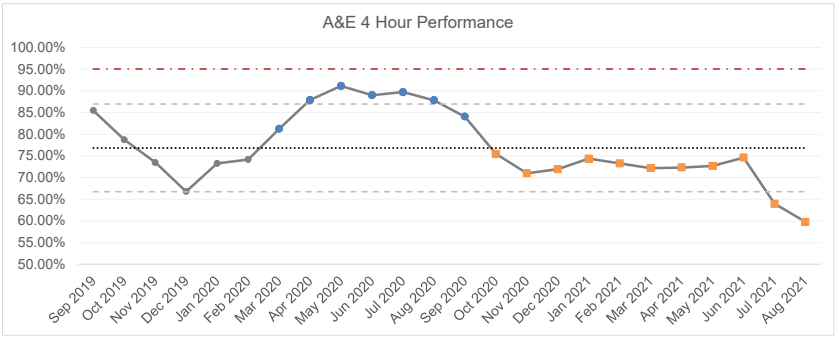
Patients With Confirmed Cancer Diagnosis Transferred by Day 38

The trust continues to struggle to meet the 38 day standard. This is largely because for some tumour types tertiary diagnostics/staging/biopsy is required to confirm treatment options - longer waiting times (upto 21 days in some cases, e.g. EUS/lung biopsies) result in the pathway being beyond Day 38 when results are received back at NLAG. This is then followed by local/specialist MDT discussion, and agreement with the patient, to transfer care to a tertiary consultant for treatment. If the tertiary provider treats within 24 days of receipt, the 1.0 whole breach is reallocated to NLAG (increasing the volume of accountable breaches).

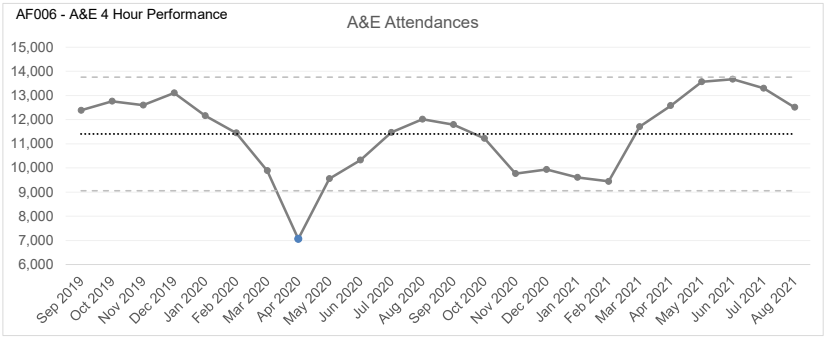
Issues/Risks: Capacity within the tertiary centre for diagnostics/staging scans within 7 days
Treatment capacity within tertiary centre - robotic prostatectomy, head & neck surgery
Oncology - capacity for consultant 1st appointments to be within 7 days of referral

Actions: Transformation pathway work has commenced between NLAG and HUTH as part of the Humber Cancer Transformation programme (overseen by the Humber Cancer Board). Some single services are proposed, e.g. Upper GI and Lung.

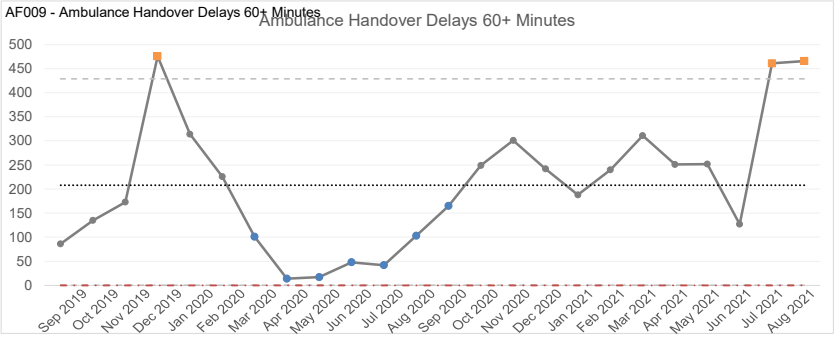
Mitigations: Same as 62 day pathway challenges



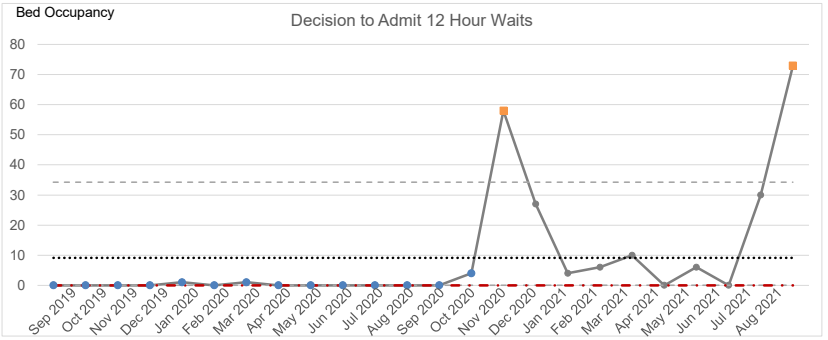
Aug 2021
59.76%
Target
95.00%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Variation indicates consistently failing short of the target



Aug 2021
12,511
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant



Aug 2021
466
Target
0
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates inconsistently hitting passing and falling short of the traget



Aug 2021
73
Target
0
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates inconsistently hitting passing and falling short of the traget

Data Analysis:

A&E 4 hour performance: Special cause of concerning nature where the measure is significantly lower than the average value. This occurs where there is deteriorating performance. It will FAIL the target without system change.

A&E Attendances: Common cause variation, no significant change.

Ambulance handover 60+ minutes: Special cause of concerning nature where the measure is significantly higher than the average value. This occurs where there is higher pressure in the system or worse performance. This system will not consistently hit or miss the target. (This occurs when the target lies between the process limits).

DTA 12 hours: Special cause of concerning nature where the measure is significantly higher than the average value. This occurs where there is higher pressure in the system or worse performance. This system will not consistently hit or miss the target. (This occurs when the target lies between the process limits).

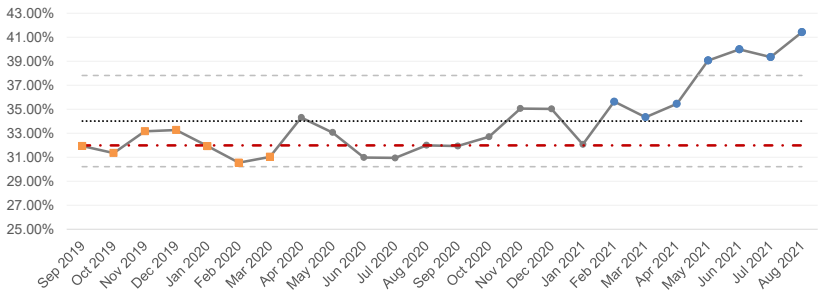
ED 4 Hour Performance: High attendances are creating challenges within the Emergency Departments (ED) due to physical departmental capacity, workforce capacity, covid-19 implications and patient flow out of ED into the hospital. The challenges are having a negative effect on the Trust's ED waiting time performance. Aug 2021 saw a deterioation of performance. These challenges are not unique to NLAG and are being experienced nationally. Longer patient waits in ED are also having a negative effect on the ambulance handover performance and Decision to Admit (DTA) waits. **Issues and Risks:** • Exit block from ED for admission due to lack of patient flow causing long delays for patients in ED. • Implications of COVID19 (zoning segregation, PPE, awaiting swab results, staff sickness and isolation) creating challenges and delays for patient pathway through the ED • Medical staffing vacancies, sickness, and isolation resulting in over reliance on locum/agency doctors and junior skill mix • Nurse staffing vacancies, sickness and isolation resulting in unfilled nursing shifts and over reliance on agency nurses with less ED experience • Delays in diagnostic imaging at times and in specialty in-reach not meeting the less than 30min attendance to review Emergency Care Standards • Lack of clinical cubicle capacity to see incoming patients and hold patients awaiting admission • Delays in mental health input out of hours resulting in long patient delays within ED for vulnerable patients • Inappropriate attendances to ED due to lack of access to alternative, more appropriate services. **Actions:** • A large transformational project to establish an Urgent Care Service (UCS) at both ED's is underway wokring in conjunction with CCGs and primary care to start implementation during October 2021 • Discharge to assess initiative to enable prompt discharges and create improved bed occupancy levels. • Integrated Acute Assessment Unit (IAAU) to enable improved access for incoming admissions with same day emergency care (SDEC) Task & Finish (T&F) Group to increase SDEC and avoid admissions. • NHS111 First Initiative to reduce avoidable ED attendances • ED Medical Recruitment Strategy. • NHSE/I Emergency Care Improvement Support Team (ECIST) Support, point of prevalence study and missed opportunities audit • New ED/AAU build in development • Frailty service continuing at DPOWH due to success of pilot with 93% of frailty patients discharged home from SDEC • Patient Flow Improvement Group established to progress the cross-divisional actions identified through the ECIST audits **Mitigations:** • Fast track paediatric process in place • Increased staffing in ED • 2 hourly board rounds with EPIC and Clinical Coordinator • Nursing care needs monitored through care round document – risk assess for pressure ulcers, falls, nutrition, hydration, comfort • Alternatives to trolleys – beds, recliner chairs • Choice of meals for patients during prolonged ED stays • Medication and observations as required • Support offered to staff for health and wellbeing.

Ambulance Handover Delays 60+ Minutes : 60min+ handover breaches occur when the handover area is full and there are no clinical cubicles available to accept incoming patients due to exit block from ED. Increased ED attendances and lack of patient flow out of the ED is resulting in crowding within the department and lack of physical capacity. There has been improvement in the reduction of over 60 min handovers from 9% in Nov 20 down to 4% in Jun 21. Jul and Aug 2021 saw a deterioration in ambulance handover performance due to ED exit block resulting in a lack of clinical cubicle capacity to offload incoming ambulance patients. This was further exacerbated by significant workforce shortfalls due to medical and nursing absence and reductionin agency pick up. **Issues/Risks:** • Bed occupancy levels and COVID-19 implications have created challenges in balancing the ward configuration to meet the changing demand of bed requirements.

• Lack of IT interface ability between EMAS and NLAG systems • Temporary ambulance drop off locations due to new ED build works creating longer physical journey for ambulance patients • Patients receiving delayed assessment and treatment whilst waiting in ambulances • Long ambulance waits for handover result in reduction of ambulances to attend emergencies in the community • Negative impact on A&E 4hr performance. **Actions** • Ambulance Handover Task and Finish Group with system partners to drive System-wide Ambulance Handover Improvement Plan which includes 32 actions including reducing inappropriate conveyances by increasing hear and treat/see and treat; making the actual handover process as efficient and clinically safe as possible; and improving patient flow to reduce the exit block from preventing handovers from commencing due to lack of clinical cubicle availability for incoming patients • UTC at SGH moved out of ED footprint to increase ED physical capacity • New ambulance handover process with digital triage now in place • New ED/AAU build in development • New direct streaming process from EMAS to SDEC now in place • New EMAS patient self-handover SOP now in place • Exploring options to interface and data share patient details between EMAS Siren system and NLAG's Symphony system • Further review and revision of direct EMAS to SDEC pathway to increase usage and improve successful referral rate.

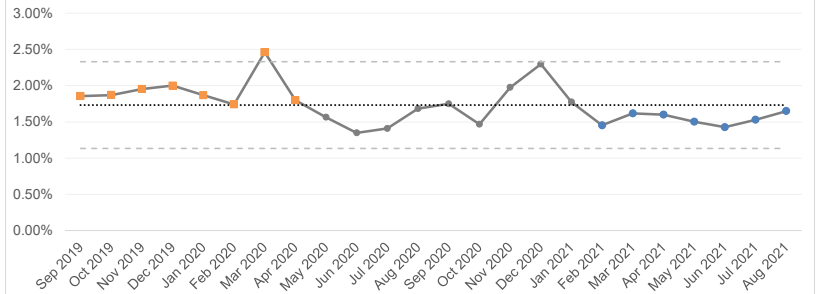
12 Hour DTA: The overall aim is to have zero 12 hour trolley breaches within the Trust. 12 hour breaches are when a patient within the Emergency Department has had a decision to admit made and accepted by the relevant specialty but there is a delay of 12 hours or more for a bed to be made available for their admission. This lack of required patient flow across the hospital results in patients having long waits in the emergency department, negatively affecting the department's ability to see and treat new patients and offload ambulance arrivals. Significant pressures in bed occupancy, patient demand and acuity have seen daily challenges in admitting patients from ED into IAAU for both Yellow A and Red patients. This has seen an increase from zero breaches in June 2021 to 34 during July and 72 during August 2021. This pressure is continuing into September. **Issues/Risks:** • 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. **Actions:** • Daily operational meetings to review and amend the ward zoning and patient movements to enable bed availability for the patients requiring admission. • Discharge to assess initiative to ensure patients are discharged in a timely manner to support adequate patient flow throughout the hospital. • Review of the 12 hour escalation process to support early exploration of radical options to support prompt patient admission and 12 hour DTA breach avoidance. • Validation of all 12 hour breaches to identify themes and lessons to be learned to avoid future breaches. • Senior second reviews and long length of stay (LOS) reviews carried out by Medicine Divisional Clinical Directors and Divisional Head of Nursing. • OPEL actions implemented to create capacity and increase support to wards to enable discharges. **Mitigations:** • Increased staffing to ECC • 2 hourly board round with EPIC (Emerg. Physician in Charge) and Band 7 coordinator to identify risk. Nursing care needs monitored through Care Round document (risk assessments for pressure ulcers, falls, nutrition, hydration and comfort) • Alternatives to trolleys – beds, recliner chairs and also red mattresses provided where needed • Choice of meals including hot meals • Medication and observations as required.

same day discharge

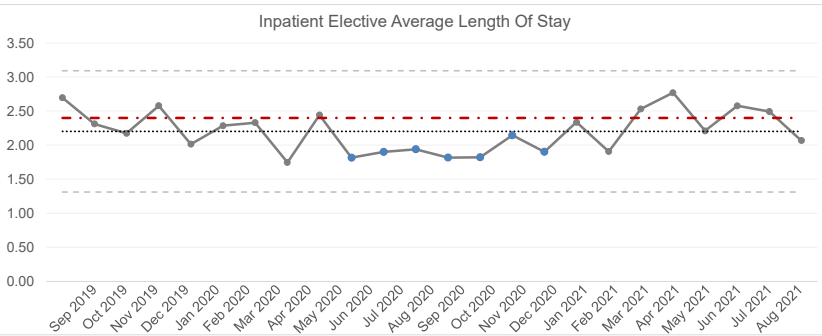


Aug 2021	Target	Variance	Assurance
41.42%	32.00%	Special cause of improving nature or lower pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the traget

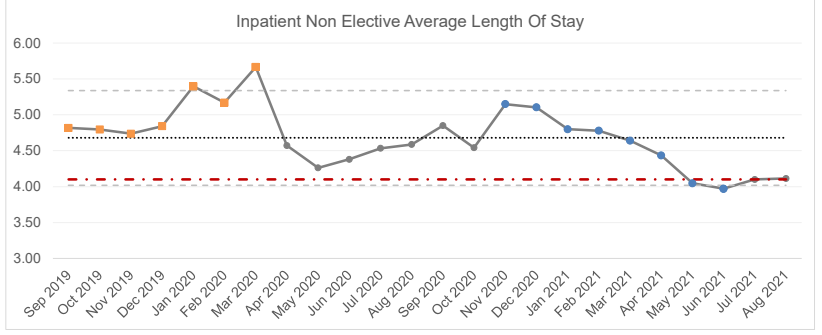
inpatient extended 21+



Aug 2021	Target	Variance	Assurance
1.65%	No target	Common cause - no significant change	There is no target therefore target assurance is not relevant



Aug 2021	Target	Variance	Assurance
2.07	2.40	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the traget



Aug 2021	Target	Variance	Assurance
4.11	4.10	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the traget

Data Analysis:
Discharged same day as admission: Special cause of improving nature where the measure is significantly higher than the average value. This occurs where there is improving performance. This system will not consistently hit or miss the target. (This occurs when the target lies between the process limits).
Extended stay 21+ days: Special cause of improving nature where the measure is significantly lower than the average value. This occurs where there is improving performance.
Elective length of stay: Common cause variation, no significant change. This system will not consistently hit or miss the target. (This occurs when the target lies between the process limits).
Non elective length of stay: Common cause variation, no significant change. This system will not consistently hit or miss the target. (This occurs when the target lies between the process limits).

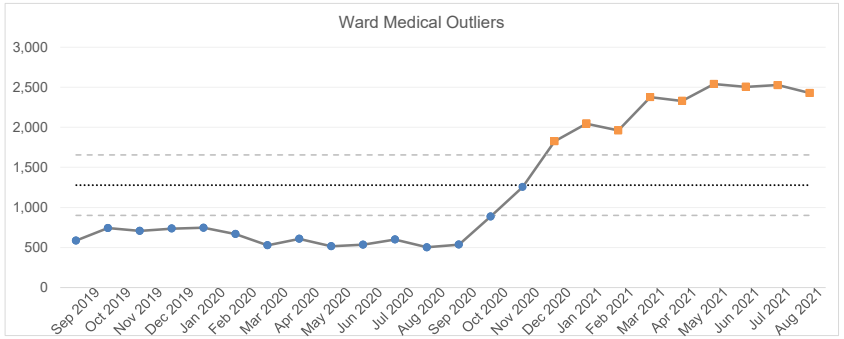
Discharged the Same Day As Admission
There continues to be improvement work taking place within our SDEC services to further improve the trusts posistion which includes extended opening times & speciality in reach. There are issues around physical space and capacity on both sites, howeer the new ED/SDEC builds will see ED and SDEC areas expanded on both sites.

Extended Length of Stay (21+ days)
The chart shows that there has been an improvement in patients with a length of stay over 21 days, although there have been some peaks in 2020 due to COVID peaks the LOS has shown improvement, there has been a significant amount of improvement work take place around the discharge process which has resulted in the trust sitting below the national target of 12%.
Issues/Risks: Lack of dedicated specialty wards cause issues and has increased length of stay. Ongoing issues around workforce shortages and consistency of board rounds and decision making.
Actions: Discussed at S&CC M&M speciality meetings. S&CC attend daily Discharge to Assess meeting to discuss any stranded patients. Through the discharge to assess implementation there has been significant improvement work carried out around the discharge process, actions agreed to ensure continuous improvement in 21 day length of stay are:
* Ensuring all wards have daily board rounds before 10am to help facilitate early discharge & planning
* Working with the ward MDT to carry out effective board rounds
* Patients requiring support on discharge leave following a discharge to assess pathway on the same day
* Escalation process in place to ensure any delays in patient pathways are highlighted and actioned
* Working with clinical leads to highlight patients with a length of stay over 7 days to ensure patient plans are in place and any pathway delays are escalated
* Twice weekly long length of stay walk rounds on all sites taking place
Mitigations: The Trust are part of a NHS E/I Ward/board round collaborative with external support and guidance around best practice board/ward rounds and decision making.

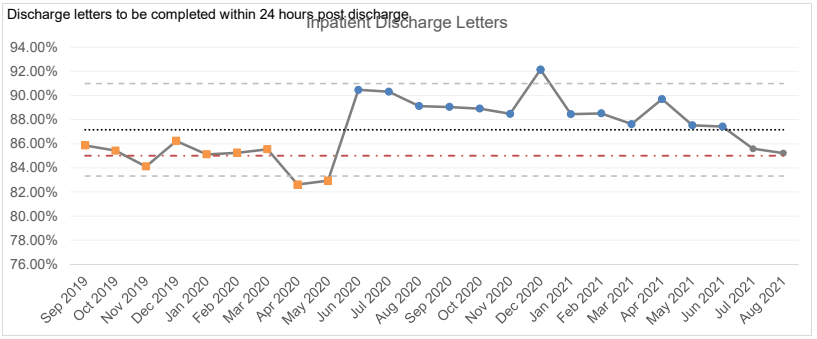
Elective and Non Elective LoS
Elective LoS is on target for the third month in a row and have seen an improvement in LoS since June 2021.
A large amount of improvement work continues to take place around our discharge process including discharge to assess & daily MDT board rounds.
Since commencing the improvement work in December 2020 Non elective LOS has continued to improve across the trust.
Through the discharge to assess implementation there has been significant improvement work carried out around the discharge process, actions agreed to ensure continuous improvement length of stay are:

* Twice weekly LOS walkrounds for patients who have a LOS over 7 days
* Ensuring all wards have daily board rounds before 10am to help facilitate early discharge & planning
* Working with the ward MDT to carry out effective board rounds
* Patients requiring support on discharge leave following a discharge to assess pathway on the same day
* Escalation process in place to ensure any delays in patient pathways are highlighted and actioned
* Working with clinical leads to highlight patients with a length of stay over 7 days to ensure patient plans are in place and any pathway delays are escalated

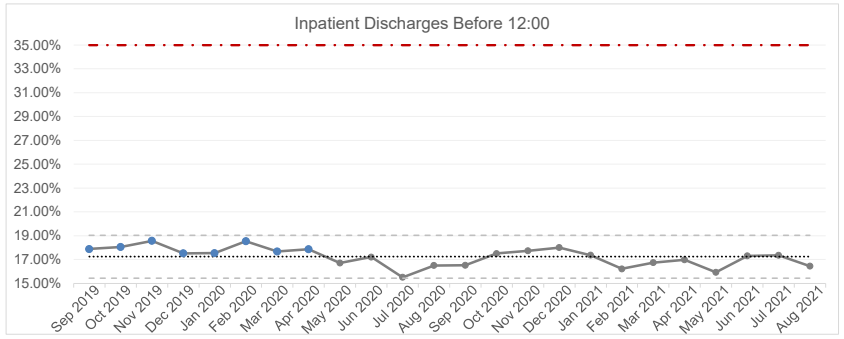
Issues/Risks
Medical Outliers



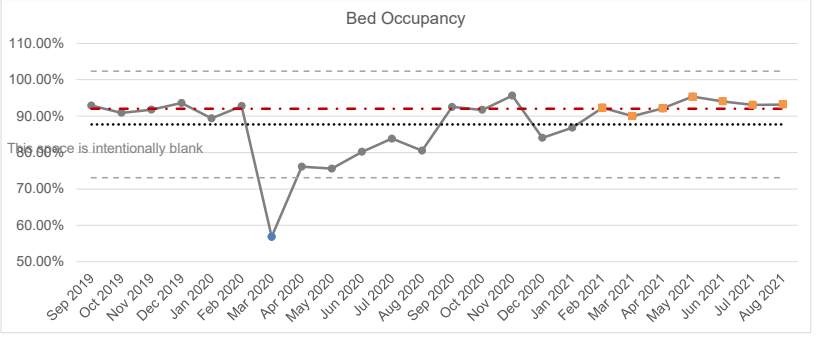
Aug 2021	2,428
Target	No target
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	There is no target therefore target assurance is not relevant



Aug 2021	85.22%
Target	85.00%
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and falling short of the traget



Aug 2021	16.46%
Target	35.00%
Variance	Common cause - no significant change
Assurance	Variation indicates consistently failing short of the target



Aug 2021	93.20%
Target	92.00%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Variation indicates inconsistently hitting passing and falling short of the traget

Data Analysis:

Ward medical outliers: Special cause of concerning nature where the measure is significantly higher than the average value. This occurs where there is higher pressure in the system or deteriorating performance.

Inpatient discharge letters: Common cause variation, no significant change. This system is not reliably capable. It will FAIL the target without system change.

Inpatient discharges before 12:00: Common cause variation, no significant change. This system is not reliably capable. It will FAIL the target without system change.

Bed Occupancy: Special cause of concerning nature where the measure is significantly higher than the average value. This occurs where there is higher pressure in the system or worse performance. This system will not consistently hit or miss the target. (This occurs when the target lies between the process limits).

Medical Outliers

The amount of medical outliers is showing an increase since Novembember 2020, this is reflective of the increased ED attendances and aquity of patients requiring admission. **Actions:** Further improvement work with the IAAU model to ensure right patient right bed and continued improvement work on daily MDT board rounds to ensure all patients have a plan in place with a clear estimated discharge date. The ward configurations / business rules that determine outliers in terms of data analysis is also due to be reviewed in light of changing ward configurations due to COVID and since implementation of the IAAU.

Inpatient Discharges before 12:00

Work has been ongoing to implement the new hospital discharge policy, one of the outcomes of implementation of this policy is identifying discharges at morning board round and facilitating a patients discharge much earlier in the day. Support and education currently being rolled out across all wards to ensure effective MDT board rounds are taking place resulting in clear plans for all patients.

Issues/Risks: * Workforce continues to be an issue across the trust therefore not all actions following a board round are carried out in a timely manner
* Capacity & Resource issues within our community services

Actions:
* Board round Support & Education
* Embedding Discharge to Assess pathway
* Work with the wider system to facilitate discharge in the morning
* Work through discharge improvement plan and esnure we fully utilise our discharge lounge

Mitigations:
* Support & Monitoring across all wards taking place on a daily basis and introduced an escalation process working with the operations centre to support wards
* Working with our system partners to look at Demand & Capacity

Bed Occupancy

The unprecidented number of ED attendances implies more admissions from ED which would increase the bed occupancy rate in turn. Elective bed capacity is limited. There are a reduced number of beds due to various factors including social distancing, specific wards for COVID patients, and pop up beds.

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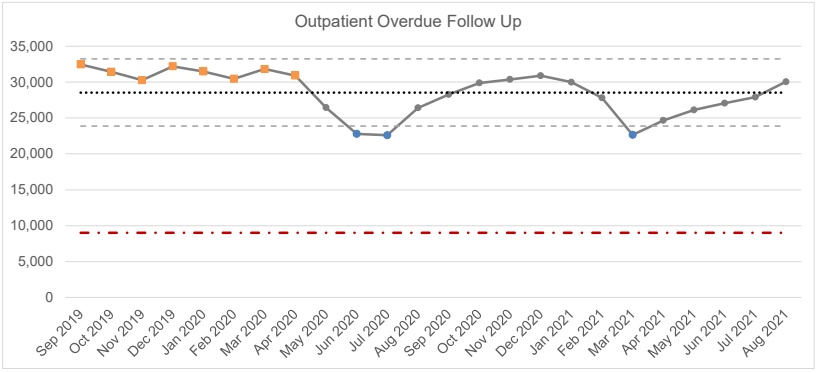
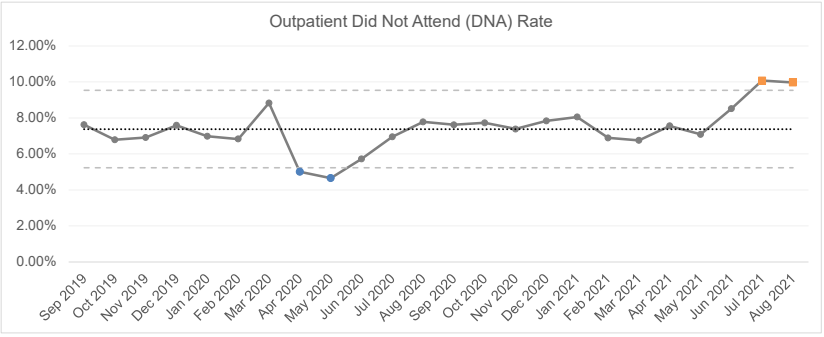
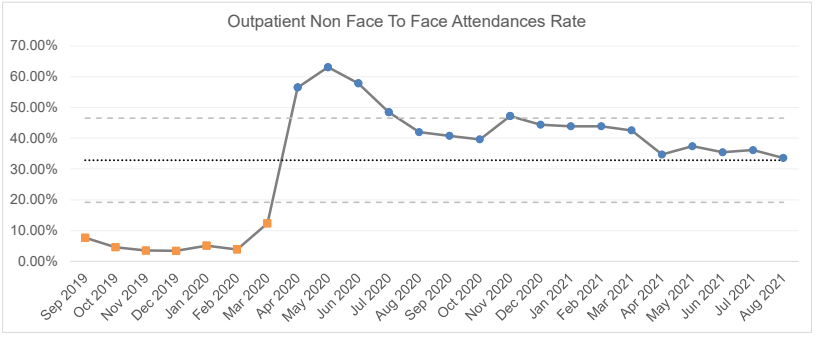


Aug 2021	30,040
Target	9,000
Variance	SPCNoChange
	Common cause - no significant change
Assurance	SPCFailing
	Variation indicates consistently failing short of the target



Aug 2021	9.96%
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



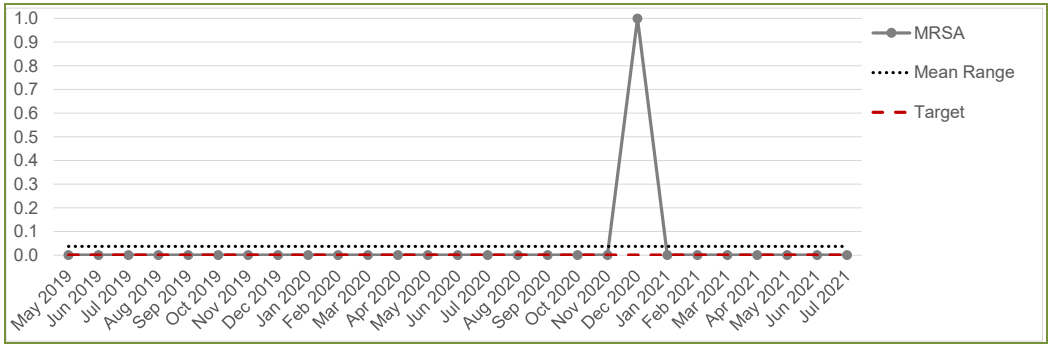
Aug 2021	33.62%
Target	No target
Variance	
	Special cause of improving nature or lower pressure due to higher values
Assurance	
	There is no target therefore target assurance is not relevant

Data Analysis:
Outpatient Overdue follow up: Common cause variation, no significant change. This system is not reliably capable. It will FAIL the target without system change.
Outpatient DNA rate: Special cause of concerning nature where the measure is significantly higher than the average value. This occurs where there is higher pressure in the system or deteriorating performance.
Non Face To Face Outpatient Attendances: Special cause of improving nature where the measure is significantly higher than the average value. This occurs where there is improving performance.

Outpatient Overdue Follow Up
The overall position against the target of a maximum 9,000 oupatient follow ups has started to worsen since March 21, however the majority of specialties feel confident in delivery. For those specialties unable to commit to delivery, the main reasons include:- Services not back to pre-covid levels, vacancies and discharge rates. As part of the H1 plan (April 21 to Sept 21), the specialties have been focussing on seeing new referrals which, in some areas, has shifted the capacity from follow ups to new which will have impacted on the overdue follow up position.

Indicator: QS001, QS003 & QS004 Infection Control

Jul 2021



Background and What Are The Charts Telling Us?	
MRSA:	Cases of MRSA hospital onset bacteraemia remain stable and within parameters.
E Coli:	The new NHS standards contract gives the Trust a thereshold of 5% reduction on 2019 cases, for NLaG this is 110.
C Diff:	The new NHS standards contract gives the Trust a thereshold of 5% reduction on 2019 cases, for NLaG this is 33 for Hospital-Onset Healthcare Associated (HOHA) and COCA cases.

Actions	
MRSA:	No actions
E Coli:	Seasonal variation as expected.
C Diff:	On track although cases likely to rise due to activity pressures and change in prescribers.

Issues And Risks	
MRSA:	N/A
E Coli:	N/A
C Diff:	N/A

Mitigations	
MRSA:	N/A
E Coli:	N/A
C Diff:	N/A

Indicator: QS006 Venous Thromboembolism (VTE) risk assessment

Period	Lower CL
Jul 2021	76.28%

Value	Mean
76.33%	82.86%

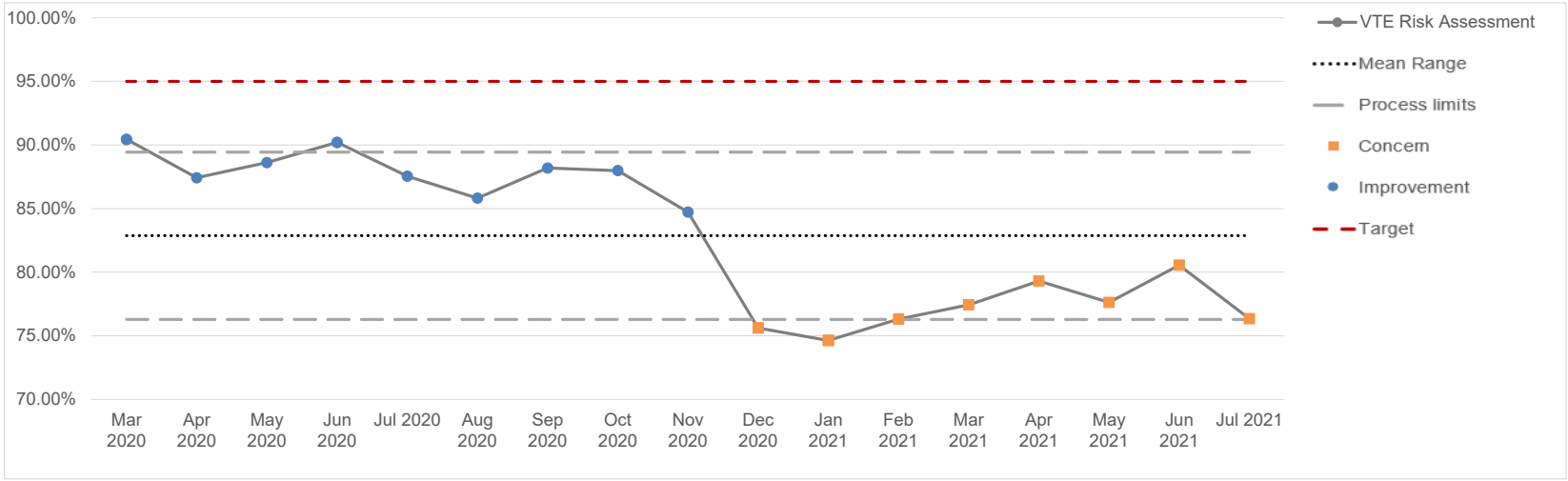
Target	Upper CL
95.00%	89.44%

Variance

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

Assurance Inconsistency

Variation indicates consistently falling short of the target



Background And What Is The Chart Telling Us?	Actions
This chart demonstrates the number of patients who have been admitted to hospital and that have had a VTE risk assessment. This is the numerator in the calculation against the denominator which is the number of patients admitted to hospital. This is a nationally mandated indicator in the 2021/22 performance oversight framework, with the target of 95% in the national contract. Within the Trust the number of patients who have been screened for VTE is determined for reporting purposes using the WebV system to record when a VTE risk assessment has been completed and coding reviews of the same. Established pre-determined 'cohorts' of patients who are at low risk (i.e. day case procedures), in line with older Department of Health (DH) guidance, also form part of the numerator. The chart is telling us that the Trust's performance is very close to the lower control limit this month. July 2021 performance is 76.33% against the 95% target.	The Trust's improvement plan is being led on by clinical leads from medicine and surgery. Work is currently underway to update the Trust policy and patient information leaflets in line with the latest NICE guidance. There has been a delay in reviewing and refreshing the Trust's current VTE risk assessment, which is paper based. The intention had been to link this as an electronic document via the EPMA system to make the process easier for medical staff and more responsive. An issue prevented this from being developed and rolled out and development of an e-screening tool utilising WebV commenced. A solution has now been found to utilise EPMA and a go live of the e-screening tool via EPMA is planned during September 2021. Performance with VTE and the improvement plan is being monitored in the Trust's Performance Review meetings.

Issues And Risks	Mitigations
VTE risk assessment performance has been impacted upon adversely during the Trust's response to Covid-19. The Trust are still operationally very challenged in response to an increasing demand of Covid-related (or Covid-suspected) acute admissions. The actions being taken now to launch an e-screening tool will not be shown in the data reported within the Integrated Performance Report (IPR) until December 2021, which will focus on performance during the month of October 2021.	Clinical leads identified and actively working to review and update VTE related policy and patient intended information in line with latest guidance from NICE. The e-screening tool is planned to be launched in September which will make it easier for medical staff to use. Ongoing education work with clinical staff. Engagement with trainee grades of medical staff to understand and overcome identified barriers.

Indicator: QS007 Duty of Candour

Period	Lower CL
Jul 2021	95.50%

Value	Mean
100.00%	99.19%

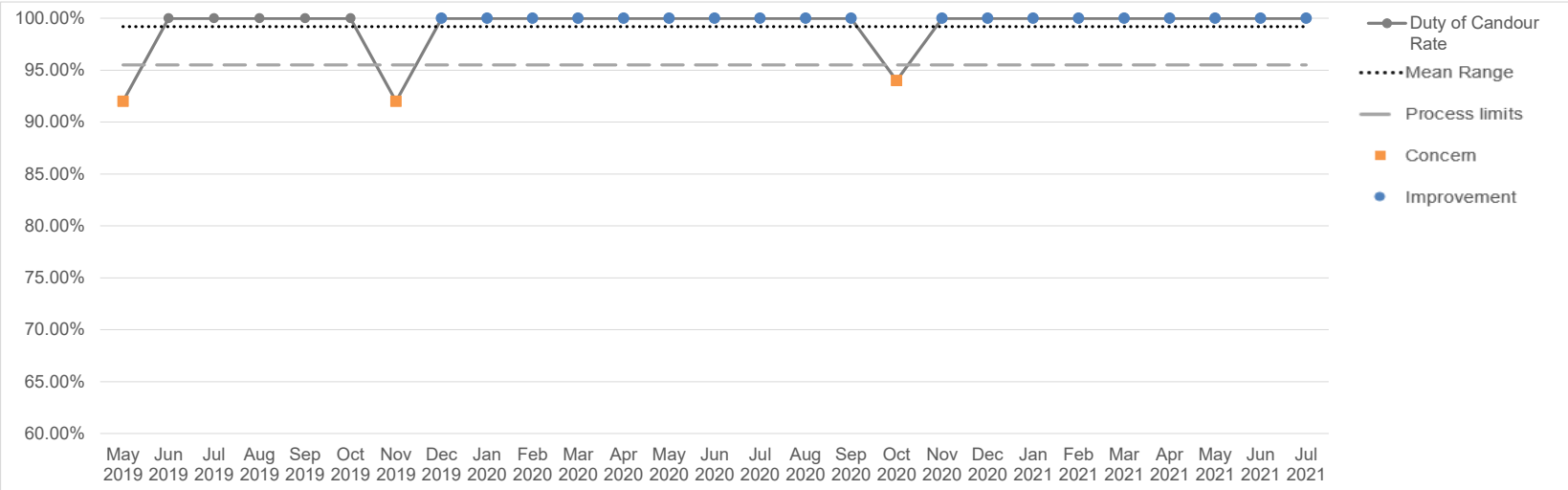
Target	Upper CL
No target	102.87%

Variance

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

Assurance Inconsistency

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



Background And What Is The Chart Telling Us?	Actions
The Duty of Candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. Incidents that require a Duty of Candour are incidents (unintended or unexpected) that resulted in, or appears to have resulted in the death of a service user or severe or moderate harm or prolonged psychological harm. The data source is from DATIX and shows compliance with duty of candour requirements in relation to Serious Incidents only. The Trust's target for this area is 100%. As a result, the Statistical Process Control (SPC) upper control limit is based on the statistical confidence 'rules' and therefore exceeds 100%. In this setting this should be deemed as not applicable in this instance.	Ongoing oversight and action, working with Divisions to obtain assurance that all moderate (and above) harm instances have duty of candour completed.

Issues And Risks	Mitigations
There is a requirement to ensure duty of candour is completed for all instances of harm at moderate level or above. There is a gap at present in relation to moderate level harm. Divisions approach to resolve this has been hampered by operational responses to the Covid-19 pandemic. There is therefore a risk that the Trust may not be capturing this robustly, therefore at risk of not complying with regulations requiring Duty of Candour to be completed for cases of moderate (or above) levels of harm. Risk of financial penalty from the Trust's regulators.	Ongoing work and focus on with Divisions with support from the central team.

Indicator: QS008 Emergency C-Section rate

Period	Lower CL
Jul 2021	10.30%

Value	Mean
18.50%	14.82%

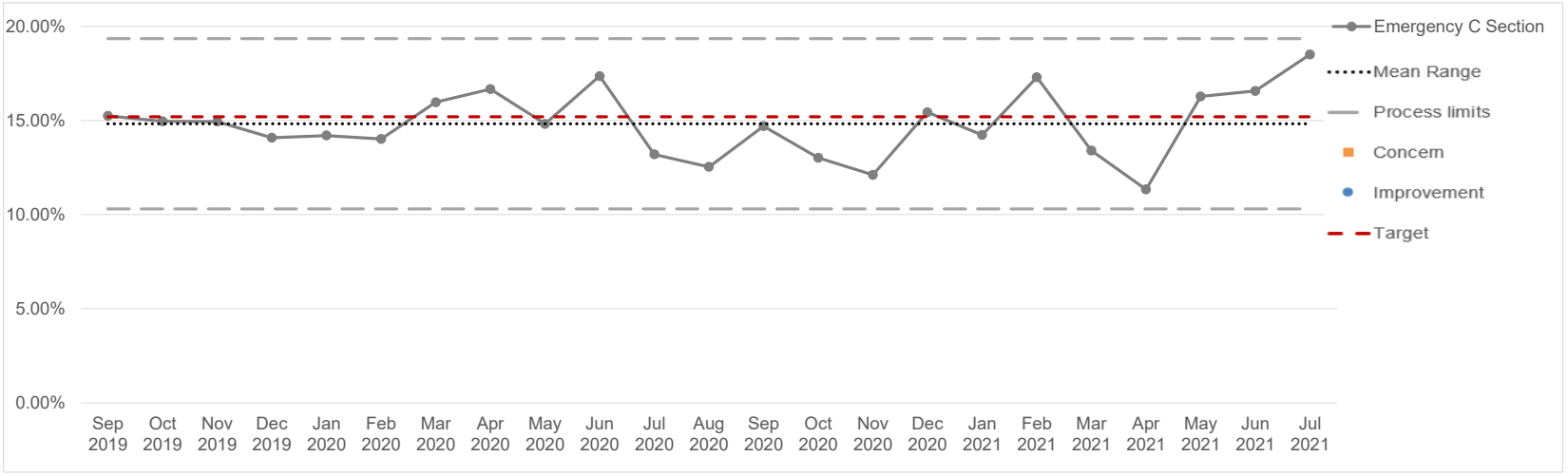
Target	Upper CL
15.20%	19.33%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
This indicator looks at the percentage of deliveries where the mother had an emergency C-section as a proportion of all deliveries in the reported month. This is submitted as part of the Maternity Services Dataset (MSDS) and the rates are also published on the Yorkshire and Humber Maternity Dashboard. The data comes from the Trust Maternity Information System (CMIS). Indicator from the Single Oversight Framework (SOF). The month of July 2021 shows performance of 18.5%. This is slightly above the 15% target.	Ongoing monitoring.

Issues And Risks	Mitigations
None.	N/A

Indicator: QS009 Patient Safety Alerts to be actioned by specified deadlines

Period	Lower CL
Jul 2021	93.88%

Value	Mean
100.00%	95.11%

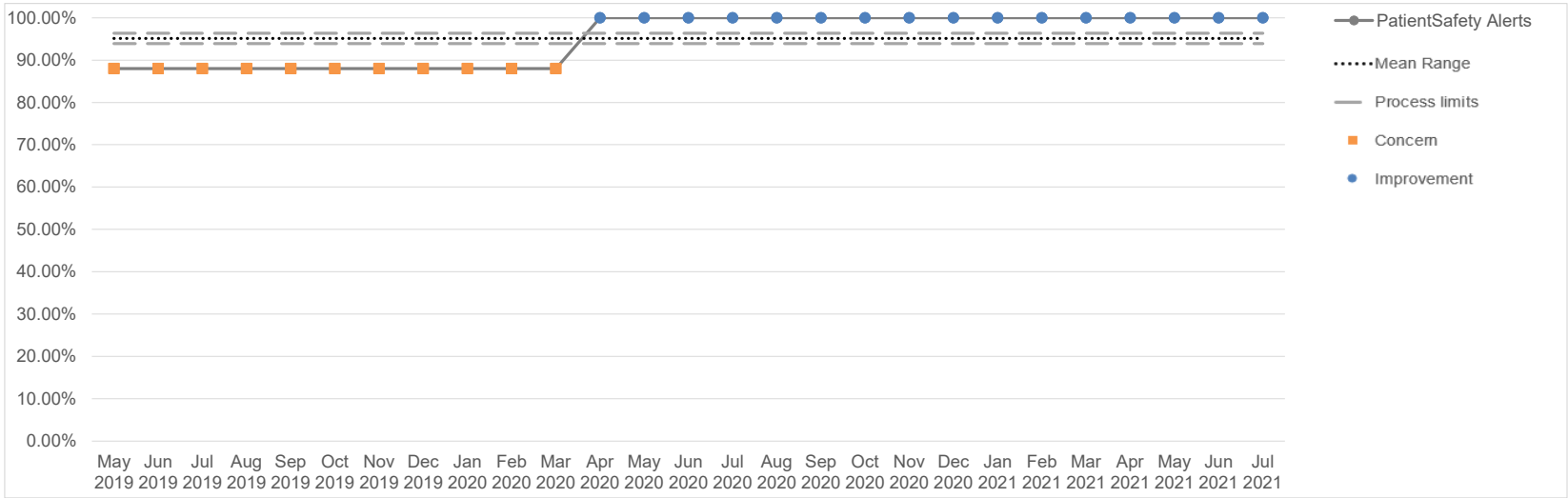
Target	Upper CL
No target	96.34%

Variance

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

Assurance Inconsistency

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



Background And What Is The Chart Telling Us?	Actions
This indicator is based on National Patient Safety Alerts (NatPSAs), a type of alert received via the Central Alerting System (CAS). There are no National Patient Safety alerts open past the specificed deadline. The Insights report, a document used by CQC, also presents data on a related indicator, the number of open alerts. In the Insights data, this is wider than just National Patient Safety Alerts overdue and instead includes other formal alerts received via CAS. The Insights report is also more historic (in terms of timescales) than the Trust's data and is likely to indicate 1 alert as being overdue. This alert related to an Estates and Facilities Alert (EFA) regarding ligature risk. The Trust left this open whilst agreed building work was completed to improve anti-ligature mental health rooms within the Trust's Emergency Department. This buildling work is now complete and the alert has been closed following review by the Quality Governance Group in July.	The Quality Governance Group receives a monthly update on this subject which includes a review of all open National Patient Safety Alerts as well as other alerts received via CAS.

Issues And Risks	Mitigations
None.	N/A

Indicator: QS010 Serious Incidents raised in month

Period	Lower CL
Jul 2021	0.00

Value	Mean
6	8.21

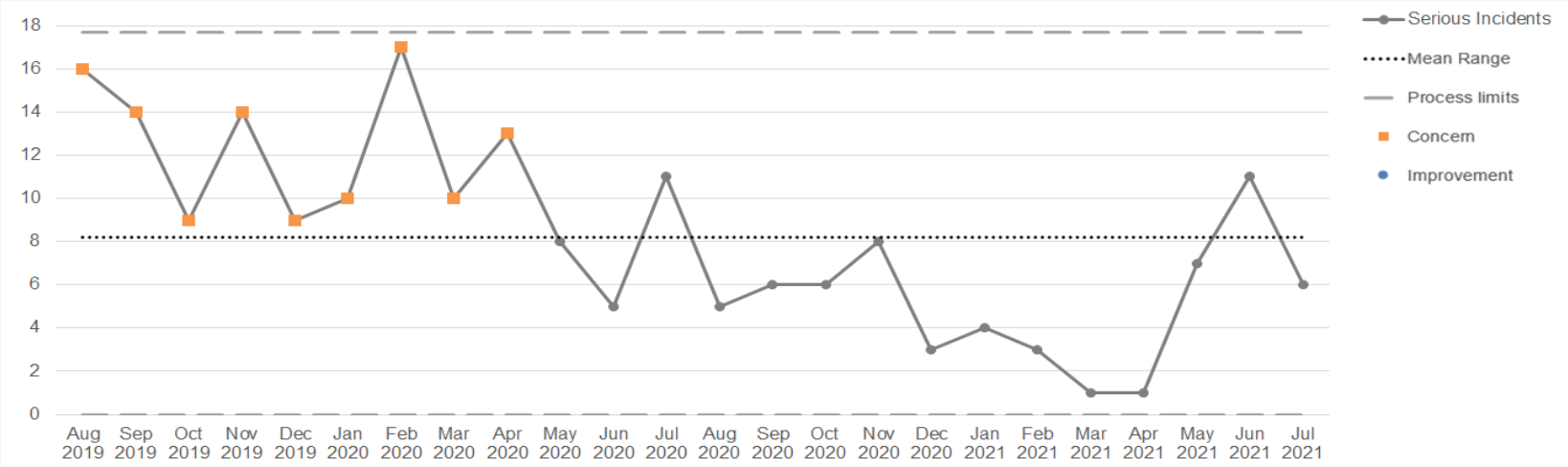
Target	Upper CL
No target	17.69

Variance

Common cause - no significant change

Assurance Inconsistency

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



Background And What Is The Chart Telling Us?	Actions
This data is calculated from a count of reported Incidents coded as 'Serious Incidents' (regardless of severity of harm). Data is obtained from the Datix system. This is both a national and local requirement. National monitoring is undertaken following SIs being reported on the national Strategic Executive Information System (STEIS) by the Risk Management Central Team. Locally, performance is monitored on a monthly basis by the Central Team and reported within the Trust and monitored also by local Clinical Commissioning Groups (CCGs) at the joint monthly Serious Incident Collaborative meeting. The chart shows that the number of Serious Incidents (SIs) raised in month had been reducing. May and June saw the number of SIs increase. July 2021 however shows the number reduce again to 6 in month.	Ongoing monitoring and review of incidents reported is overseen by the Trust's SI Panel that reports into Quality Governance Group and a monthly report is produced for the monthly Quality & Safety Committee.

Issues And Risks	Mitigations
None.	A Serious Incident Review Group undertakes deep dive focus into specific and identified themes arising from SIs to support a focus on embedding improvements in response and support the Trust's aspiration of being a learning organisation. A Learning Group has also commenced to focus on intensive sharing of learning around a key theme taken from integrated risk intelligence. The current area of focus for this group is documentation and record keeping.

Indicator: QS011 Occurrence of any Never Event

Period	Lower CL
Jul 2021	

Value	Mean
1.0	

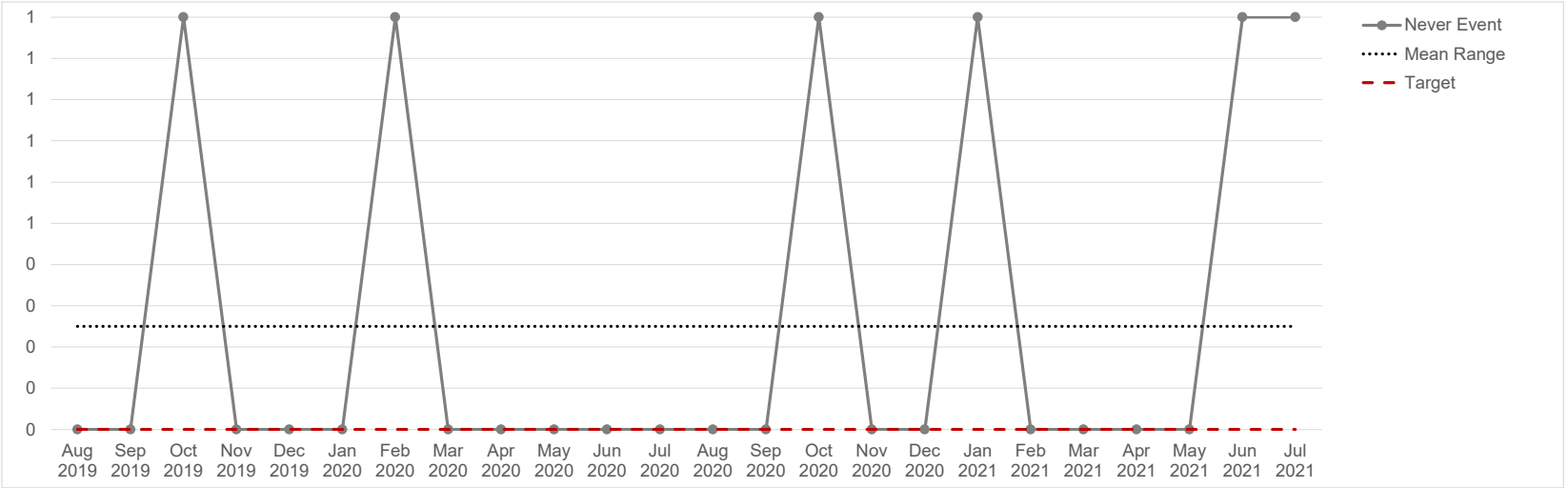
Target	Upper CL
0.0	

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 Inconsistency

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



Background And What Is The Chart Telling Us?	Actions
Never events' are defined as "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers". The data presented is a count of the Never Events in a rolling twelve-month period, presented per month. The data is made available from the Datix system and this is both a national and local requirement, similar to SIs. Data is reported nationally via the Strategic Executive Information System (STEIS) by the Trust's Risk Management Central Team. This data is further monitored and reported on locally within the Trust and to local CCGs at the joint monthly Serious Incident Collaborative meeting. This indicator is included in the Single Oversight Framework (SOF). In June there was one never event declared, a wrong site injection. In July there was a further never event declared which related to a retained swab in Theatres at SGH.	The Trust oversees incidents and Sis reported to ensure Never Event criteria is applied to ensure accurate reporting. Once reported a Never Event is thoroughly investigated to distill the learning and ensure actions are taken.The post Never event meeting, chaired by the Medical Director, seeks to identify where the error occured and any related issues that require further investigation as part of the never event investigation process that follows. Actions are followed up at the Quality Governance Group.

Issues And Risks	Mitigations
None.	Each never event reported will identify key learning and mitigations. The WHO checklist usage is being regularly assessed.

Indicator: QS012 Hospital Standardised Mortality Ratio (HSMR)

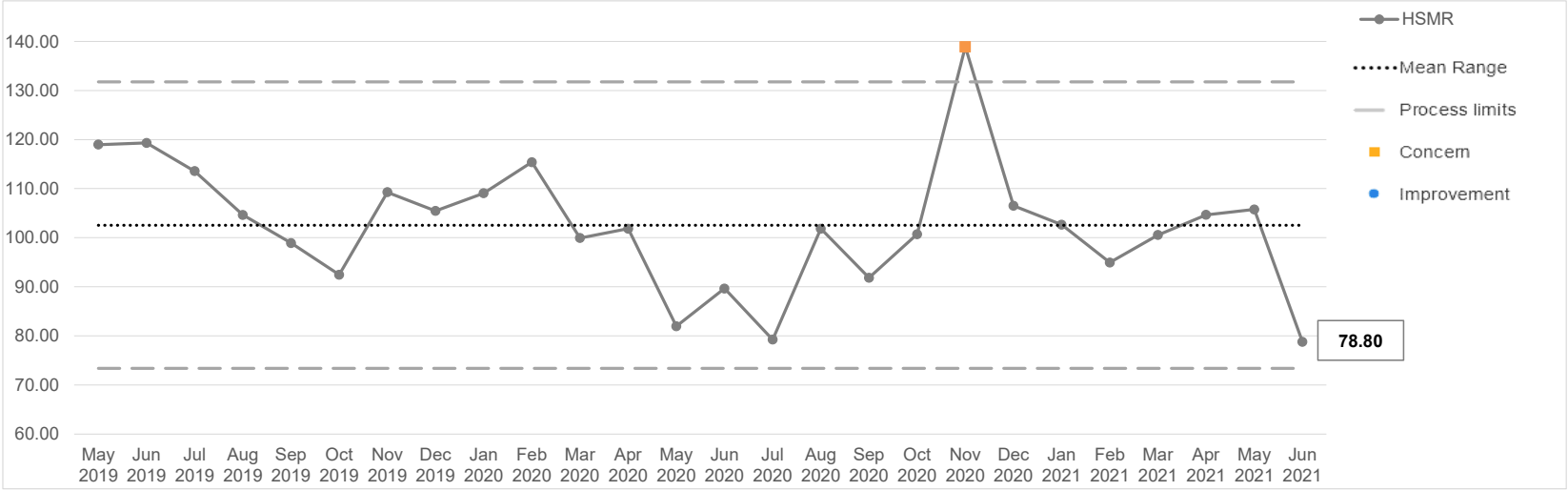
Period	Lower CL
Jun 2021	73.36
Value	**Mean**
As Expected	102.57
Target	**Upper CL**
As Expected	131.77

Variance

Common cause - no significant change

Assurance Inconsistency

Within 'Expected' Range



Background And What Is The Chart Telling Us?	Actions
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 the England average, given the characteristics of the patients treated. This is reported on a rolling 12 month basis and is a national indicator. The data pertaining to number of actual deaths is reported on by the Trust from its Patient Administration System (PAS) system. The statistical analysis that results in a monthly reported (12month rolling average) HSMR, based on individual patient risk factors, is undertaken by NHS Digital. This is performed across the country using data from all hospitals. This information is used by NHS Digital to provide the Official SHMI data. Analytical products, such as the Healthcare Evaluation Data (HED) tool provide the Trust with the ability to cut the Trust's SHMI for further analysis and obtain other forms of mortality data including the HSMR data. The Trust's HSMR remains under the target of 100 (as expected) which is positive.	The HSMR along with other mortality indices are overseen by the Trust's Mortality Improvement Group (MIG). Significant progress has been seen with SHMI and HSMR since January 2020.

Issues And Risks	Mitigations
None.	N/A

Indicator: QS013 Summary Hospital level Mortality Indicator (SHMI)

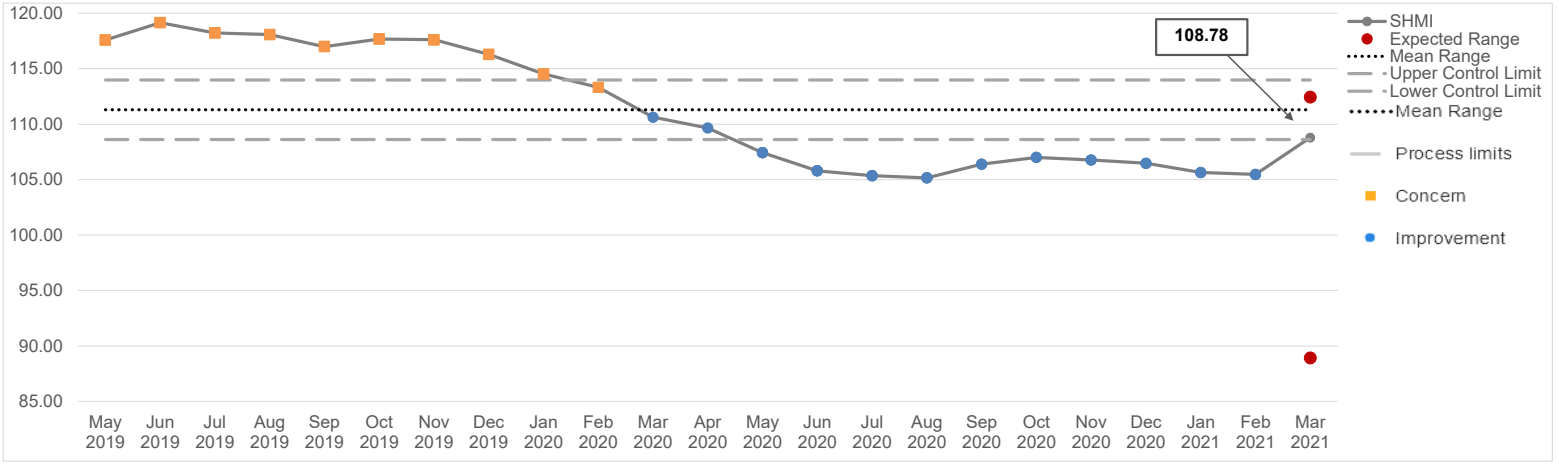
Period	Lower CL
Mar 2021	108.63
Value	**Mean**
As expected	111.31
Target	**Upper CL**
As expected	113.98

Variance

Common cause - no significant change

Assurance Inconsistency

Improving and within 'Expected' Range



Background And What Is The Chart Telling Us?	Actions
SHMI (Summary Hospital-Level Mortality Indicator) is a ratio calculation that compares the number of actual deaths (in hospital and within 30 days of discharge from hospital) against the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. This is reported on a rolling 12 month basis and is a national indicator. The data pertaining to number of actual deaths is reported on by the Trust from its PAS system. The statistical analysis that results in a monthly reported (12month rolling average) SHMI, based on individual patient risk factors, is undertaken by NHS Digital. This is performed across the country using data from all hospitals. This information is used by NHS Digital to provide the Official SHMI data. Analytical products, such as the HED tool provide the Trust with the ability to cut the Trust's SHMI for further analysis. The Trust's SHMI remains as expected which is positive. The Mar 2021 release (which covers the April 2020 - March 2021 period) showed an increase from 105.5 to 108.78. This jump is as a result of the annual rebasing process undertaken by NHS Digital. Whilst a normal part of the SHMI publication process, this has been impacted on more significantly by a large number of retrospective amendments to the national data, from 2020, linked to Covid-19 and the SHMI's exclusion of Covid-19 related deaths.	SHMI performance as well as the Trust's performance against other mortality indices is overseen by the Trust's Mortality Improvement Group (MIG). The out of hospital SHMI is a Trust Quality Priority for 21/22 working with local System partners.

Issues And Risks	Mitigations
The Trust's SHMI is above the national average (100) but is statistically described as being 'as expected'. The SHMI includes out of hospital deaths as well as in-hospital deaths. when breaking the indicator down into its component parts, the in-hospital SHMI is beneath 100, but the out of hospital component, which measures deaths within 30 days of discharge, is higher than 100. The April 2020 - March 2021 data demonstrated a significant step change in terms of the SHMIs numerical performance, from 105.5 to 108.78, an increase of 3.28. This increase was out of kilter with 'normal' variation observed. From further investigation this relates to annual rebasing of the SHMI indicator, made more significant by the removal of (historic) deaths from the SHMI calculation that were identified as related to Covid-19. SHMI excludes all deaths related to Covid-19. 20,000 patient episodes were removed as a result of this nationally, which has reduced the 'expected deaths', the denominator used in the SHMI calculation. The Trust's overall data, as a result of improved coding practices during 2020 supported accurate recording of Covid-19 when this was a factor in a patient's death, and consequently did not change significantly. Therefore, whilst the actual number of deaths remained largely unchanged, the 'expected' deaths reduced slightly, which results in the larger step change increase observed between Feb-21 and Mar-21 data points.	N/A

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: QS014 Formal Complaints

Period	Lower CL
Jul 2021	

Value	Mean
5.53	

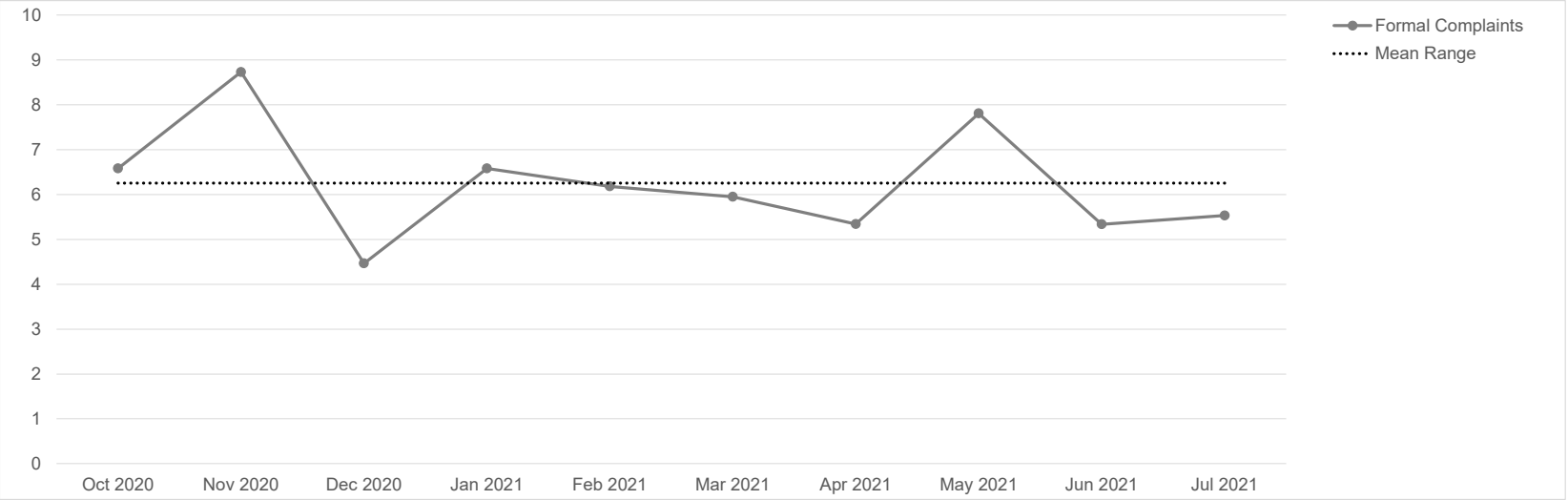
Target	Upper CL
No Target	

Variance

There is currently insuffcient data for an SPC chart.

Assurance Inconsistency

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



Background And What Is The Chart Telling Us?	Actions
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.)	> Alignment of process against new Parliamentary & Health Service Ombudsman (PHSO) standards > 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

Issues And Risks	Mitigations
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. New Governance report delayed do to capacity in central complaint team	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

Indicator: QS027 Reduction in the number of patients dying within 24 hours of admission to hospital

Period	Lower CL
Jul 2021	7.31

Value	Mean
14	19.07

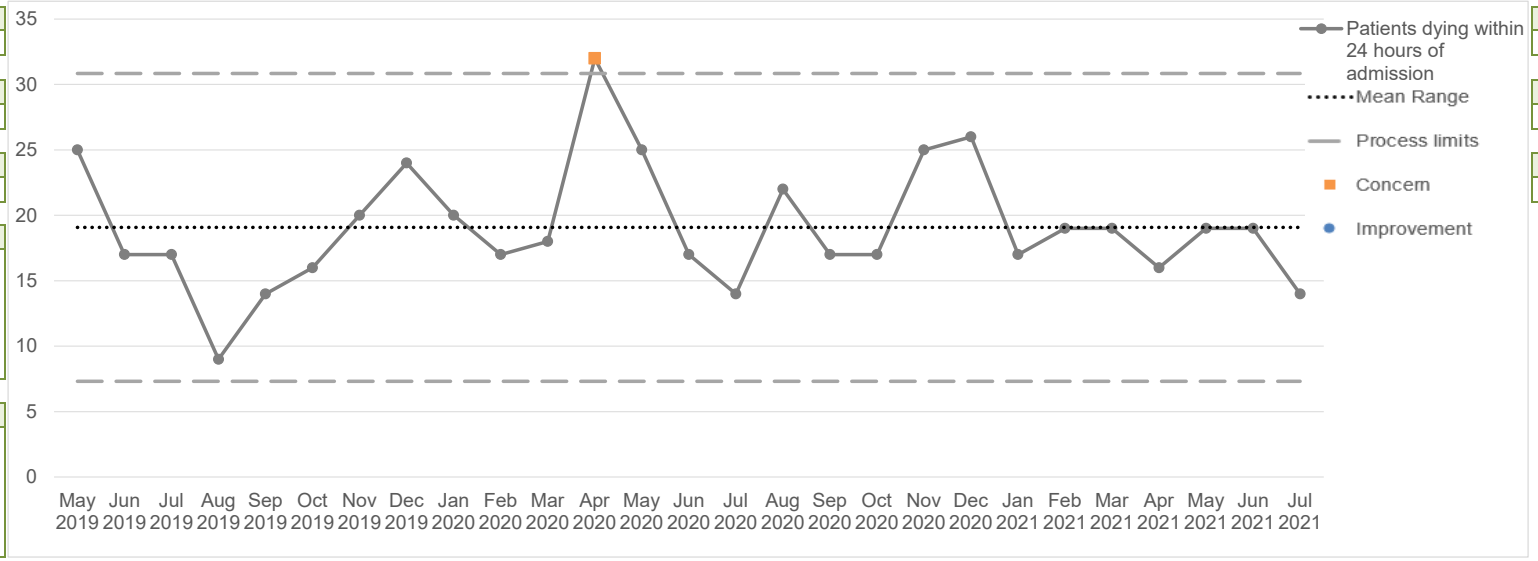
Target	Upper CL
Reducing	30.84

Variance

Common cause - no significant change

Assurance Inconsistency

Reducing



SGH
4

DPoW
10

Goole
0

Background And What Is The Chart Telling Us?	Actions
To support the Trust's quality priority for 2021/22, this indicator is intended to support a focus on patients at end of life (EOL) being admitted to the acute hospital and dying soon after admission. Admissions at end of life sometimes signal a breakdown of advanced care plans. In such occurrences, the patient's experience is adversely affected alongside relatives and carers. It is not possible to focus solely on patients at EOL who die within 24 hours, hence this data represents all deaths within 24 hours of admission. The data demonstrates that the average number of patients who die within 24 hours is 19. During July 2021, 14 patients died within 24 hours of admission.	During 2021/22, a review of some of these patients will be undertaken to ascertain further understanding of patient pathways and these reviews will be included in the Trust's ongoing work, alongside commissioners and other System partners.

Issues And Risks	Mitigations
The issue is that some patients admitted to hospital during their end of life phase may represent a failure in advanced care plans resulting in an unplanned admission to an acute hospital, for end of life care. It is ackowledged that an unplanned admission to the acute hospital and the admissions process via Emergency Department (ED) does not represent good care for patients who are actively at end of life. The Trust's SHMI is now normalised, but the out of hospital SHMI remains high. Patients admitted at EOL due to a breakdown in advanced care plans, even if they are fastracked home / community care, will feature within the Trust's SHMI.	EOL is one of the Trust's priorities and reports into the Mortality Improvement Group. The Trust also work closely with community partners to review System themes for sharing and learning. This indicator will support this continued focus.

Indicator: QS028 Reduction in the number ofdischarges in relation to emergency admissions for people in the last three months of life

Period	Lower CL
Jul 2021	82.55

Value	Mean
107	129.81

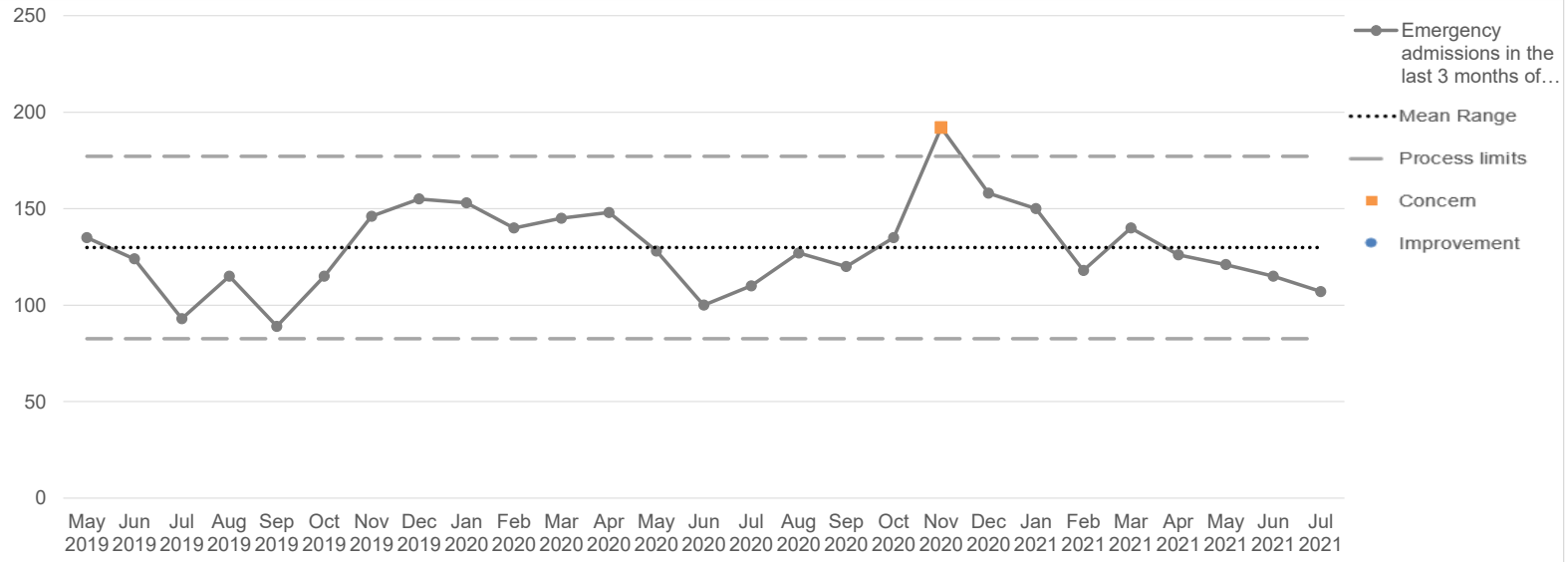
Target	Upper CL
No target	177.08

Variance

Common cause - no significant change

Assurance Inconsistency

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



Background And What Is The Chart Telling Us?	Actions
To support the Trust's focus on end of life improvements and the Trust's aim to reduce the out of hospital SHMI this indicator is a new addition to the IPR. Taken from the EOL strategy, this indicator aims to support an ongoing review of EOL pathways to identify learning for improvement across the wider healthcare system with the aim of improving the quality of advanced care planning to reduce the number of emergency admissions to hospital in the last 3 months of a persons life. The aim of this indicator is to support EOL pathway improvement, however it is not possible to identify from the data those patients at EOL so this includes an assessment of all patients identified as having died within Hospital and within 30 days of discharge who had one or more emergency (unplanned) admissions to the Trust's acute hospitals in the last 3 months of life. The data presented in the chart is at patient level. During July, 107 individual patients died who had one or more previous emergency admissions - based on the date of discharge - in the lead up to the date of death.	A sample of these patients pathways will be reviewed with community partners to understand the patient journey and to identify key themes for sharing and learning from. This will be shared with the Trust's EOL group to inform the ongoing delivery of the EOL strategy and improvement plan.

Issues And Risks	Mitigations
The issue is that some patients admitted to hospital during their end of life phase may represent a failure in advanced care plans resulting in an unplanned admission to an acute hospital, for end of life care. It is ackowledged that an unplanned admission to the acute hospital and the admissions process via ED does not represent good care for patients who are actively at end of life. The Trust's SHMI is now normalised, but the out of hospital SHMI remains high. Patients admitted at EOL due to a breakdown in advanced care plans, even if they are fastracked home / community care, will feature within the Trust's SHMI.	EOL is one of the Trust's priorities and reports into the Mortality Improvement Group. The Trust also work closely with community partners to review System themes for sharing and learning. This indicator will support this continued focus.

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: QS022 Inpatient Friends and Family Test - percentage positive

Period	Lower CL
Jul 2021	

Value	Mean
92.87%	

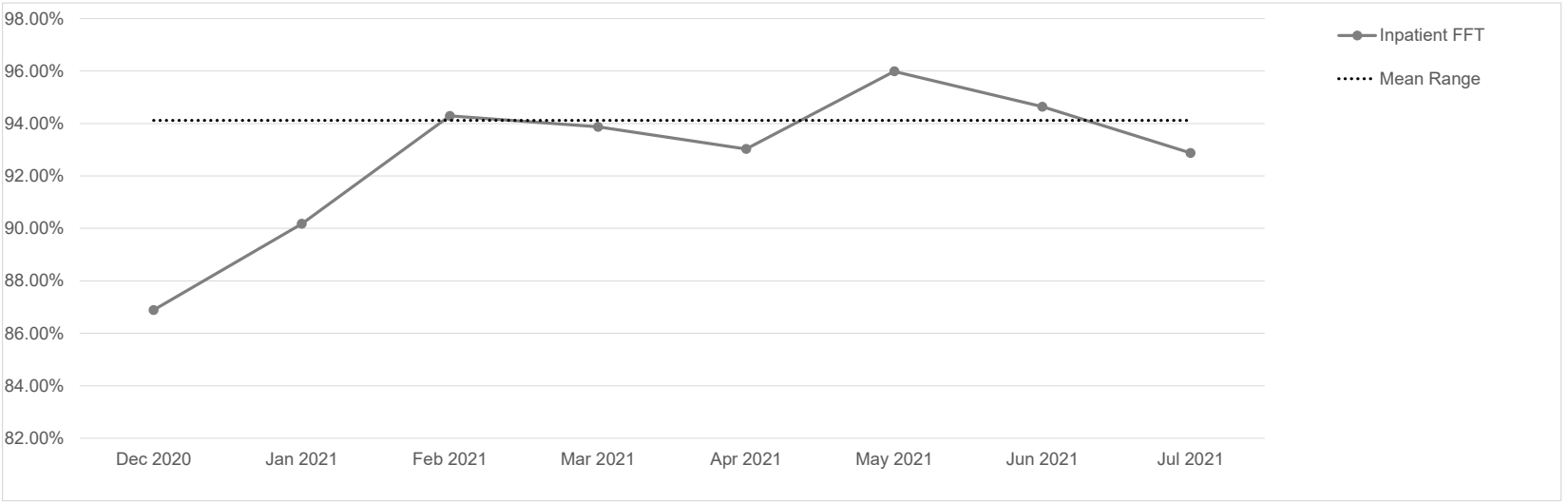
Target	Upper CL
No target	

Variance

There is currently insuffcient data for an SPC chart.

Assurance Inconsistency

There is currently insuffcient data for an SPC chart.



Background And What Is The Chart Telling Us?	Actions
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. 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.	> Monthly FFT Oversight Meetings refreshed > Weekly meetings with IWANTGREATCARE and monthly performance meetings > Monthly message and data sharing through Nursing & AHP leadership community > Review of paper solution ordering to esnure good stock levels > IWANTGREATCARE to support further with staff engagement

Issues And Risks	Mitigations
Staff engagement with process resulting in poor response rates Delays in stock ordering Difficulties using data due to low numbers	Monthly performance meeting with IWANTGREATCARE from July Review of paper processes commenced Consistent message to staff to utilise methods available

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: QS023 A&E Friends and Family Test - percentage positive

Period	Lower CL
Jul 2021	

Value	Mean
77.09%	

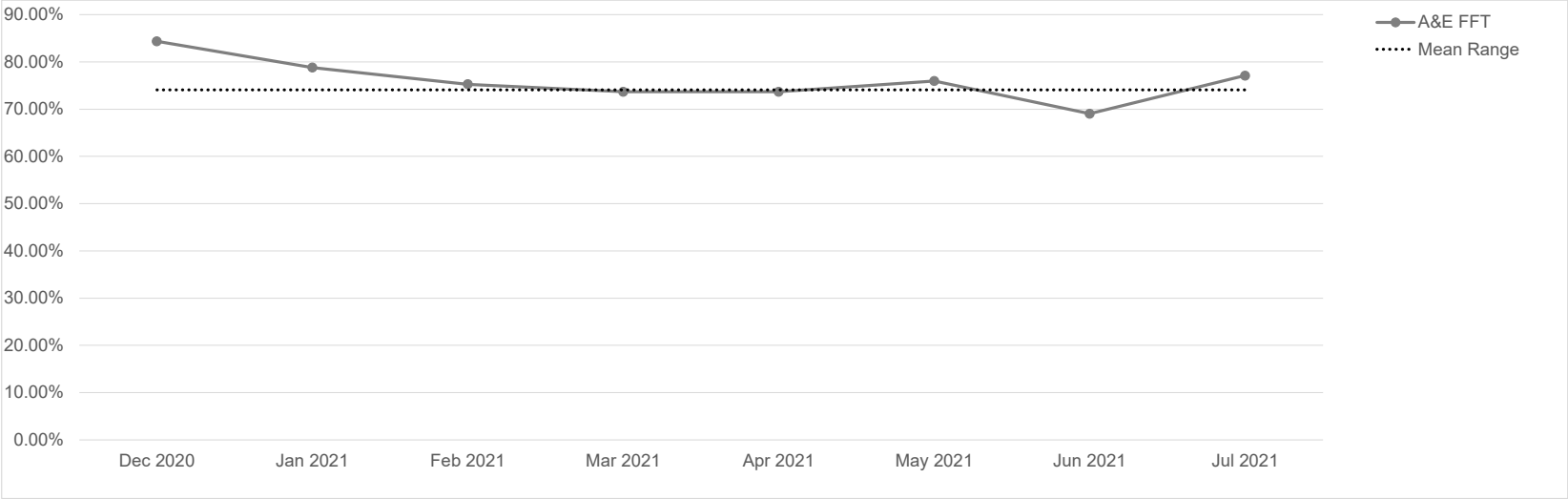
Target	Upper CL
No target	

Variance

There is currently insuffcient data for an SPC chart.

Assurance Inconsistency

There is currently insuffcient data for an SPC chart.

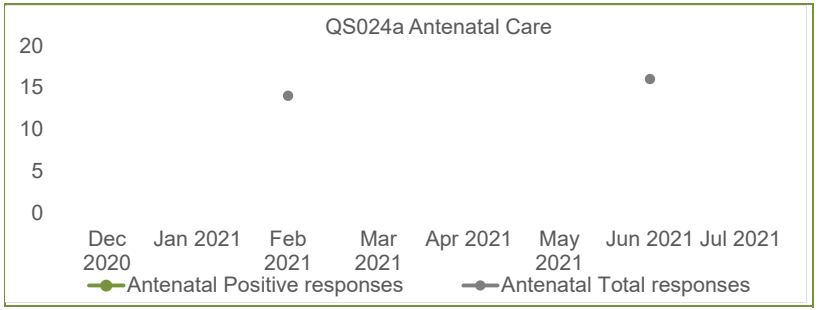


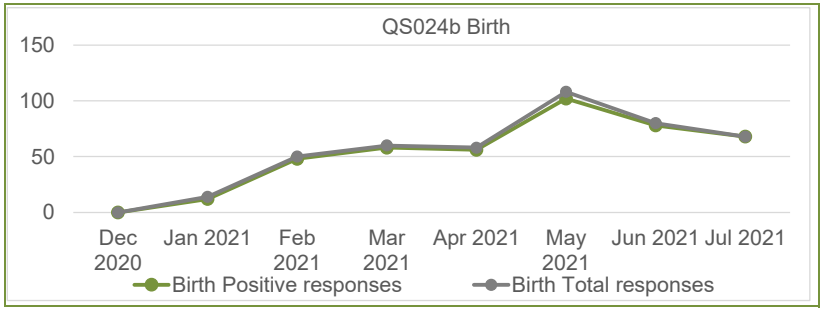
Background And What Is The Chart Telling Us?	Actions
The Friends and Family Test is a mandated patient experience measure which enables patient insights to gathered across all services within the Trust. During the COVID pandemic all mandated collection and reporting of data was paused until December 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 COVID19. Emergency Care Centre (ECC) FFT is collected via SmS/ paper/QR Response rates still require increasing to ensure the patient voice is representative in extracting information from the themes.	> Monthly FFT Oversight Meetings refreshed > Weekly meetings with IWANTGREATCARE and monthly performance meetings > Monthly message and data sharing through Nursing & AHP leadership community > Review of paper solution ordering to esnure good stock levels > IWANTGREATCARE to support further with staff engagement > IWANTGREATCARE developing tracker to montior "drop off point " in SmS journey and identify ongoing solution

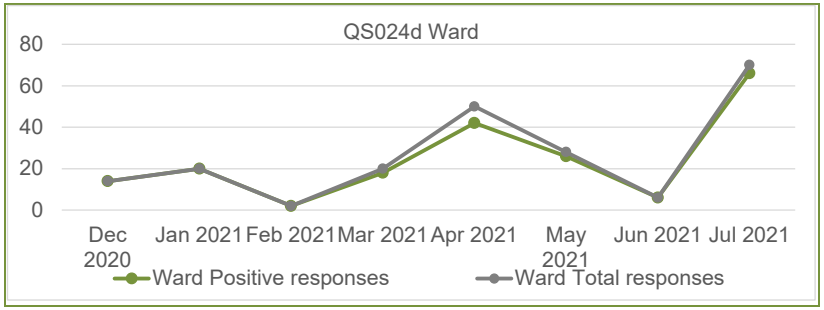
Issues And Risks	Mitigations
Staff engagement with process resulting in poor response rates Delays in stock ordering Difficulties using data due to low numbers	Monthly performance meeting with IWANTGREATCARE from July Review of paper processes commenced Consistent message to staff to utilise methods available

Indicator: QS024 Maternity Friends and Family Test - number of responses

Jul 2021







Background And What Are The Tables Telling Us?	Actions
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. maternity FFT is delivered via SmS/ QR/paper. Response rates still require increasing to ensure the patient voice is representative in extracting information from the themes.	> Monthly FFT Oversight Meetings refreshed > Weekly meetings with IWANTGREATCARE and monthly performance meetings > Monthly message and data sharing through Nursing & AHP leadership community > Review of paper solution ordering to esnure good stock levels > IWANTGREATCARE to support further with staff engagement

Issues And Risks	Mitigations
Staff engagement with process resulting in poor response rates Delays in stock ordering Difficulties using data due to low numbers	Monthly performance meeting with IWANTGREATCARE from July Review of paper processes commenced Consistent message to staff to utilise methods available

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: QS025 Community Friends and Family Test - percentage positive

Period	Lower CL
Jul 2021	

Value	Mean
92.86%	

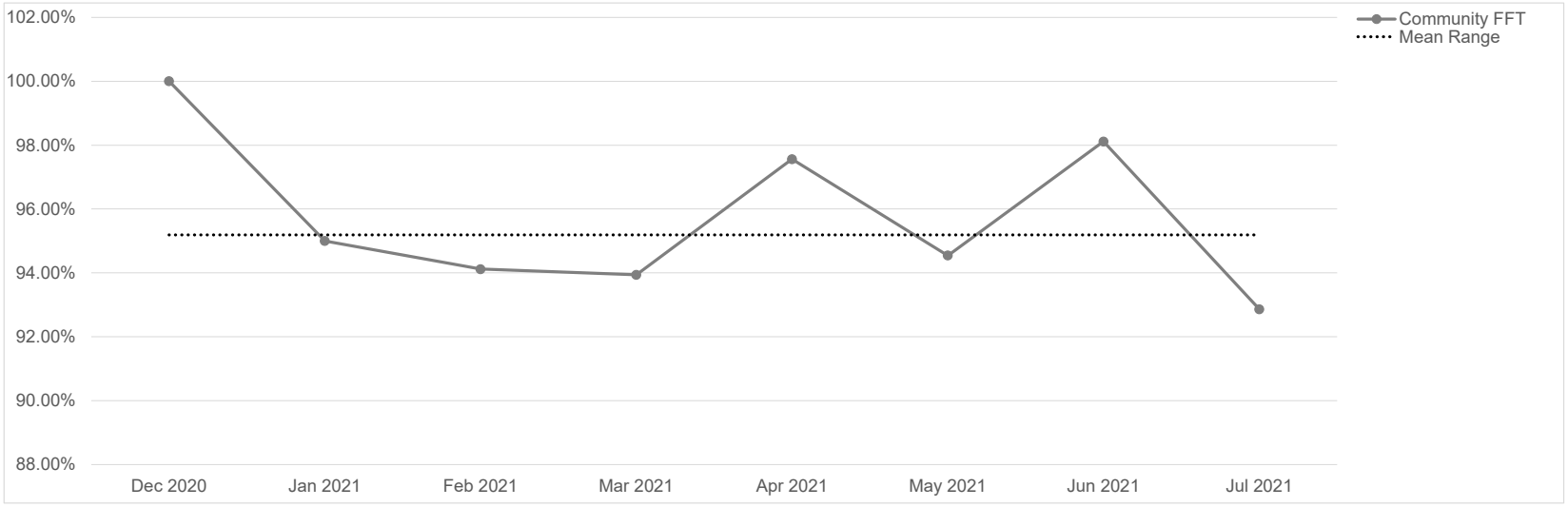
Target	Upper CL
No target	

Variance

There is currently insuffcient data for an SPC chart.

Assurance Inconsistency

There is currently insuffcient data for an SPC chart.



Background And What Is The Chart Telling Us?	Actions
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.Community FFT is delivered via paper/online/QR. Response rates still require increasing to ensure the patient voice is representative in extracting information from the themes.	> Monthly FFT Oversight Meetings refreshed > Weekly meetings with IWANTGREATCARE and monthly performance meetings > Monthly message and data sharing through Nursing & AHP leadership community > Review of paper solution ordering to esnure good stock levels > IWANTGREATCARE to support further with staff engagement > Full internal review of community services to create improved collection systems

Issues And Risks	Mitigations
Staff engagement with process resulting in poor response rates Delays in stock ordering Difficulties using data due to low numbers	Monthly performance meeting with IWANTGREATCARE from July Review of paper processes commenced Consistent message to staff to utilise methods available

Indicator: QS029 Out of hosptial SHMI

Period	Lower CL
Mar 2021	126.19

Value	Mean
128.65	135.16

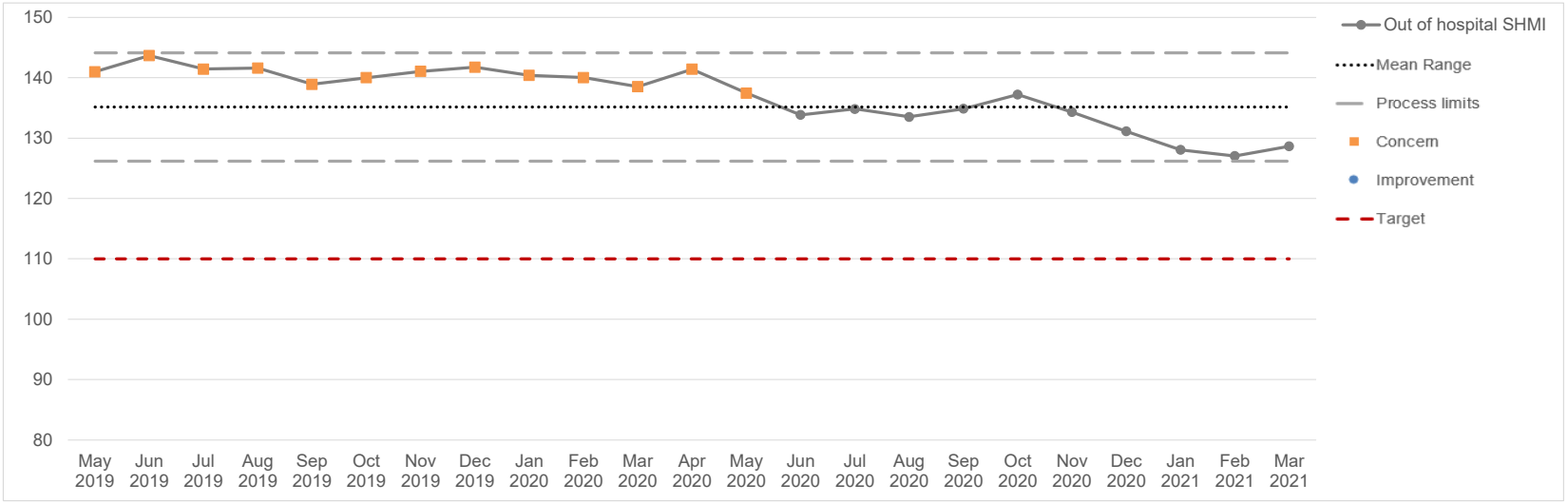
Target	Upper CL
110.00	144.13

Variance

Common cause - no significant change

Assurance Inconsistency

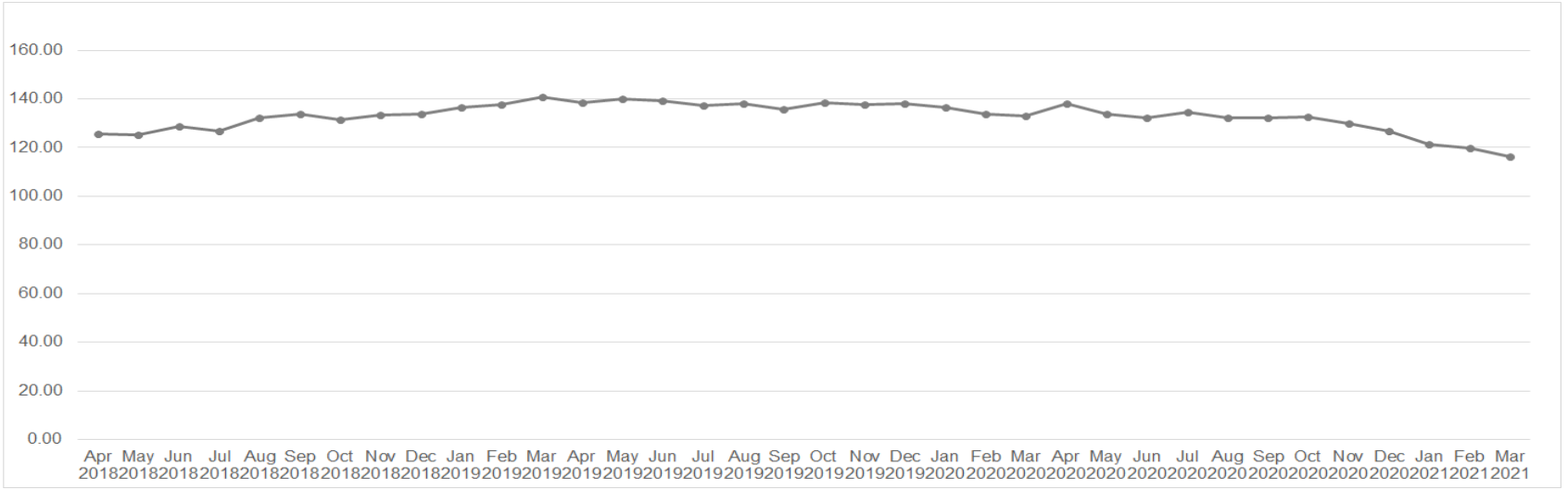
Variation indicates consistently falling short of the target



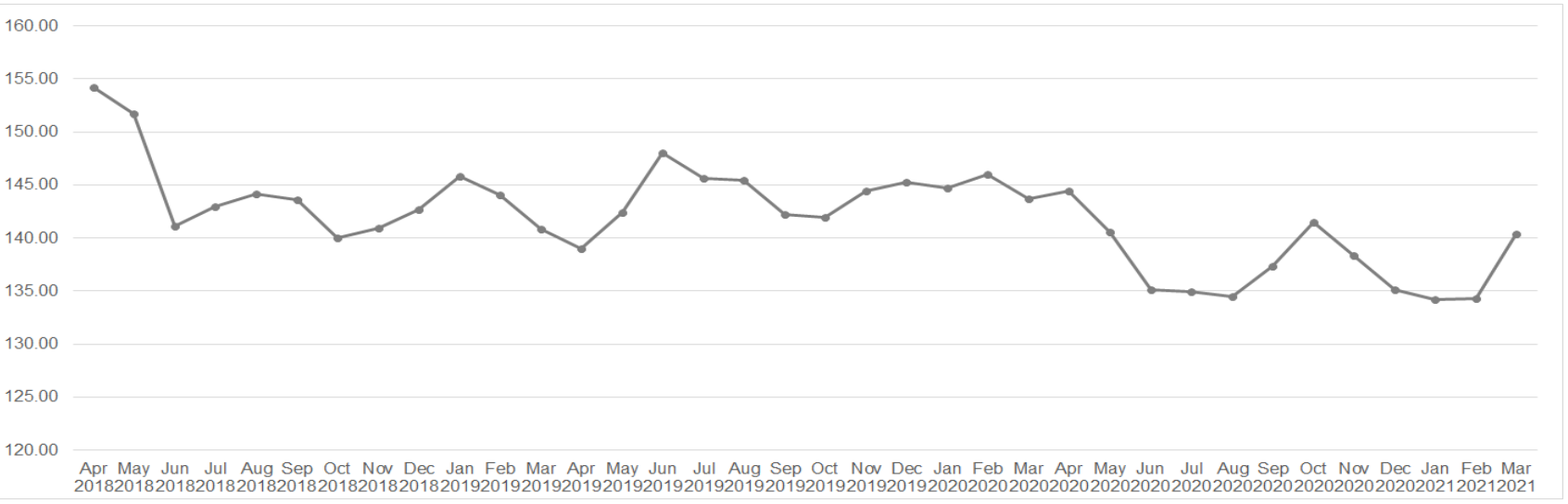
Background And What Is The Chart Telling Us?	Actions
The SHMI is made up of the in-hospital and out-of-hospital component parts. The monthly official SHMI relase is presented as a headline indicator including both components. Further analysis using the HED data is required to breakdown into the in-hospital and the out-of-hospital SHMI. This data is therefore the HED SHMI data. The HED model is rebased monthly which reduces the impact on the data by an annual rebasing, as seen this month in the official national SHMI release. The Trust's SHMI has reduced significantly but this has been driven largely by the in-hospital SHMI reduction, out-of-hospital (<30 days of discharge) SHMI remains high with the average ~128. The data does demonstrate a reduction in the out-of-hospital SHMI since November 2020. This appears to be be being driven by the NL out-of-hospital SHMI performance. NEL data remains static.	Local CCGs have set up and established an out of hospital oversight group. The Trust collaborates with the CCGs to undertake end to end mortality reviews to identify learning when patients are felt to have been admitted to hospital when this could have been avoided. NHSE/I have been reviewing care at EOL and have reported their findings to MIG and the Strategic EOL group. It is likely this will support greater articulation of the issues that need further work/action. Action plans in response are being developed by System partners and will be overseen by the Strategic EOL group.

Issues And Risks	Mitigations
The Trust's OOH SHMI is high and could negatively impact the Trust's headline SHMI figure. Benchmarking with local peers identifies the Trust as having a higher OOH SHMI rate.	Ongoing review work to understand and share themes for improvement.

QS029 Site specific rolling 12 month out of hospital SHMI - SGH



QS029 Site specific rolling 12 month out of hospital SHMI - DPoW



Indicator: QS030 Structured Judgement Review (SJR) in 100% of those requiring a review

Period	Lower CL
Jul 2021	60.88%

Value	Mean
31.00%	83.39%

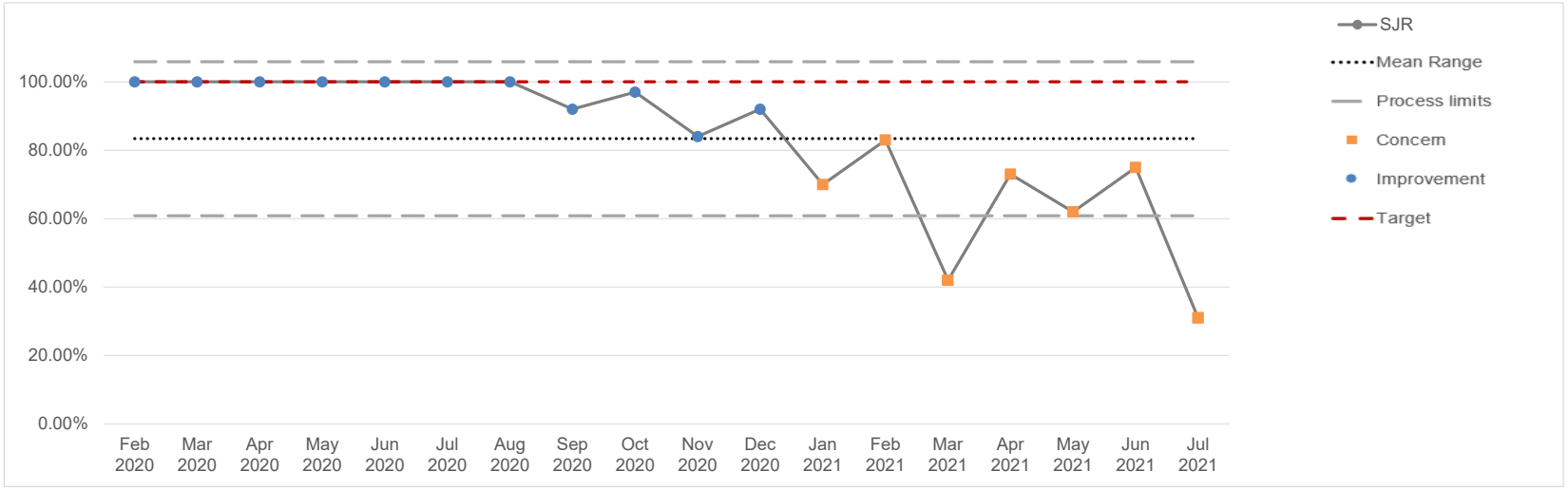
Target	Upper CL
100.00%	105.90%

Variance

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

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
The chart tells us that cases requiring more detailed review using SJR are currently not being completed in a timely manner which has resulted in a backlog. The Trust is ensuring these cases are reviewed, but at present this is not within agreed timescales. It should be noted that the most recent months reported data should be interpreted with caution as reviewers are provided with 6-weeks to undertake a review so the latest available data may not reflect cases still being reviewed in line with these timescales. PLEASE NOTE Data shown reflects the month of July 21 as run on 27th August 21	The Trust's Mortality Improvement Group oversees this alongside other mortality performance indicators. This has been added to the Trust's risk register as an identified risk. NHSE/I have supported the Trust during August with some targetted SJR training for clinical staff to help improve the number of trained reviewers and improve the quality and consistency of reviews being undertaken. In Medicine this has resulted in 50 staff being trained with further plans in place for trainee doctors and other Divisions. Access is now being organised for these staff to the electronic SJR system to enable them to receive cases for their review using the e-SJR and their training. This should support more timely initial review using SJR by broadening the number of trained reviewers available. Specific gaps have been identified in some medicine sub-specialties at DPoW which have been escalated to the Divisional Clinical Directors (DCDs) in Medicine for support in resolving. This has resulted in a focussed review of older cases still outstanding to good effect. Further work is now underway to chase down these specific cases forming the backlog.

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

Indicator: QS032 Adults: Timeliness of observations within 30 minutes of due time

Period	Lower CL
Jul 2021	86.49%

Value	Mean
91.00%	89.08%

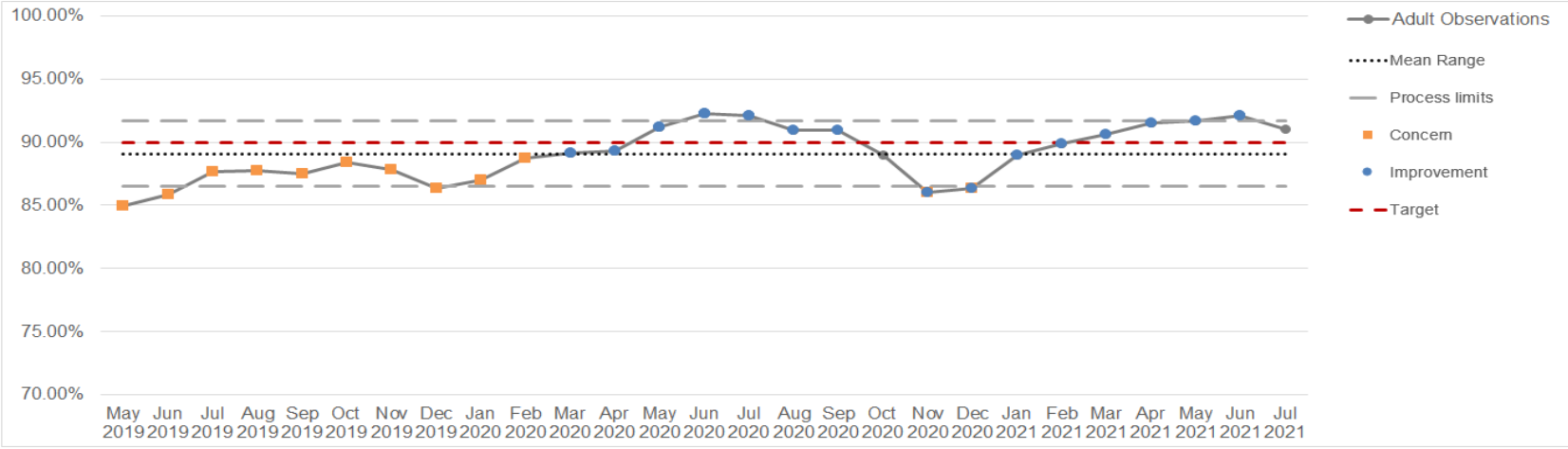
Target	Upper CL
90.00%	91.67%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
This data includes all adult patients that have there observations completed on time (+30 minute grace period). It is based on the use of the National Early Warning Score (NEWS) which enables early identification and prioritisation of patients at risk of deterioration and is the national standard. The source of the information is the Trust's WebV system. The chart tells us that the Trust has met the 85% target for the 20/21 period. There are some dips seen in performance during Wave-2 pressures of Covid-19 during November and December linked to time required to don/doff PPE. Despite the significant challenges from the pandemic, performance has remained above the target set. For 2021/22 the target has been increased from 85% to 90%. Since April 2021 the 90% target has consistently been met.	Ongoing oversight by the Deteriorating Patient and Sepsis group. Work is underway to seek assurance on the action taken in response to NEWS observations.

Issues And Risks	Mitigations
None.	N/A

Indicator: QS033 Children: Timeliness of observations within 30 minutes of due time

Period	Lower CL
Jul 2021	60.27%

Value	Mean
83.33%	89.90%

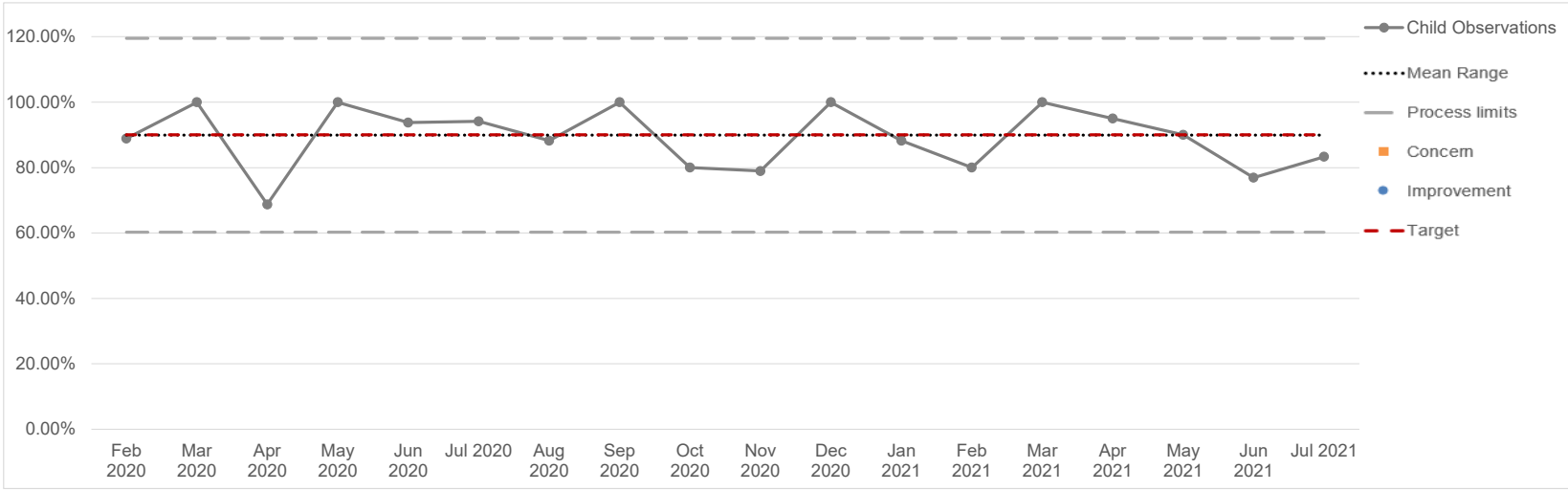
Target	Upper CL
90.00%	119.54%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
The spot checks are undertaken on the paediatric wards at each site (Disney at SGH and Rainforest at DPOW) by the ward managers. 10 children per site are identified randomly based on those on each ward at the time of data collection on a monthly basis (if fewer than 10 on the ward, all patients will be audited). The target for 21/22 has been increased to 90% alongside the adult (NEWS) indicator. Performance in June and July 2021 has been below the 90% target. July data is 83.33%.	This is an area of continuous audit data collection within the Division and is overseen regularly.

Issues And Risks	Mitigations
None.	N/A

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: QS045 Diabetes Audit Finding

Period	Lower CL
Jul 2021	

Value	Mean
81.21%	

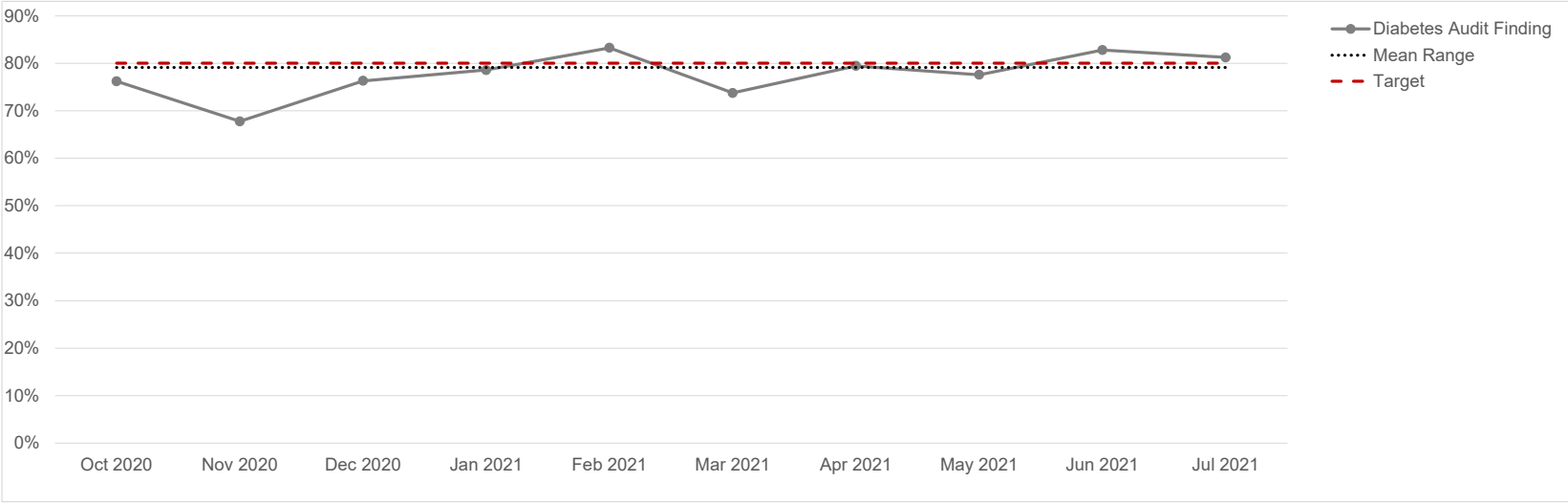
Target	Upper CL
80.00%	

Variance

There is currently insuffcient data for an SPC chart.

Assurance Inconsistency

There is currently insuffcient data for an SPC chart.



Background And What Is The Chart Telling Us?	Actions
The chart provides the average results from the 4 main elements of the audit standards set. The audit includes a focus on patients who have been prescribed insulin and/or sulphonylureas who are outside of the target range (below 4 - Hypo or above 11 - Hyper). The standards are: 1) Minimum monitoring of 4 times per day, over previous 7 days (dependant on length of stay (LOS)) 2) Blood glucose readings should be undertaken within 2-3am timeframe 3) Blood glucose readings should be repeated 10-15 minutes after the hypoglycaemic episode 4) If unresolved, blood glucose readings should be repeated every 10-15 minutes until hypoglycaemia is resolved. The audit demonstrates that improvements in the management of hypoglycaemia are indicated, specifically in relation to standards 3 and 4.	The Audit data is overseen by the Diabetes Task and Finish group. This group links closely with nursing teams to support focussed education and awareness raising regarding diabetes management.

Issues And Risks	Mitigations
None.	N/A

Indicator: QS046 Blood glucose taken in ECC if NEWS over 1 for adults

Period	Lower CL
Jul 2021	81.00%

Value	Mean
95.00%	94.45%

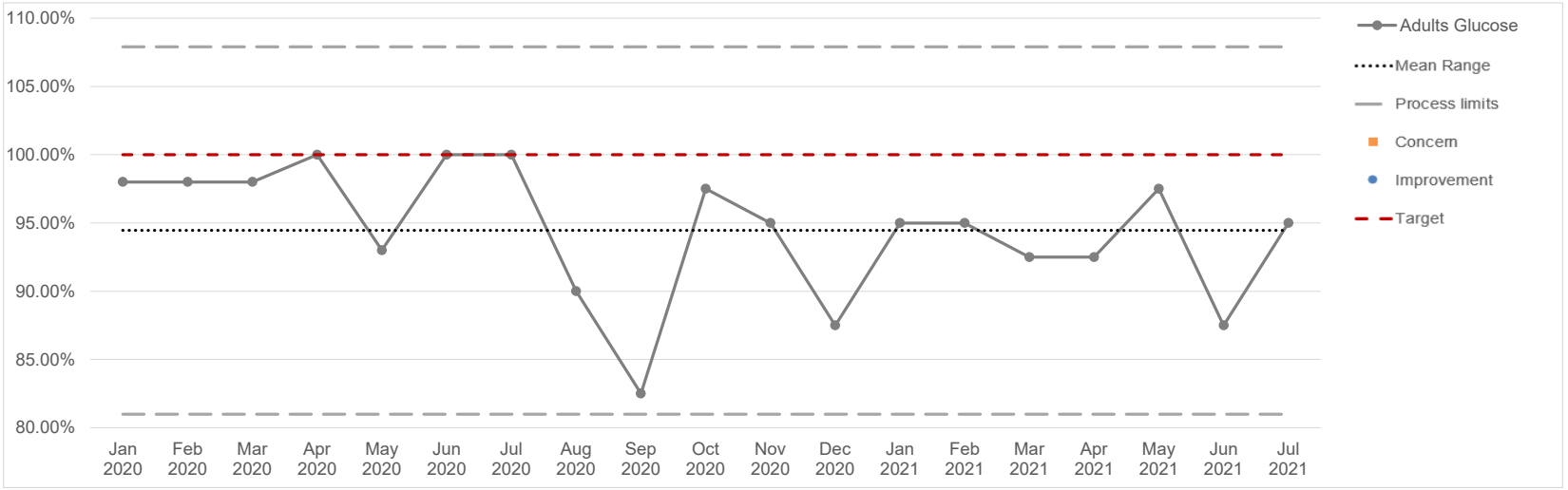
Target	Upper CL
100.00%	107.90%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
A random sample of patients (Adult and Paediatric) presenting to the ED are extracted from Symphony (A&E Record) in each time period with abnormal vital signs with a NEWS or PEWS of 1 or more. These cases are then audited with data accessed from Symphony, Web V and ECC documentation to determine if blood glucose was recorded. In the case of Children, the Paediatric Nursing Team, will sometimes determinine that blood glucose recording is not clinically indicated. In these instances, if this decision has been recorded, these children will be excluded from the analysis against this standard. Paediatric audit results are shared with the Matron for the team to identify any learning and ensure this is shared. The chart is telling us that for adults, on average for this period, 94% of patients with a NEWS score indicating the need for blood glucose to be recorded have had this recorded within the Trust's Emergency Department. The month of July demonstrates 95% compliance.	Ongoing oversight by the Diabetes Task and Finish group.

Issues And Risks	Mitigations
None.	N/A

Indicator: QS047 Blood glucose taken in ECC if PEWS over 1 for children

Period	Lower CL
Jul 2021	62.25%

Value	Mean
82.50%	82.76%

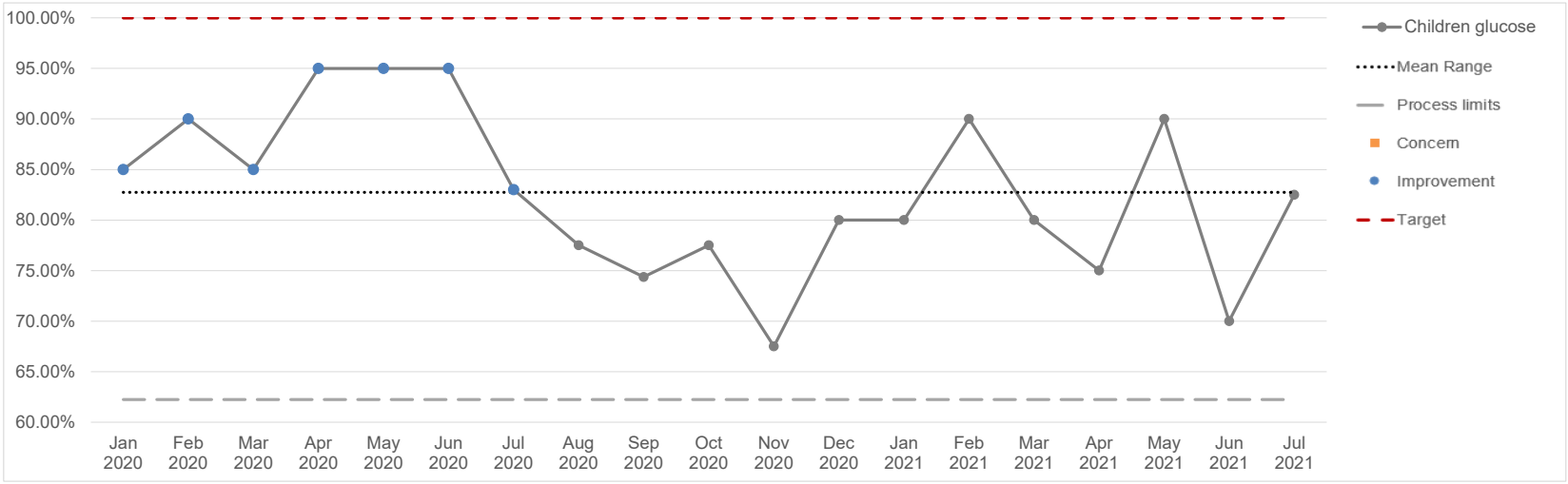
Target	Upper CL
100.00%	103.26%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
A random sample of patients (Adult and Paediatric) presenting to the ED are extracted from Symphony (A&E Record) in each time period with abnormal vital signs with a NEWS or PEWS of 1 or more. These cases are then audited with data accessed from Symphony, Web V and ECC documentation to determine if blood glucose was recorded. In the case of Children, the Paediatric Nursing Team, will sometimes determinine that blood glucose recording is not clinically indicated. In these instances, if this decision has been recorded, these children will be excluded from the analysis against this standard. Paediatric audit results are shared with the Matron for the team to identify any learning and ensure this is shared. The chart is telling us that for adults, on average for this period, 83% of children with a PEWS score indicating the need for blood glucose to be recorded have had this recorded within the Trust's Emergency Department. The month of July demonstrates 83% compliance.	The BM taken in ED has fluctuated. The addition of the PEN team has led to a change to be set down in protocol, to allow for clinical judgement from a Paediatric expert. Paediatric cases are being reviewed in more detail with the Paediatric team each month to understand the involvement in the case of the Paediatric Nursing Team and whether there is evidence that not undertaking Blood Glucose investigations was as a result of a clinical judgement. When the findings from this review identify learning for the PEN team around the need to undertake blood glucose monitoring unless it is not clinically indicated and if not, to ensure this is clearly recorded, this is shared with them via the Matron.

Issues And Risks	Mitigations
The change in protocol to, in certain clinicially indicated situations, not undertake blood glucose recordings for children is monitored by the audit and a review and validation of this is completed each month with the PEN team.	Ongoing oversight and monitoring by paediatric and ED teams. Quality Governance Group (QGG) supported a proposal in June for the standards in this audit to change to reflect the input of the PEN team removing the need for a blood sugar in all cases, and allows senior clinical judgement to be taken into account. This has been reflected in the SOP. Ongoing validation of the data each month with the Paediatric team.

Indicator: QS048 Diabetes role specific training compliance

Period	Lower CL
Jul 2021	76.61%

Value	Mean
87.97%	81.24%

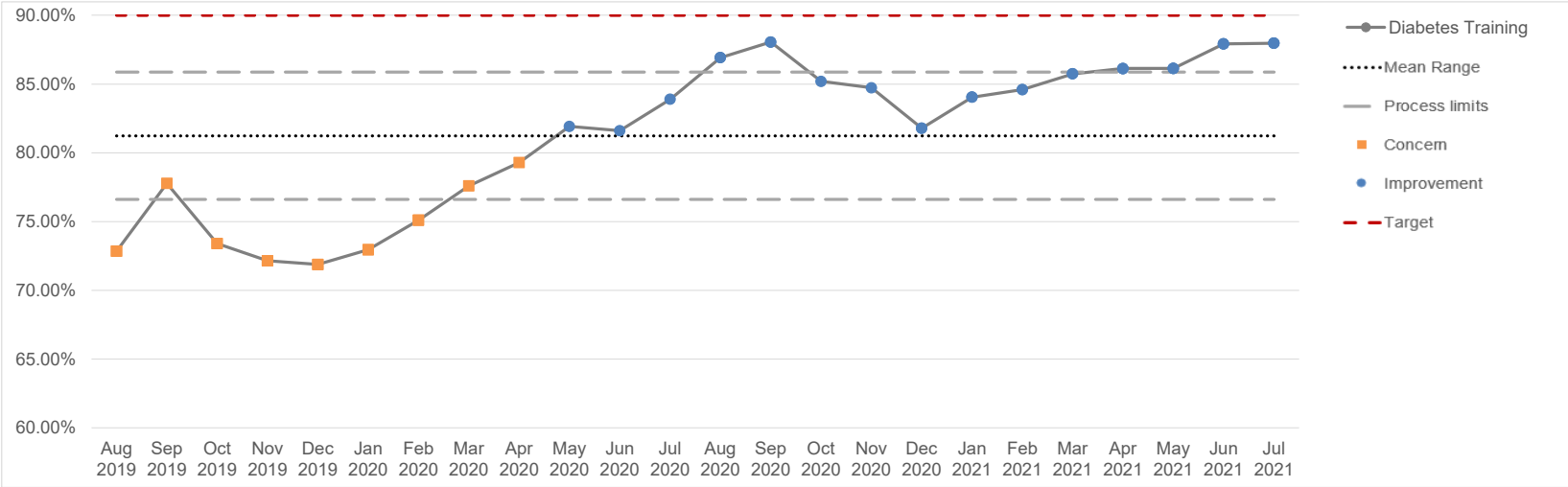
Target	Upper CL
90.00%	85.87%

Variance

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

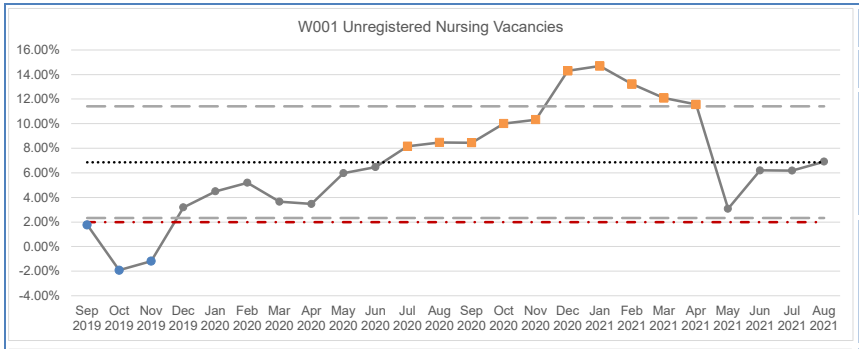
Assurance Inconsistency

Variation indicates consistently falling short of the target

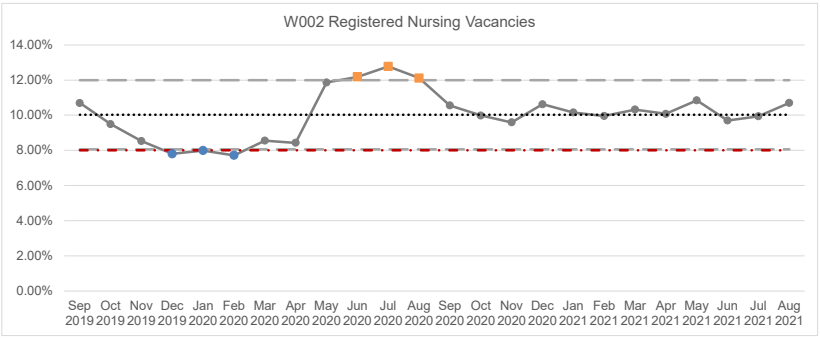


Background And What Is The Chart Telling Us?	Actions
The data here is taken from mandatory training records for medical and nursing staff who are required to undertake the Safe Use of Insulin mandatory training. The chart tells us that for July 2021 more than 87% of applicable staff have completed mandatory training regarding the safe use of insulin. The chart shows a gradual increase from December 2020. Whilst improving, the target of 90% has not yet been attained.	This is overseen by the task and finish group established to support a focus on the diabetes quality priority and at Safer Medication Group.

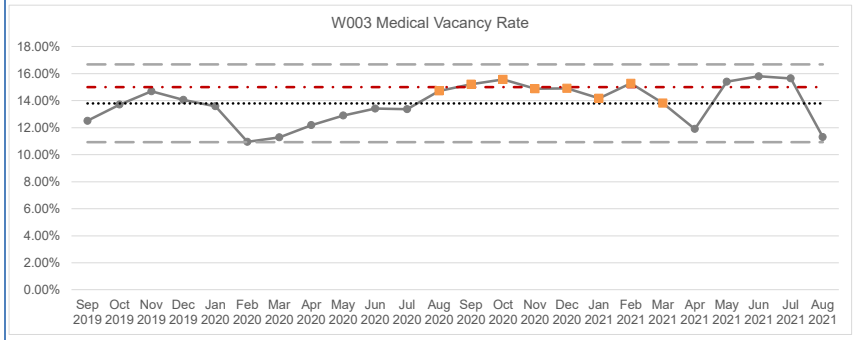
Issues And Risks	Mitigations
While the overall training figures are good, there are areas where there is lower compliance, particularly Medical staff .	N/A



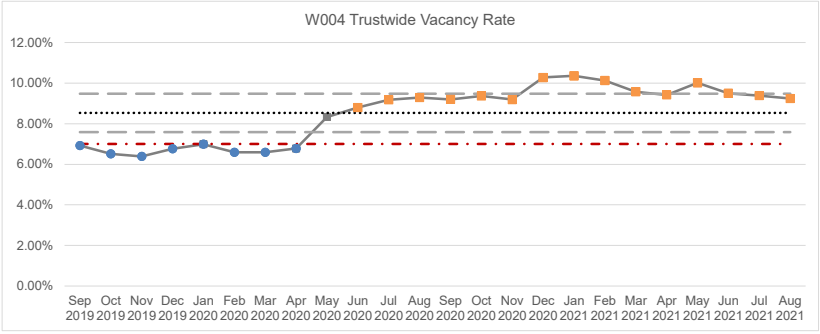
Aug 2021	Target	Variance	Assurance
6.92%	2.00%	Common cause - no significant change	Variation indicates consistently failing short of the target



Aug 2021	Target	Variance	Assurance
10.70%	8.00%	Common cause - no significant change	Variation indicates consistently failing short of the target



Aug 2021	Target	Variance	Assurance
11.31%	15.00%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the traget



Aug 2021	Target	Variance	Assurance
9.24%	7.00%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates consistently failing short of the target

Analytical Analysis:

Nursing vacancies (Unregistered and Registered): Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Medical Vacancy Rate: Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Trustwide Vacancy Rate: Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or deteriorating performance. This process is not capable. It will FAIL the target without process redesign.

Operational Commentary:

Unregistered Nursing Vacancies: The unregistered nursing (HCA) vacancy rate has dropped considerably since the implementation of a recruitment project aiming to achieve an operational zero vacancy rate (operational zero accounts for normal levels of turnover). This was achieved through collaboration with Indeed aiming to source candidates without prior formal healthcare experience and a review of recruitment processes. This includes the formation of a pool of HCAs appointed ready for allocation to vacancies as they arise. The vacancy rate has risen in month due to an increase in leavers. **Issues/Risks:** Retention of HCAs, particularly new starters. Unfamiliarity with the role and expectations of what the role entails influencing decisions to leave. **Mitigations:** Large pool of HCAs appointed awaiting allocation and continued recruitment to this pool. Implementation of information regarding the HCA role to new starters without prior healthcare experience. A project group led by the Chief Nurse's office to oversee activity. Update position: The adjusted vacancy report equates to 53.98 WTE vacancies when 13.80 WTE not being recruited to are removed. The current pipeline is 46 WTE within the pool. Of these 19 have completed employment checks and are awaiting allocation, 27 are undergoing pre-employment checks. **Actions:** Continue advertising to maintain the pool of HCA appointments ready for allocation. Implement changes for the recruitment of new HCAs, including webinars and talks on the role in detail and a "day in the life" to manage expectations.

Registered Nursing Vacancies

The vacancy rate saw an increase in April 2021 due to an increase in establishment, the rate has since dropped due to pre-registered nurses starting in post. The vacancy rate in month has remained stable. Regular recruitment activity is underway sourcing candidates from overseas via the internal Talent Acquisition Team, and via an agreement with Yeovil NHS Trust, and regular ongoing activity. **Issues/Risks:** Travel difficulties are impacting upon start dates for international nursing cohorts. Issues with identifying and allocating appropriately skilled candidates to wards/specialties in a timely manner is impacting upon the withdrawal rate of candidates sourced via Yeovil and delays in the timesclaes initially agreed with NHSE/I. The shortlisting, recruitment and allocation process are revised, and onboarding and pastoral support are strengthened. This will impact on reducing the overall vacancy rate as initally planned and continued high spend on temporary staffing. **Actions:** Newly qualified nurse (NQN) recruitment with 73 in the pipeline due to commence between September and October. Continue sourcing of nursing candidates via the Talent Acquisition Team - Domestic and international. Continued engagement with both Chief Nurse Directorate and Operations to review existing recruitment practices has resulted in the implementation of a new process for selection and allocation. Development of a 3 year Nurse Recruitment Strategy as part of the Nursing Strategy inclusive of all pipelines including apprenticeship development and a strengthened domestic presence in the existing market place. **Mitigations:** Ongoing recruitment activity for pre-registered nurses with a very large pool of candidates available. A project group led by the Chief Nurses office to oversee all activities. 20 nurses from overseas due to join in October, and a further 26 nurses from overseas planned to start in December. 73 newly qualified nurses commencing between September and October.

Medical Vacancies

The vacancy rate saw an increase in April 2021 due to an increase in establishment of 27.37 WTE. The vacancy rate remained steady until July. The drop seen in July is due to Foundation 1 trainees commencing shadowing as part of their trainees while existing Foundation 1 trainees were in post. The vacancy factor then rose in August due to a fill rate for trainees of 80.10%.

Issues/Risks: Travel restrictions are impacting upon start dates. Available accomodation can delay recruitment processes.

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

Mitigations: Recruitment team continuing to engage with candidates. Introduction of Talent Acquisition Team support in sourcing senior hard to fill medical staff posts introduced following a pilot within medicine to explore this methodology for medical staff. A large pipeline of 65 medical staff appointed and awaiting start between August and November has been established. A network of private landlords has been established to support accomodation needs where the Trust is unable to accomodate locally, and work undertaken by the onsite accommodation team to free up onsite accommodation.

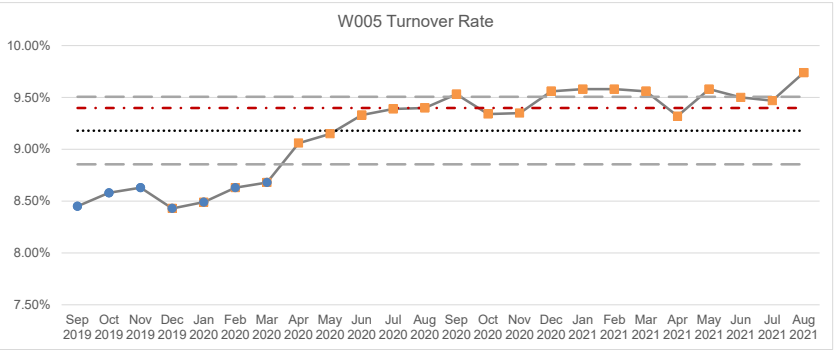
Trustwide Vavancy Rate

The overall vacancy rate saw an increase in April 2021 due to an increase in budgeted establishment of 86.31 WTE. The vacancy rate increased in month by 37.61 WTE, this is attributed to the trainee rotation and a slight increase in unregistered nursing vacancies Recruitment at an increased rate is ongoing, with recruitment activity increasing by 19.88% over the last 12 months, sourcing candidates locally, nationally, and internationally.

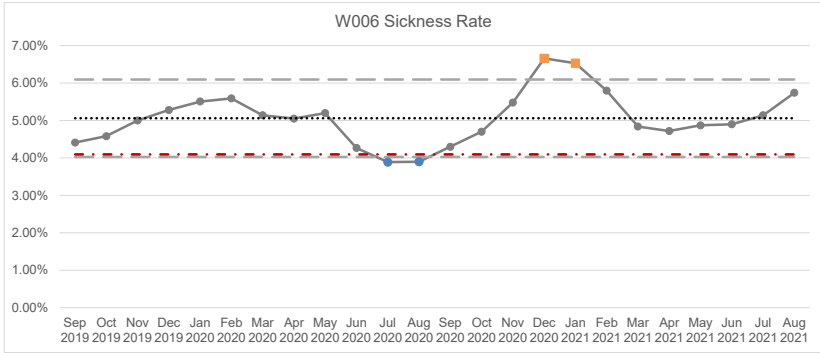
Issues/Risks: Travel difficulties are delaying starts for new employees coming from overseas.

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

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



Aug 2021
9.74%
Target
9.40%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
SPCVariation
Variation indicates inconsistently hitting passing and falling short of the traget



Jul 2021
5.14%
Target
4.10%
Variance
Common cause - no significant change
Assurance
SPCVariation
Variation indicates inconsistently hitting passing and falling short of the traget

Analytical Analysis:

Turnover Rate: Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or worse performance. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
Sickness Rate: Common cause variation, no significant change. It is extremely unlikely that this target will be achieved as the target line is very close to the lower process limit. Process redesign is required.

Operational Commentary

Turnover Rate
During August 2019 to April 2020 the Turnover Rate significantly improved. This has gradually deteriorated over time since the start of the pandemic in April 2020 to present. The latest turnover data point (9.84%) is over the Trust target of 9.4% which indicates that the turnover position is not improving or seeing signs of recovery in relation to pre-pandemic levels of turnover of 9%.
Issues/Risks: The risk of increase turnover ahead of recruitment is increased bank and agency costs and potential decrease in quality of patient care.
Actions: Greater understanding of leavers data via ESR data and exit questionnaires to understand any trends to form an appropriate response. An increased emphasis on prevention of avoidable leavers by improving culture (mid to long term goal) and strengthening leadership capability and behaviours where required. Creation of talent pools for high frequency leaver areas to ensure a quicker recruitment turnaround. Promote a leadership and career development framework and processes for the identification of high potential, feeding in to talent development and succession planning. Improve quality of PADR and coaching skill in line managers to strengthen engagement; implementation of culture and engagement programme of work focused on proactively improving engagement levels.
Mitigations: Planned earlier intervention in relation to known leavers. Creation of talent pools. Strengthen engagement levels; proactive health and wellbeing plan to address common themes affecting wellbeing-related retention.

Sickness Rate
The recent variation seen is common variation which shows no significant change and is within the control limits. Following the last covid wave and sickness peak in November 2020, sickness had been in decline and entered a period of plateau during the early part of 2021. The last couple of months has seen a slight increase in sickness but still within the control limits. Please note sickness will always be a month in arrears due to the extraction of information from the Health Roster System.

Sickness Rate cont/d

Issues/Risks: Staff who are isolating due to post travel, Household Member with Symptoms and Track and Trace are not reflected on the chart above, however this impacts staffing levels as the special leave type is starting to increase. Winter pressures combined with seasonal illness and covid are likely to increase levels of sickness both directly because of illness and indirectly because of increased pressures - fatigue, mental resilience and other mental health related issues .
Mitigations: Continued close monitoring of sickness levels with increased operational reporting - volume, trends & themes. Targeted preventative intervention in known high pressure areas. Greater levels of health and wellbeing resource via PEO and identified external funding. Greater levels of Occupational Health clinician time and on-site face to face counselling now in place.
Actions: The Trust has now employed a new Health and Wellbeing business partner to specifically drive the Health and Wellbeing agenda and commenced in post August 21. Daily sickness monitoring has recommenced with ICC and Infection Control lead to monitor specifically covid absences. A revised operational dashboard will be available in October that will allow managers to have a greater level of access to data in relation to sickness which will support the wider management. Targeted preventative work has commenced to support in high pressure areas such as ITU (critical care) with a specific focus on mental health and resilience. The Flu campaign has now launched with delivery via the peer vaccinator model with a later link into the covid hubs. The covid booster programme is due to be launched towards the end of September pending government advice. High levels of vaccination should translate into a reduced sickness level throughout the winter months.
Mitigations: Continued close monitoring of sickness levels with increased operational reporting - volume, trends & themes. Targeted preventative intervention in known high pressure areas. Greater levels of health and wellbeing resource via PEO and identified external funding. Greater levels of Occupational Health clinician time and on-site face to face counselling now in place.

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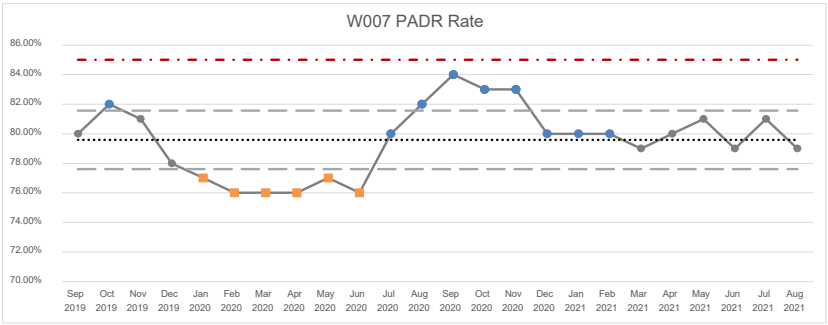
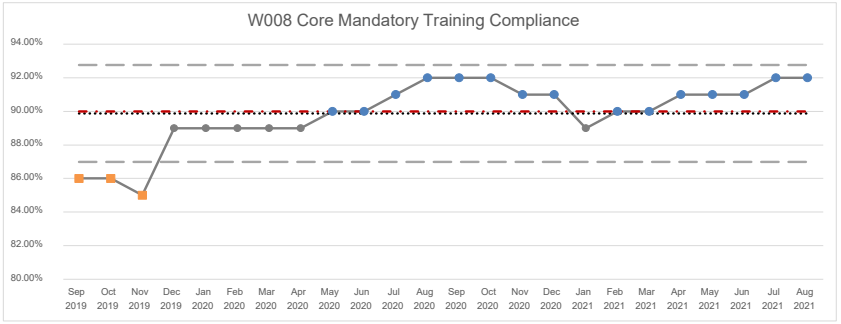
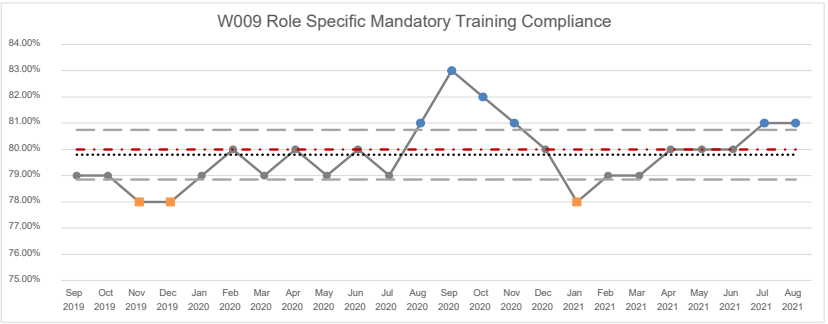


Aug 2021
79.00%
Target
85.00%
Variance
Common cause - no significant change
Assurance
Variation indicates consistently failing short of the target



Aug 2021
92.00%
Target
90.00%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Variation indicates inconsistently hitting passing and falling short of the traget



Aug 2021
81.00%
Target
80.00%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Variation indicates inconsistently hitting passing and falling short of the traget

Analytical Analysis:

PADR Rate: Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.
Core Mandatory Training: Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
Role Specific Mandatory Training: Special cause of improving nature where the measure is significantly higher than the average value. This occurs where there is improving performance. This system will not consistently hit or miss the target. (This occurs when the target lies between the process limits).

Operational Commentary:

PADR Rate:

The Trust wide non medical PADR compliance position currently stands at 81% this is below the Trust target of 90% . Please note that this figure does not include Medical Staff this is due to Medical Staff PADR's being extended for a 6 month period these are now excluded for this figure to show only non-medical appraisals **Issues/Risks:** Low PADR compliance will result in the risks moral, performance and demotivation.
Actions: The Training and Development Department will continue targeting Managers with low compliance by sending out reminders, and guidance for completion. We will continue to target and consider an escalation process for those areas not complying.
Mitigations: Historically the trend data shows that the Trust's PADR compliance has decreased for this time of year at as of August 2020 the PADR Position was at 84% . It is predicted that the PADR compliance will continue to rise over the next few months.

Core Mandatory Training Compliance
The Core Mandatory Training position currently stands at 92%. This continues to be above the Trust target of 90%, historically the trend data shows that the Core Mandatory Training compliance is around the same for this time of year, as of August 2020 the Core Mandatory Training Position was also at 92%.
Issues/Risks: Low MT compliance will result in the risks around safe and effective care. **Actions:** The Training and Development Department will continue targeting employees with low compliance by sending out reminders, guidance and workbooks for completion. We will continue to target and consider an escalation process for those areas not complying. The Training and Development Department will ensure all data is processed and support class administrators are supported with data collections. Auto enrolment has now been switched on in ESR making this easier for staff to complete eLearning modules. Work continues on the BI reporting tool and is due to be launched shortly with the HR Business Partners to work with their allocated areas. A review is currently been under taken on core mandatory and role specific training the aim of this work will streamline processes and as a result see an increase in compliance.

Core Mandatory Training Compliance cont/d

Mitigations: It is predicted that the Mandatory Training compliance will continue to remain above target due to the Actions that will take place. Over the last 3 months Core Mandatory Training compliance has increased and is now close to pre-COVID19 levels for this time of year. The Core Mandatory Training compliance position has been static for the last 3 months.

Role Specific Mandatory Training Compliance
The Role Specific Mandatory Training position currently stands at 82% (August 2021). This is within the Trust target of 80%, historically the trend data shows that the Role Specific Mandatory Training compliance is around the same for this time of year, as of August 2020 the Role Specific Mandatory Training Position was also at 83%.
Issues/Risks: Low MT compliance will result in the risks around safe and effective care.
Actions: The Training and Development Department will continue targeting employees with low compliance by sending out reminders, guidance and workbooks for completion. We will continue to target and consider an escalation process for those areas not complying. The Training and Development Department will ensure all data is processed and support class administrators are supported with data collections. Auto enrolment has now been switched on in ESR making this easier for staff to complete eLearning modules. Work continues on the BI reporting tool and is due to be launched shortly with the HR Business Partners to work with their allocated areas. A review is currently been under taken on core mandatory and role specific training the aim of this work will streamline processes and as a result see an increase in compliance.
Mitigations: It is predicted that the Mandatory Training compliance will continue to rise over the next few months due to the Actions that will take place. Role Specific Mandatory Training saw a rise in August and September last year, 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.

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)198

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Kate Wood, Medical Director and Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Angie Legge, Associate Director for Quality Governance with support from: Jenny Hinchliffe, Deputy Chief Nurse Mel Sharp, Deputy Chief Nurse Vicky Thersby, Head of Safeguarding Jane Warner, Head of Midwifery Maurice Madeo, Deputy Director of Infection Prevention Sara Wood, Lead Nurse for Patient Safety Jennifer Moverley, Head of Compliance Jeremy Daws, Head of Quality Assurance Kelly Burcham, Head of Risk
SUBJECT	Executive Governance Report
BACKGROUND DOCUMENT (if any)	None
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None
EXECUTIVE SUMMARY	Staffing pressures continue, particularly with a fresh rise in Covid-19. Mandatory training continues to be below target. .

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

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

Partnership & System Working			

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

Executive Governance Report

Dr Kate Wood, MD
Ellie Monkhouse, CN

Safe Staffing

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

Current Position	Risk	Mitigation
CHPPD 8.3 compared to national median of 9.1 and peer median 8.9. Combined fill rate dropped to 93.3% from 95% for May and June. Family Services fill rate 83.0%; drop of 9.7%. Substantive fill rate decreased for RNs and HCSWs. 16 wards with RN substantive fill rates on nights below 50%. RN vacancy 10.7%, 179.49 wte & HCSW vacancy 6.92%, 58.3 wte - both have increased slightly in July.	There is a risk to the quality and safety of care of patients on the wards due to availability of staff and poor bank and agency fill rates (Risk 2421 scored 25)	Safecare Live data reviewed daily at 10am. 3 x daily staffing reviews in place. Staffing red flag incidents monitored and actioned daily. 73 newly qualified nurses to join the Trust in Sept/Oct. International nurse recruitment continues with enhanced training and support. Block booking of regular agency nurses who are familiar with the wards. CNO ward establishment reviews
	Increased Complaints / PALS due to staffing levels	Family liaison assistants are supporting communication with families which is supporting frontline staff to prioritise bedside care. Additional funding secured to continue over the winter.
	Risk of increased sickness due to stress from pressures of Covid-19 and persistent staffing shortfalls	Trust wellbeing offer. Professional Voice email address. Leadership training is being offered to equip staff with skills to lead through this challenging period. Initiatives to help improve morale being explored.
Community nurse staffing remains under pressure – slight decrease in RN vacancies but increase in HCSW vacancies. 32 red flag incidents reported in July, an increase of 20 from June. 27 were related to staffing levels.	There is a risk to the quality and safety of patient care due to demand exceeding capacity, particular risk on evenings and nights (Risk 2921 scored 15)	Work ongoing to fill vacancies with support from the Talent Acquisition Team. Bank staff to increase staffing on an evening and overnight whilst consultation completed re shift patterns. Electronic allocation system go live from 21.09.21 to assist with allocating work and capacity and demand modelling. Participating in national project for safe staffing tool for community.
Midwife: Birth ratio 1:24.9 in May (below 1:28 & in line with national guidance)	Risk to the quality and safety of care due to shielding as a result of contact tracing, and at SGH as a result of long term sickness and vacancies	Escalation processes and plans are in place with daily oversight from the head of Midwifery. Actively recruiting to fill vacancies

IPC

Aim: To minimise cross infection to maintain patient safety

Current Position	Risk	Mitigation
The period of July and August has seen a dramatic rise in the number of COVID cases admitted being identified. June 5, July 83, August to date >190. With the staffing sickness levels and changes to the isolation guidance this has unfortunately resulted in an increase in hospital onset cases. New IPC assurance framework and estates HTM 03-01 with emphasis on hierarchy of controls, with greater emphasis on mechanical ventilation Updated national IPC guidance – very little change. Reinforcing continuation of IPC precautions.	Prevalence of COVID remains high and above the UK levels. This is a significant issue especially as the effect of the vaccines will begin to wain in vulnerable groups. Risk 2794 (ECC cross infection scored 20) Risk 2697 (Risk of staff contracting Covid scored 6)	National guidance 30 Redirooms for isolation Cubiscreen (shielding curtain) Architectural walls on B3, Ward 23, Ward 28, IAAU SGH Lateral flow testing Vaccination available for16 yrs and over Capital projects to look at refurbishment of ward 25 to create additional isolation capacity.
The trust is seeing more pillar 2 COVID-19 cases admitted and significant number not vaccinated	Given the rise of Delta variant and busy nature of ECC and movement to IAAU risk of cross infection if patient not swabbed or isolated as per guidance.	Redirooms All ECC patients to be rapid tested if due for admission Utilise single rooms / Pods if result unavailable or symptomatic.

Patient Experience

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

Current Position	Risk	Mitigation
Positive position of complaints responded to within timescale – 87% closed within timescale and average of 41 days open. Current Open complaint position = 52 of which 46 (88%) in timescale with 6 > 60 WD timescale (Med 3 , SCC 3) Audit commenced as part of new policy 100% all areas ,except evidence of actions arising from learning at divisional level where further work is required	• Generalised actions which may not influence learning • Capacity of Lead investigators to undertake timely investigations – • Allocated Lead Investigator change causing process delays at times (Risk 2659 scored 12)	• Monthly governance report to highlight learning • Continued DCN quality contribution to response process • Weekly central team Support and Challenge meetings ,with central team escalating issues directly to Divisions • Central Complaint Team contributing to system build of new incident reporting software to ensure continued/improved oversight • Complaints position discussed at PRIMs • Monthly report to divisions for governance purposes • Patient Experience Action plan
Patient/family feedback mostly related to lack of communication with In-patient wards. Family liaison 6 month fixed term roles making difference to communication , and patient experience (mental and emotional wellbeing)	• Increased in PALS/complaints • Reputation as caring • Staff morale in the face of dissatisfied families	• Family liaison Assistants business case in development • 3 Pt experience officer across 3 sites • Patient Contact helpline • Leadership development for frontline staff • Staff well being initiatives/resilience • Sage & Thyme training programme
Impact of capital builds on DpOW patient experience	• More challenging to park, way find and mobilise to appointments	• Volunteers are being recruited for wayfinding roles • Working closely with estates project team to reduce risks and improve communication • Signage review to be arranged

Patient Safety - Pressure Ulcers and Falls

Aim: To provide harm free care, ensuring that learning is shared across the organisation, that risks are identified and mitigated through robust action plans.

Current Position	Risk	Mitigation
Numbers of reported pressure ulcers have decreased for two consecutive months (acute) and remain consistent in the community Themes from serious incidents remain consistent	• Capacity of Ward Sisters and Deputy Chief Nurse Office to scrutinise incidents • Capacity of TV Team to facilitate training reduced due to sickness within team • Staffing shortfalls impacting upon patient care	• The backlog of incidents have been allocated across the Divisions and will be reviewed by the end of September • Training prioritised to higher reporting areas/areas of concern. • Recruitment to HCA vacancies, use of bank and agency staff. Themes fed in to establishment reviews.
Ongoing roll-out of Supportive Care and the AFLOAT tool to support decision making and escalation for resource	• There is a risk of falls for all patients coming into hospital which carries the risk of serious harm • Staffing to resource additional shift requirements	• Documentation fully reviewed to focus on actions to reduce individuals risks with plan to roll-out Trust wide in late Autumn. • Learning shared to reduce risk and training delivered as required • Action plan developed from themes of huddles and serious incidents • Recruitment to HCA vacancies, use of bank . • Roll-out of new falls documentation will include full roll-out of Supportive Care

Safeguarding and Vulnerabilities

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

Current Position	Risk	Mitigation
No changing Places toilet facilities at SGH. Legal requirement for new hospitals	Reputational to the Trust Breach of Equality Act Personal Hygiene and Dignity for users	On risk register Estates working with NL for expression of interest for funding deadline submission 26.9.21
Increase in attendances of Children and Young people to ECC with a mental health concern	Attendances not reviewed in a timely manner by the Missed opportunity to safeguard children and young people (Risk 2914)	Raised at NL Safeguarding Children's Partnership. Audit undertaken- further review with CCG and other partners for next steps
Safeguarding Level 3 adults and children not met trust 85% target	Missed opportunity to safeguard children and adults/ not following procedures (Risk 2910 scored 9)	Safeguarding team Mon-Fri 9-5 Information on Hub/ Policies and procedures Plans to provide additional methods
Liberty Protection Safeguards awaiting draft Code of Practice from the Government	The Trust is not prepared to implement new system Financial implications Training	Awaiting draft Code of Practice (Autumn 2021) MCA lead is linked with local networks/ nationally Lead for LPS established in NLAG Work stream to be implemented once further development
No identified funding to continue with equitable provision of an acute LD Liaison nurse (SGH) and Transition Lead Trust wide. Covid Money applied for.	Delay in responding to any unmet heath needs in particular unplanned care (Risk 2531 scored 12)	LD Liaison nurse DPOW cover arrangements and Named Nurse Adult Safeguarding (only 0.8WTE)

CQC Action Progress

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

Current Position	Risk	Mitigation
Signed off: 35% (50 actions) Complete: 39% (56 actions) In Progress: 18% (26 actions) On Hold : 3% (4 actions)	There is a risk that actions may not be fully embedded (Risk 2820 scored 9)	Each action is monitored with the relevant division regularly. Quarterly reviews are in place of all previously closed actions to ensure the monitoring is robust and compliance sustainable.
Off track actions (Red): 5% (8 actions)	The Trust will not be compliant with mandatory training by the CQC visit (Risk 2898 scored 16)	Prioritisation of individuals who have not done the training at all, or who are longer out of date. Prioritisation of key modules in each speciality to maintain patient safety. Factoring in mandatory training into staffing rotas. Focused push on areas of low compliance. New BI report to allow detailed breakdown to give focus. Message to staff relayed in various forums to increase compliance.
	The trust will not be compliant with appraisals by the CQC visit	Message to staff relayed in various forums to increase compliance e.g. SLC, hub page, trust learning group, trust wide email communication. Focused push on areas of low compliance.
	Additional resources are needed to meet staffing levels (community nurse staffing specific) (Risk 2921 scored 15)	See Slide 1 for wider view on staffing Presentation of community staffing to CCGs on 19th July following which a further review will be undertaken to support a business case. Daily monitoring to ensure safe service. Monthly update provided in CQC progress report.

Maternity & CNST

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

Current Position	Risk	Mitigation
CNST Year four released. Submission date 30 June 2022. Increased requirements in every action	Failure to submit the evidence to provide assurance on safety in maternity units	Leads for Safety Actions allocated. Any gaps currently being reviewed
Evidence submitted to NHSE/I – awaiting feedback (mid Oct 21). Action plan – 28 actions met, 22 outstanding with a number reliant on national work programmes.	Safety in maternity units	Provision of independent senior advocate role (awaiting further detail). Implementing Local Maternity System SOP with sharing of Serious Incidents established. Embedding submission to Trust Board of Serious Incidents. Implementation of LMS oversight being embedded
MDT Training - Compliance >90%, HCA 84%, Obs drs 56%	Staff training and working together in emergency situation	No. of Obs Drs new to trust. Comply with MDT training compliance across all staff cohorts – need to meet 90%
Saving Babies Lives – revised 5 elements with CNST yr 4. Q1 21/22 – NLAG 5.6/1000 birth stillbirth rate. Region average 3.4.	Managing complex pregnancy and ability to escalate to regional centres(Risk 2918 scored 9, Risk 2765 scored 12, Risk 2855 scored 12)	To establish National Antenatal Risk Assessment process once guidance released To develop a pathway and SOP for referral to Regional Maternal Medicine Centres once national guidance released. Review of stillbirth review completed
Midwifery staffing challenges	Inability to safely staff maternity units Risk 2960 scored 12)	Agency requests out of trust process (accessing sooner). Utilisation of specialist midwives. Block booked agency midwife.

Mortality

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

Current Position	Risk	Mitigation
Q4 20/21: 92% **Q1 21/22: 90%** (Apr 21: 93%; May 21: 91%; Jun 21: 87%, Jul 21: 61%; Aug 21: 22%) Latest data tends to be an under-reporting due to timescales involved in undertaking reviews.	Risk of failing to meet the Trust's target of screening 90% of deaths (Risk 2797 scored 9)	Ongoing work. Linked to clinical coding validation work led on by divisional lead mortality/coding leads. Assurance reporting on process from Coding report to MIG and quality screening reported to MIG in monthly mortality report.
2020/21: 90% There is a backlog of cases not yet reviewed going back to Oct 2020 [Risk 2797; risk rating 8].	Risk of not achieving the 100% of SJR on cases identified from screening, within 6 weeks. (Risk 2797 scored 9) There is the risk that some older cases may require escalation for further investigation and consideration of duty of candour on the back of the SJR review.	Mortality SOP revised in line with NHSE/I guidance to reduce number of SJRs being indicated and share cases with community concerns with CCGs via incident reporting instead of NLAG internal review. Escalation to and working with DCD in Medicine; 50+ staff trained in Medicine for SJR by NHSE/I, further external training to be provided.
(Month ending May 21) In hospital SHMI 96, out of hospital is 128, broken down to NEL: 135 and NL: 121	Risk of harm reflected in a high SHMI position Out of hospital SHMI significant disparity of 29 points (39 at DPoW and 18 at SGH (was 31 so reduction noted). (Risk 2418 scored 10)	NHSE/I audit completed looking at the management of patients at EOL. Recommendations received by MIG; action plan being developed. CCG/out of hospital improvement action plan, reporting to MIG.

Serious Incidents

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

Current Position	Risk	Mitigation
16 out 29 investigations in progress are within timescale (From January 2021 onwards)	There is a risk of delay in investigation due to staffing pressures or complexity of the case (Risk 2606 scored 8)	Key dates initiated at commencement of investigation Early booking of interviews and RCA meeting Weekly timeliness monitoring Escalation of delays to SI Panel / division Family Liaison keeping the family up to date Liaison with CCG in respect of reasons for delay
89% assurance rate by CCGs. (From January 2021 onwards)	There is a risk that the quality of the investigation will not be enough to identify the key concerns and root cause (Risk 2606 scored 8)	Regular training on investigation skills Review process on Serious Incidents through divisional sign off to central Governance challenge and Executive sign off.
No measurement	There is a risk that actions will not be SMART and thereby not increase safety	Challenge to recommendations and actions at SI Panel
Currently 5 overdue actions in total. 1 off track within Medicine, 1 in Family Services and 3 in Surgery but less than 3 months over due date and verbal assurance on safety received	There is a risk that actions will not be delivered in a timely way	Action plan monitoring monthly at SI Panel Action plan delivery part of PRIM Action change process for when the context changes and action no longer applies
Risk & Learning Manager in post First themed learning campaign as determined by the Learning Group has commenced.	Insufficient learning from a Serious Incident	Learning on a Page to all wards and departments Learning Strategy Serious Incident Review Group to look at any further action needed Learning Strategy

Never Events

Aim: Zero Never Events

Current Position	Risk	Mitigation
2021/22 – 3 Never Events: 1 Wrong Implant (plus one in the previous financial year) 1 Wrong site Surgery 1 Retained item	There will be further wrong implant or wrong site surgery in Ophthalmology or other specialties linked to poor application of the WHO checklist	Regular WHO Checklist audit on both sites Assessment of the WHO checklist audit by Patient Safety Specialist on both sites Review of induction / competencies for new theatre staff to look at culture Review of evidence and embedding of immediate actions and actions from older SI's via QGG

VTE

Aim: 95% of patients risk assessed for VTE

Current Position	Risk	Mitigation
76.33% VTE Risk assessments completed	VTE risk assessment will continue to fall below the 95% target. VTE risk assessment performance has not recovered to pre-Pandemic performance levels. Risk 2893 scored 12 Risk 2824 scored 12	Clinical leads identified and actively working to review and update VTE related policy and patient intended information in line with latest guidance from NICE. E-screening tool for VTE launched on the 13 September as part of the EPMA system which will make it easier for medical staff to use. Ongoing education work with clinical staff. Engagement with trainee grades of medical staff to understand and overcome identified barriers.

Quality Priorities

Aim: Delivery of all Trust Quality Priorities

Current Position	Risk	Mitigation
End of Life No. of patients dying within 24 hrs of admission =14 Out of hospital SHMI 128 107 patients had an emergency admission in the last 3 months of life	The out of hospital SHMI will continue to affect the Trust position Risk 2811 scored 12	A project is underway with NHSEI to address the out of hospital SHMI Local CCGs have established an oversight group Collaborative end to end mortality reviews focussing on two QPs related to deaths within 24 hours of admission and unplanned emergency admissions in last 3 months of life to identify and share learning
Adult observations within 30 mins =91% Child observations within 30 mins =83.33% Escalation of NEWS = 8% Sepsis screen = 56% Sepsis screen in those with red flag = 63%	There is a risk that delayed observations and delayed escalation of observations will lead to significant harm to a patient (Risk 2388 scored 15) Risk of delayed availability of e-sepsis screening data via WebV.	Deteriorating Patient and Sepsis Group oversee. Action plan being developed from latest audit data following discussion at Deteriorating patient and sepsis group on the 9 September. Action taken in response to NEWS and Sepsis screening to be included on divisional risk registers.
Recording patient weights on IAAU (actual; patient reported or estimated) = 64% Actual weight recorded = 36% Compliance with medications requiring adjustment for weight = 80%	There is a risk that not adjusting prescribed medicines to a patients weight could lead to harm. Risk 2844 scored 9 Risk 2848 scored 9	To share with Governance groups for action/reminders to prescribers. Share specific case reviews with leads for further action (i.e. nutritional assurances). Focus on with IAAU teams.
BM in adults when NEWS >1 = 95% BM in paediatrics when PEWS>1 = 82.5% Diabetes training = 87.97%	A risk that DKA may be missed in a patient with diabetes Risk 2812 scored 9	Diabetes Task and Finish Group PEN Team in ECC and reviews of all children where BM recording not completed to determine if there is learning lessons opportunity or if this was not undertaken due to the clinical context.

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)199

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Mike Proctor, Non-Executive Chair of Quality & Safety Committee
CONTACT OFFICERS	Angie Legge, Associate Director for Quality Governance
SUBJECT	Quality & Safety Committee Highlight Report
BACKGROUND DOCUMENT (if any)	Quality & Safety Committee Terms of Reference
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None
EXECUTIVE SUMMARY	

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

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

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

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5 October 2021
Report From:	Quality & Safety Committee on 18th August 2021 and 17 September 2021

Highlight Report:

18th August

The Committee noted progress relating to understanding the risks and potential harm to patients who were waiting for outpatient reviews. A total of 794 patients were now identified as high risk and were monitored closely. Assurance was received that any harms were identified and escalated via the Serious Incident process.

An increase in pressure ulcers were identified in the Community, likely to be linked to workload and staffing issues in this division. The work to provide additional resources for staffing was welcomed.

In discussing the learning from Serious Incidents, further work strengthening staff culture to challenge practice outside standard operating procedures was noted and recognized as an ongoing continual piece of work as staff turnover meant that reinforcement was a constant requirement.

The Committee noted the analysis of integrated themes across incidents, complaints, claims and mortality assessed in line of where work was already in progress and linking to the Trust 5 year Quality Strategy. It was agreed to support the proposal to engage with Commissioners with a view to the PSIRF themes for Serious Incident investigations in 2021/22 to be discharge, medication, end of life and results acknowledgement.

Items in the Executive Governance Report
The VTE performance in the IPR was discussed and mitigations noted to be included in the Executive Governance report.

17th September

Membership received a report and assurance from the Medicine Division which included the mitigations in place to maintain patient safety and clinically prioritise patients queuing outside the Emergency Departments.

Ongoing concerns were noted in relation to nurse staffing exacerbated by high levels of sickness and difficulties in securing temporary replacements. Mitigations are included in the Executive Governance report.

The Annual Safeguarding Report was received and discussed and noted to be included on the Board agenda for October. The Board are asked to note the

legislation changes and increased responsibility on the Board in regards to the deprivation of liberty decisions and impact of Covid-19. Mitigations as to the risks are included in the Executive Governance report.

The annual Infection Control report was received and commended to the Board.

Assurance was received from the Medicines Optimisation annual report and from the SI Annual report.

A report on Serious Incidents was received and the Committee noted the lessons learned following a Maternity SI involving major haemorrhage where placenta accreta had been missed. The immediate action to stop the local scanning for placenta previa / accrete was noted and that these were now sent to the specialist centre. Further actions were noted to disseminate the new process, produce and disseminate the Trust guideline, reassess both the cell saver service and clinical pathway and to transfer a patient with suspicion of placenta accreta to a tertiary centre going forward.

A joint report on the findings and actions from the CCG and Trust was discussed related to whistleblowing concerns. Whilst the particular incident required no further follow up by the committee, it was resolved to keep a watching brief on the experience of our patients in the Emergency Care Centre.

A report on secondary malignancy mortalities highlighted the need to accelerate the work on end of life care. The Committee noted that this work was an early test of the effectiveness of system working as the only way to improve the patient and family experience and care was if all agencies contributed and cooperated together.

<u>Items in the Executive Governance Report</u>
Ongoing concerns were noted in relation to nurse staffing exacerbated by high levels of sickness and difficulties in securing temporary replacements. Mitigations are included in the Executive Governance report.

The Annual Safeguarding Report was received and discussed and noted to be included on the Board agenda for October. The Board are asked to note the legislation changes and increased responsibility on the Board in regards to the deprivation of liberty decisions and impact of Covid-19. Mitigations as to the risks are included in the Executive Governance report.

The annual Infection Control report was received and commended to the Board.

Confirm or Challenge of the Board Assurance Framework:

The Quality Board Assurance Framework was not discussed, however no concerns were raised.

Action Required by the Trust Board:

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

Mike Proctor
Non-Executive Director / Chair of Quality & Safety Committee

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)200

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Mike Proctor, Non-Executive Chair of Quality & Safety Committee
CONTACT OFFICERS	Mike Proctor, Chair of Quality & Safety Committee
SUBJECT	Quality & Safety Committee (QSC), subcommittee evaluation report 2021and workplan
BACKGROUND DOCUMENT (if any)	Annual review of the Quality & Safety Committee 2021 & Committee Workplan
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Quality & Safety Committee
EXECUTIVE SUMMARY	The report summarises the composite views of the four respondents (two executive; two non-executive) who have contributed to this years' self-assessment.

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

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

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

EVALUATION OF QUALITY & SAFETY COMMITTEE (QSC) 2021

Introduction

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

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
Terms of Reference					
1. The Committee has clearly defined Terms of Reference which have been approved bythe Trust Board.	4	0	TOR and minutes from the QSC where agreed, and the Trust Board minutes.		Terms of reference for further review September 2021
2. The Terms of Reference are regularly reviewed and updated.		0	Annual process	QSC ToR are now due for review again	See above
3. The Committee has been trueto its Terms of Reference.	4	0		It's been a challenging year and many Trust processes have been subject to change and interim measures, however, I feel everything has been done in the spirit of the ToR or on the direct agreement of the Board.	To resolve the confusion regarding quoracy and deputisation within and between all sub-committees
4. The Committee has worked purposefully and methodically to achieve the objectives it set for itself in order to fulfil the Terms ofReference.	4	0		The Committee met monthly throughout the pandemic crisis	Complete process for objective and priority setting for 2021/22

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
Reporting & Accountability					
5. The Committee has reported regularly and in a way that has furthered the work of the Trust Board and / or provided the necessaryassurance to The TrustBoard on quality and patient experience matters	4	0	Board minutes	Monthly highlight reports from Executives and Committee Chair focus the Board attentions on relevant issues. A lot of positive Board discussion has been prompted and facilitated bythe reports and insight fromthe Committee.	To continue
6. The Committee has escalatedmatters to the Trust Board as necessary.	4	0	Highlight reports to TrustBoard		To continue
7. The Committee has received regular reports and / or minutesfrom the sub-committees whichreport to it.	4	0	All QSC agendas	Clear and helpful minutes received monthly from Mortality Improvement Group, Governance Assurance Group and others.	To continue
8. Issues are escalated from thesesub-committees as necessary.	4	0	See highlight reports andminutes to QSC	See above	To continue
9. The Committee has provided timely support to Clinical & Non-Clinical Directorates (either directly or via the relevant sub- committees) on quality and improvement of patient experience in order to reduce risk to the Trust.	4	0	Committee minutes, Committee Workplan	The Divisions and support services, including pharmacy report on a regular basis to the Committee	To continue

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
10. The roles of and relationship between Quality Governance Group (QGG) and the Mortality Improvement Group (MIG) are clear and avoid duplication of effort.	4	0	Committee minutes	The QGG and MIG provide prompts for further QSC discussions and assurance on key issues.	
11. The roles of and relationship between the Quality & Safety Committee and the sub-groupsare clear and avoid both duplication of effort and ensureQSC is able to retain its strategic focus.	4	0	See above		
Leadership					
12. The Committee is well led.	4	0			
Frequency of Meetings					
13. The Committee has met at the frequency defined in its Terms of Reference.	4	0	Yes but at the beginning of the pandemic meeting times were shortened.		None
14. Where necessary, additional meetings of the Committee have been held.	4	0	An Extra-ordinary QSC was held on 12.07.2021 for CNST sign off		None

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
Duration of Meetings					
15. There is sufficient time during meetings to consider and debate agenda items and ensure sufficient challenge.	4	0	The agendas continue to be long but are improving. The discussion and debate is good.		None
Attendance					
16. Meetings have been well attended.	4	0	Committee minutes		Considering establishing an ongoing register of attendance
Membership					
17. The Committee consists of the right number of appropriately knowledgeable, experienced, developed and supported members who have been able to contribute effectively and who have the authority to make decisions	4	0	Committee Minutes	The Committee is supported by the CEO, the Medical Director, the Chief Nurse and their teams.	
18. The membership of the committee is kept under review.	4	0		This feels as if it is continuallyunder review to ensure the Committee remains effective and relevant.	None
Content					
19. The business of the committeeis appropriate and relevant.	4	0			

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
Receipt of Information					
20. The Committee has received timely, accurate and relevant information to achieve the objectives it set for itself in orderto fulfil the Terms of Reference and in order to enable assurance to be provided to the Board	2	2		The IPR still not fully developed. Some papers are excessively long and not focused, there is an ongoing issue of late submission of papers and Committee members sometimes have insufficient time to consider information presented. This is not unique to Q&S, and things generally are improving	Staff preparing papers need to develop their understanding of the needs of the Committee
Effectiveness of the Committee					
21. The Committee can demonstrate its effectiveness over the last 12 months	4	0	Board highlight reports.		

Quality & Safety Committee (QSC)
Committee Workplan

Northern Lincolnshire and Goole NHS Foundation Trust

Item of Business	Committee Oversight	BAF Requirement	Reference to TOR	Trust Priority	Delivery Method	Frequency	Lead	2021			2022								
								October	November	December	January	February	March	April	May	June	July	August	September
Divisional Assurance																			
Medicine	✓		✓	✓	Paper	6 monthly	Dr Anwer Qureshi						✓						✓
Surgery	✓		✓	✓	Paper	6 monthly	Mr Matthew Thomas			✓						✓			
Family Services with Maternity / CNST	✓		✓	✓	Paper	Quarterly	Ms Preeti Gandhi	✓			✓			✓			✓		
Clinical Support Services	✓		✓	✓	Paper	6 monthly	Mr Steve Griffin		✓						✓				
Community	✓		✓	✓	Paper	Quarterly	Ant Rosevear		✓			✓			✓			✓	
Quality Priorities																			
IPR	✓	✓	✓	✓	Paper	Monthly	TBC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality Priorities & Quality Account	✓	✓	✓	✓	Paper	Monthly	Hayli Garrod	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Cancer & Learning	✓	✓	✓	✓	Paper	Quarterly	Denise Gale	✓			✓			✓			✓		
Risk Stratification & Clinical Harm	✓	✓	✓	✓	Paper	Bi-monthly	Kishore Sasapu	✓		✓		✓		✓		✓		✓	
PROMS	✓	✓	✓		Paper	6 monthly	Hayli Garrod		✓					✓					
Patient Experience	✓	✓	✓	✓	Paper	Quarterly	Mel Sharp			✓			✓			✓			✓

Quality & Safety Committee (QSC) Committee Work plan

Item of Business	Committee Oversight	BAF Requirement	Reference to TOR	Trust Priority	Delivery Method	Frequency	Lead	2021			2022								
								October	November	December	January	February	March	April	May	June	July	August	September
National Inpatient Survey	✓	✓	✓		Paper	Quarterly	Mel Sharp			✓			✓			✓				✓
Diabetes Management	✓			✓	Paper	Quarterly	Simon Buckley	✓			✓			✓			✓		
Statutory Reports																			
BAF	✓	✓	✓		Paper	Quarterly	Helen Harris	✓			✓			✓			✓		
Annual Review of Committee Effectiveness	✓		✓		Paper	Annual	Mike Proctor												✓
Nursing Quality Report	✓	✓	✓	✓	Paper	Monthly	Ellie Monkhouse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Key SI Update incl Maternity	✓	✓	✓		Paper	Monthly	Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CLIP Report & Annual SI Report	✓	✓	✓	✓	Paper	Quarterly	Angie Legge		✓			✓			✓			✓	
DoLS & Safeguarding	✓		✓		Paper	Quarterly	Vicky Thersby			✓			✓			✓			✓
QIA	✓		✓		Paper	Quarterly	Hayli Garrod		✓			✓			✓			✓	
Deviations from NICE	✓		✓		Verbal / Paper	Monthly	Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Register of External Agency Visits	✓		✓		Paper	6 monthly	Hayli Garrod	✓						✓					
Annual Medication Report	✓	✓	✓		Paper	Annual	Simon Priestly											✓	
Strategy Monitoring																			
Mental Health Act and Strategy	✓		✓		Paper	6 monthly	Kay Fillingham		✓						✓				

Quality & Safety Committee (QSC) Committee Work plan

Item of Business	Committee Oversight	BAF Requirement	Reference to TOR	Trust Priority	Delivery Method	Frequency	Lead	2021			2022								
								October	November	December	January	February	March	April	May	June	July	August	September
Annual Clinical Audit Programme	✓	✓	✓		Paper	Annual	Hayli Garrod							✓					
CQC Framework	✓	✓	✓	✓	Paper	Monthly	Jennifer Moverley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Highlight Reports																			
Quality Governance Group	✓	✓	✓	✓	Paper	Monthly	Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mortality Improvement Group	✓	✓	✓	✓	Paper	Monthly	Kishore Sasapu	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Safety Champions	✓		✓		Paper	Monthly	Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Serious Incident Review Group	✓		✓		Paper	Quarterly	Angie Legge		✓			✓			✓			✓	

NLG(21)200

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee
CONTACT OFFICER	Helen Harris, Director of Corporate Governance
SUBJECT	Membership & Terms of Reference for Quality & Safety Committee
BACKGROUND DOCUMENT (if any)	Existing Membership & Terms of Reference
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	The Quality & Safety Committee
EXECUTIVE SUMMARY	The Quality & Safety Committee Membership and Terms of Reference document has been updated with various changes as highlighted throughout in yellow (see attached), and a new Committee workplan template has also been appended. Changes proposed to the Terms of Reference are: - Trust Secretary to Director of Corporate Governance throughout - Section 6.1.2.4: Board Assurance Framework reviewed on a quarterly basis - Section 6.1.2.6: to approve certain items, including Annual Quality Account and Quality Priorities, Research and Development Annual Report, Annual Complaints Report and Patient Experience Report - Section 6.3.4: Monitor the research programme - Section 7.1.1: Addition of Associate Non-Executive Directors (NEDs) for voting membership - Section 7.2: Other NEDs and Executive Directors to attend as desired, and a Governor to attend. - Section 7.3: Formal deputies can attend up to 25% of all meetings and where there are joint Trust roles attendance is 50% - Section 8.1: meetings to normally be held monthly - Section 8.4: formal deputies will be counted towards quoracy - Section 8.5: papers to the members not less than seven calendar days before each meeting. Agenda items for consideration 12 days prior to the meeting - Appendix A: new Committee Workplan template has

	been produced to ensure consistency across all committee. These changes have been actioned in order to align the various Committee terms of reference (quoracy and attendance). The Quality and Safety Committee recommend the Trust Board approve the proposed amendments in the Committee Terms of Reference.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Strategic Objective 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. Strategic Objective 5 - To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
	✓				

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Corporate Governance ~~Medical Director's~~

QUALITY & SAFETY COMMITTEE

Membership and Terms of Reference

Reference:	DCT024
Version:	3.
This version issued:	Date?
Result of last review:	Addition of work plan and various changes (as highlighted)
Date approved by owner (if applicable):	*enter* date of approval
Date approved:	*enter* date of approval
Approving body:	Quality & Safety Committee / Trust Board
Date for review:	September 2022
Owner:	~~Dr Kate Wood, Medical Director~~~~Chief Medical Officer~~Helen Harris, Director of Corporate Governance
Document type:	Terms of Reference
Number of pages:	11 (including front sheet)
Author / Contact:	Dr Kate Wood, Chief Medical Officer ~~Medical Director~~ / ~~Angie Legge, Assistant Director of Quality Governance~~Helen Harris, Director of Corporate Governance

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

1.0 Constitution

The Trust Board has established a Committee with delegated authority to receive assurance and in defined areas, to act on its behalf in matters relating to patient safety and quality governance to be known as the Quality & Safety Committee. The Committee will provide assurance to the Board and the Audit, Risk & Governance Committee on all matters that it considers and scrutinises on behalf of the Board.

2.0 Purpose

2.1 The purpose of this Committee is to provide assurance to the Board that all aspects of the delivery of safe, personal and effective care are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board.

2.2 The Committee is responsible for overseeing the development and monitoring of the Trust's overarching Quality Strategy, Trust Quality Priorities, Patient Safety Strategy, Patient Experience Strategy and both embedding and enactment of its services through its vision and values to ensure that the quality of care provided meets national and best practice guidance.

3.0 Authority

3.1 The Quality and Safety Committee is an assurance committee. The committee may take the following actions on behalf of the Trust Board (subject to the "Reservation of Powers to the Board and Delegation of Powers"):

3.1.1 Approve Trust strategies, policies, procedures and guidelines which are applicable to the Trust's quality, patient safety, and patient experience agenda

3.1.2 Approve the Trust Quality Priorities following wider stakeholder consultation

3.1.3 Receive assurance on corrective and other actions which may be required to maintain effective quality governance and in order to improve quality/patient safety the patient experience/delivery of the vision and values and/or to ensure appropriate escalation to the Trust Board

3.1.4 Authorised to investigate any issue within the scope of its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee

3.1.5 Approve, on behalf of the Trust Board, certain items which fall under the remit of Quality & Safety Committee

3.2 The Committee i**s** authorised, with the support of the Director of Corporate Governance ~~Trust Secretary~~, to obtain any independent professional advice it considers necessary to enable it to fulfil these Terms of Reference.

4.0 Accountability & Reporting Arrangements

4.1 The Quality & Safety Committee, appointed under, and subject to the Standing Orders of the Trust, is a sub-committee of the Trust Board and will submit a highlight report and copies of its minutes for inclusion on the Trust Board agenda. The Trust Board will also receive details of the outcome of the annual evaluation of performance of the Quality & Safety Committee (see also section 7.8 below).

4.2 Reports to the Board will be limited to matters of strategic importance.

4.3 The Committee will agree an Annual Work Plan which will be reviewed at each Annual Evaluation of the Committee or sooner should the need arise.

5.0 Responsibilities of the Committee

5.1 Quality: Safety

5.1.1 The Committee is responsible for providing information and assurance to the Board of Directors of the NLAG Trust on quality, safety and patient experience outcomes.

5.1.2 In particular, the duties include the following tasks:

5.1.2.1 To develop an Annual Work Plan in the agreed Trust format (see appendix A – workplan template), denoting the objectives of the Committee for approval by the Trust Board ensuring this is aligned with the Trust's vision, strategy and values, the Trust Quality Priorities and the relevant risks contained in the Board Assurance Framework

5.1.2.2 To consider the actual and potential financial consequences of the Committee's decisions; making and receiving referrals to/from the Finance & Performance Committee as necessary

5.1.2.3 To consider the actual and potential risk consequences of the Committee's decisions; making and receiving referrals to/from the Audit Risk & Governance Committee as necessary

5.1.2.4 To review the quality section of the Board Assurance Framework on a ~~monthly~~quarterly basis, giving consideration to the assurance provided, whether the key elements are appropriate in light of any concerns about which the Committee may be aware, and whether the underpinning risks provide sufficient assurance that the strategic risk is being appropriately managed

5.1.2.5 To identify risks through the business of the committee and receive assurance that these had been appropriately recorded on the Trust's Risk Register, for monitoring via the Risk Management process as laid out in the Risk Management Policy

5.1.2.6 To approve certain items on behalf of the Trust Board namely, but not exclusively:

- CNST
- Update on progress with delivering the CQC action plan
- Annual Infection Prevention and Control Report
- Annual Safeguarding Report including MCA/DoLs
- Deviations from NICE Guidance
- Annual Medications Report (Medicines Optimisation and the Accountable Officer Report)
- Annual Quality Account and Quality Priorities
- Research and Development Annual Report
- Annual Complaints Report and Patient Experience Report

5.1.3 The Committee will assure itself that adequate and appropriate integrated governance structures, processes and controls are in place across the Trust. The Trust Governance and Risk Management Strategy allows for the establishment of Divisional governance arrangements within a strong accountability framework. This will be done via a bi-annual report from the Divisional quality governance meetings at which the patient safety and quality issues and risk management processes in the Divisions are debated and monitored collectively.

5.1.4 The Committee will provide the Board with the assurance that the divisional meetings are functioning appropriately in terms of governance and risk management and contribute positively to ensuring the delivery of safe, personal and effective care through the bi-monthly updates.

5.1.5 The Committee will receive a quarterly report on Claims, Incidents, Serious Incidents and Complaints for information and discussion as to safety in the organisation. The Committee will satisfy itself that examples of good practice are disseminated within the Trust, ensuring that the investigation of incidents has been adequately scrutinised and that there is evidence that learning is identified and disseminated across the Trust.

5.1.6 The Committee will receive professional staffing reviews relating to clinical; nursing; and midwifery functions (and associated professions) and review the impact of staffing on patient care.

5.1.7 A mortality update highlight report will be received by the committee and be a standing agenda item for the Medical Director.

5.1.8 There will be close links between the Quality & Safety Committee and the Audit, Risk and Governance Committee including the sharing of ~~minutes~~ action logs and highlight reports and in some instances overlap of membership.

5.1.9 The Committee will assure itself that there is an appropriate process in place to monitor and promote compliance across the Trust with all standards and guidelines issued by the regulators, NHS England / Improvement (NHSE/I),

Care Quality Commission (CQC), the NHS Resolution, the Royal Colleges and other professional and national bodies.

5.1.10 The Committee will monitor the delivery of the Mental Health Strategy for the Trust, seeking assurance on the safety of patients with Mental Health conditions who access the Trust services.

5.1.11 The Committee will satisfy itself by the Safeguarding Board that we are meeting our statutory requirements in relation to safeguarding and the NHS accountability framework.

5.1.12 It will also satisfy itself that the appropriate actions in respect of Patient Safety and Governance have been taken following recommendations by any relevant external body, through the Register of External Agency Visits. This includes monitoring the Trust's compliance with the CQC registration requirements and any reports resulting from visits.

5.1.13 The Committee will receive periodic detailed reports on the activity of the PALs service; Patient Experience Surveys and Stories; ~~Complaints, Serious Incidents;~~ Ombudsman findings; Litigation; and seek assurance on the lessons learned and implemented.

5.1.14 The Committee will receive an annual report on the trends and themes in Serious Incidents and seek assurance on the subsequent learning.

5.1.15 The Committee will also consider matters referred to it by other committees and groups across the Trust provided they are within the Committee's remit.

5.1.16 To oversee the development and implementation of the Trust's Quality Strategy and the agreement of annual Quality Priorities and the link to strategic objectives. The Committee will seek assurance on the improvements made through these Quality Priorities.

5.1.17 To consider the assurance provided by the monthly Quality & Safety Reporting as part of the Integrated Performance Report and review of the Annual Quality Account prior to submission to the Trust Board and subsequent publication ~~of the Annual Quality Account.~~.

5.1.18 To receive assurance that actions arising from the external assurance on the Annual Quality Account are implemented.

5.1.19 To make recommendations for action to Directorates and the Trust Board for developing or improving standards, systems and processes for improving quality and safety.

5.2 Quality: Patient Experience and Friends and Family Test (FFT)

5.2.1 To oversee the development and implementation of the Trust's strategy and approach to collecting and using information to improve the experience of patients.

5.2.2 To receive reports from the Patient Experience Groups.

5.2.3 To consider the findings from the national patients surveys and seek assurance on the response to these.

5.2.4 To consider themes/trends and learning from complaints, Serious Incidents, claims and concerns and consider how this information might be used as part of the wider Trust approach to improving the patient experience. To consider the findings from Ombudsman's reports and monitor the development and implementation of appropriate action plans.

5.3 Quality: Clinical Effectiveness

5.3.1 To monitor the Trust's performance in respect of the achievement of Trust Quality Priorities.

5.3.2 To use information from the CQC and NHS England Quality & Risk Profile (QRP) and other sources of information to identify and address issues (e.g. Mortality, NICE) which may impact on the Trust's ability to deliver a safe and effective quality service to patients.

5.3.3 To agree the Annual Clinical Audit Programme.

5.3.4 To ensure the research programme and governance framework is implemented and monitored, and to approve the Research and Development annual report.

6.0 Membership

6.1 ~~Core~~ Voting Membership

6.1.1 The Committee will comprise:

- three Non-Executive Directors or Associate Non-Executive Directors.
- Medical Director
- Chief Nurse
- Chief Operating Officer

6.1.2 Associate Non-Executive Directors to be included as core members of the Committee and to be counted towards quoracy and can be counted towards voting rights (where applicable).

6.2 Invited Non-Voting Member Attendance

- Medical Director
- Chief Nurse
- Chief Operating Officer ~~or deputy~~
- Associate Director of Quality Governance

6.3 Other Persons Attending Meetings

6.3.1 The following will attend as agenda items dictate or where a pre-existing or externally driven reporting requirement exists:

- ~~Chief Executive~~
- Divisional triumvirates
- CCG Director of Nursing
- NHSEI Quality Lead
- Healthwatch Representative

6.3.2 Other Non-Executive Directors and Executive Directors can attend as desired but will not form part of the permanent membership of this committee.

6.3.3 The Chief Executive has a right of attendance of all meetings of the Committee and may be included in the quoracy subject to agreement by the Chair.

6.3.4 An invitation to join the committee as an attendee will be extended to a Governor to be identified by the Lead Governor.

6.3.5 The committee may, from time to time and as the agenda dictates, require attendance from other Directors/Senior Officers of the Trust not mentioned above.

6.3.6 Executive Directors may on occasion invite other senior officers to attend the Committee, with the approval of the Committee Chair, to present specific items, or for developmental purposes.

~~Other attendees to be invited to attend on a regular basis include:~~

6.3.7 The Director of Corporate Governance ~~Trust Secretary~~ may be in attendance at meetings as the agenda dictates.

7.0 Procedural Issues

7.1 Frequency of Meetings

Meetings will normally be held monthly ~~initially~~ although this will be kept under review.

7.2 Chairperson

One of the Non-Executive Director members of the Committee will be appointed as Chairperson. One of the other Non-Executive Director or Associated Non-Executive Director representatives shall deputise in his/her absence.

7.3 Secretary

The Medical Director's Office Executive Personal Assistant will act as Secretary to the Committee, preparing agenda papers in conjunction with the Chairperson, Chief Nurse and Medical Director. ~~and Associate Director of Quality Governance~~.

7.4 Attendance

7.4.1 Attendance is required for a minimum of 75% of all committee meetings.

7.4.2 Executive Directors who are unable to attend will arrange for the attendance of an appointed deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend. Formal deputies appointed can attend up to 25% of all meetings.

7.4.3 Joint Trust roles, where applicable, will be required to attend 50% of Committee meetings and appoint deputies for the remainder.

7.5 Quorum

7.5.1 The committee will be deemed to be quorate when there are four members, two of whom will be Non-Executive Directors or Associate Non-Executive Directors and two will be Executive Directors, one of whom must be a clinician.

7.5.2 Formally appointed deputies will be counted towards quoracy and have voting rights (where applicable).

7.5.3 A quorum must be maintained at all meetings.

7.6 Administration and Minutes of Meetings

7.6.1 Minutes of meetings will be circulated with the agenda papers to all members well in advance of each meeting but no less than ~~five 5~~seven calendar ~~working~~ days before each meeting. In addition to the circulation of minutes, the 'action log' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within timescale.

7.6.2 Agenda items for consideration to be submitted 12 calendar days before the meeting.

7.6.3 Submission of papers to members should take place seven calendar days before the meeting. Late papers may be submitted at the discretion of the Chair.

7.6.4 Minutes of meetings of the Quality & Safety Committee will also be submitted to the Audit, Risk and Governance Committee and the Trust Board.

7.6.5 The Medical Director's Executive Personal Assistant will maintain a record of attendance which must be presented at each committee meeting and included in the annual evaluation exercise.

7.7 Decision Making

7.7.1 Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.

7.7.2 Where this is not possible then the chair of the meeting will ask for members to vote using a show of hands, all such votes will be compliant with the current Standing Financial Instructions (SFIs) and Scheme of Delegation of the Northern Lincolnshire & Goole NHS Foundation Trust.

7.7.3 In the event of a formal vote the chair will clarify what members are being asked to vote on – the 'motion'. Subject to meeting being quorate a simple majority of members present will prevail. In the event of a tied vote, the chair of the meeting may have a second and deciding vote.

7.7.4 Only the members of the Committee present at the meeting will be eligible to vote. Members not present and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

7.7.5 The Trust's Standing Orders and SFIs apply to the operation of this Committee.

7.7.6 Decisions which are outside of the Scheme of Delegation will be escalated to the Trust Board with the findings and recommendations of the Sub Committee for action at board level.

7.8 Monitoring Compliance & Effectiveness

7.8.1 In accordance with the requirements of good governance and in order to ensure its ongoing effectiveness, the Quality & Safety Committee will undertake an annual evaluation of its performance and attendance levels.

7.8.2 Where gaps in compliance are identified arising from this evaluation, an action plan will be developed and implementation will be monitored by the Quality & Safety Committee. The results from the annual evaluation exercise, including any agreed actions, will be reported to the Trust Board.

7.8.3 The functioning of the Committee will be assessed within the normal annual cycle of reporting by the Audit, Risk & Governance Committee through the activities of the internal and external auditors and external regulatory bodies.

7.9 Review

These Terms of Reference will be reviewed every year at the time of the annual performance review of the committee or sooner should the need arise.

8.0 Equality Act (2010)

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

8.2 The Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

8.3 The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

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

The electronic master copy of this document is held by Document Control, Office of the Director of Corporate Governance ~~Trust Secretary~~, NL&G NHS Foundation Trust.

Appendix A

Committee Name

Committee Workplan Template

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Item of Business	Committee Oversight	BAF Requirement	Reference to TOR	Trust Priority	Delivery Method	Frequency	Lead	20xx									20xx		
								Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
SECTION HEADING																			
SECTION HEADING																			

NLG(21)201

DATE OF MEETING	5th October 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Shaun Stacey, Chief Operating Officer
CONTACT OFFICER	Richard Peasgood, Executive Assistant
SUBJECT	Executive Report - Performance
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	
EXECUTIVE SUMMARY	The Operational Update details the current position with ED and ambulance waits, as well as the Discharge to Assess program and Elective and Cancer position.

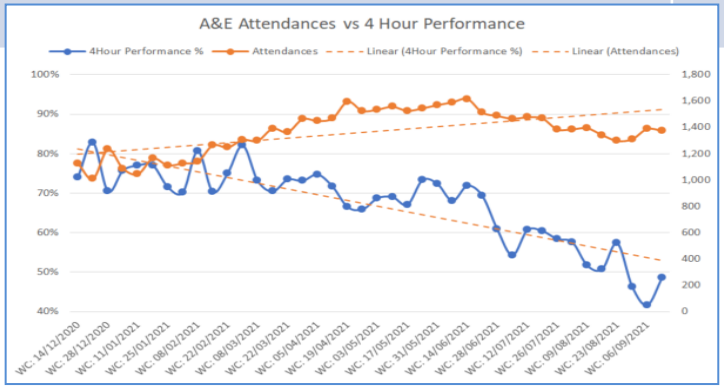
LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide good leadership**
✓			✓	✓

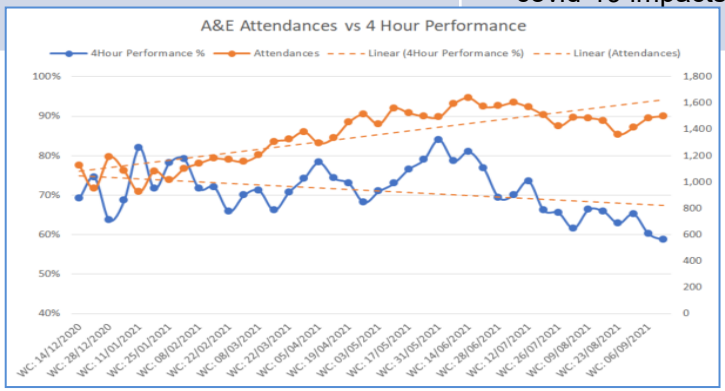
TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response	✓	**Workforce and Leadership**	✓
Quality and Safety	✓	**Strategic Service Development and Improvement**	✓
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	SO1 – 1.2 The risk that the Trust fails to deliver constitutional and other regulatory performance or waiting time targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Emergency Department Waits

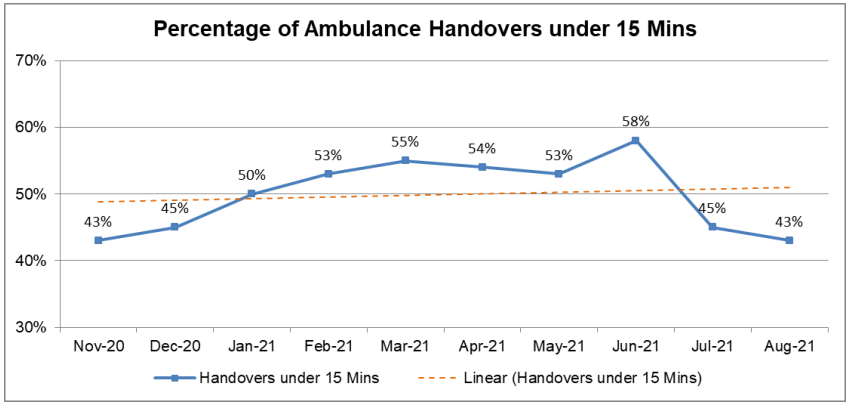
Highlights	Lowlights	Risks
• The ED's are responding to the increased attendances in August 2021 compared to August 2020, with on average 403 patients per day compared to 388 last year • Significant reduction in 60min+ ambulance handovers in June 2021 with a total of 127 compared to previous month's 252 • Increase in number of ambulance handovers completed in under 15mins to 58% - the highest within last 12 months and has seen both DPOWH and SGH rise in the regional handover rankings • Frailty assessment service at DPOWH continued beyond pilot • Improved position for medical recruitment within ED • The new ED builds are progressing well with construction ongoing at DPOWH and the final decanting and enabling works ongoing at SGH. Detailed room specifications and digital strategy being developed • Additional medical staff have been injected into ED to improve patient safety throughout the department	• Extreme challenges being faced within the ED due to a lack of patient flow which is resulting in daily long waits • August 2021 performance was 59.8%% (DPOWH 53.7%, SGH 64.4%) • 72x 12hr DTA breaches during August 2021 (22 at DPOWH and 50 at SGH) • Increase in walk-in attendances with non-ED patients due to lack of alternative service availability/accessibility • Challenges with crowding and pressures on support services turnaround times (e.g. diagnostics) due to increase in attendances • Risk of delays in booking in walk-in patients due to no capacity within ED waiting area to bring more patients into the ED (shift lead completing walk by reviews of queuing patients to identify any clinical risks) • Challenges in filling nursing and medical shifts due to vacancies/sickness	• High bed occupancy levels leading to a lack of patient flow and exit block in ED will result in delays for patients in ED and drop in 4hr performance and delays in off loading patients from ambulances and risk 60min+ handover breaches • Reliance on locum bank and agency specialty doctors in ED due to delayed recruitment pipeline • Risk of walk-in patients queuing outside ED due to lack pf physical capacity in ED • Risk of crowding in ED due to increase in attendances and reduced physical capacity due to covid-19 impacts

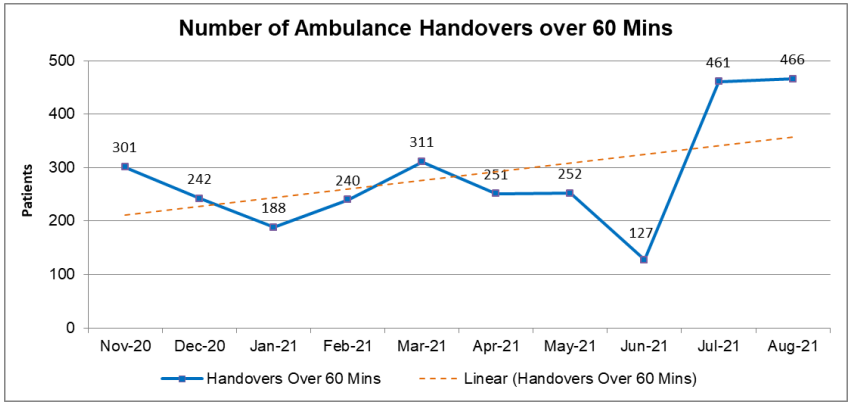




Ambulance Handovers

Performance	Quality
• Ambulance handovers completed in under 15 minutes has decreased from 45% in July 2021 to 43% in August 2021 • The percentage of 15-30 minute handovers has remained static at 28% between July and August 2021 • The percentage of 30-60 minute handovers has remained static at 14% between July and August 2021 • The percentage of over 60 minute handovers has remained static with a small increase from 14% in July 2021 to 15% in August 2021	• Reduced time between ambulance arrival and patient assessment by ED clinical staff • Implementation of the latest Manchester Triage Tool version improved patient triage • A training programme for ED nurses is improving clinical handover assessments • When patients do wait in the ambulance, an ED clinician assesses all waiting patients in the ambulances to prioritise • Paediatric patients in ambulance queue can be fast-tracked by support from the Paediatric Team





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

Highlights	Lowlights	Risks
• Work ongoing with NHSE/I to review and develop new Medicine rotas and job planning to support increasing service hours of SDEC and ED in-reach. A 2 week perfect week rota pilot at SGH is being developed for 9th August 2021 extending SDEC hours to 10pm 7 days a week • Frailty assessment service at DPOWH completed the 4 week initial pilot in May/June 2021 and has been continued going forward. The service reduces waits for frail patients within ED (bypassing direct to SEC where possible) and provides an improved pathway for the patients. Although average of small numbers through the service per day, 93% were discharged home avoiding an admission • Further developments made on IAAU dashboard linking in with the long-term phase 3 new ED/IAAU build objectives • New Medicine Management tier 3 oversight rota implemented providing improved escalation and support to ED and Acute teams • The final phase of the IAAU will be the move into the newly refurbished units located next to the new ED builds and the additional workforce required to increase the service hours	• Although significant recruitment has taken place, high levels of vacancy still exist within the Acute Medicine team while awaiting for appointed medical staff to start • The Acute Medicine team has taken on significant increases in workload during the year, with an increased number of beds coming under their remit and the introduction of covid/non-covid acute assessment wards • Continued embedding to improve specialty input times and remove traditional barriers from quick access to SDEC services • Specialty SDEC capacity and access not sufficient to meet patient demand – Focus on this is part of newly established Patient Flow Improvement Group • An IT solution has not yet been identified to enable electronic direct booking of patients from community (GP/SPA) into SDEC	• Reliance on sufficient daily discharges to enable flow out of IAAU is required to prevent bottleneck between ED and IAAU • Turnaround times for covid-19 swab results impacts on ability to move patients on from IAAU into green/red wards • A lack of sufficient specialty SDEC capacity impacts on the ED workforce, patient waits and crowding in ED • High demand of walk-in patients for ED and a lack of physical capacity within the ED waiting room is resulting in long delays and queues forming outside of the ED when the department is full and cannot physically allow anymore patients to enter

Discharge to Assess (D2A)

Highlights	Lowlights	Risks
• The Trust's performance for 21 day + currently reported at 8.6% remains under the national target of 12% and is the lowest within the Humber Coast and Vale and second best for performance within the whole of the north region • Long length of Stay reviews now taking place twice a week to support wards and staff around patient plans and highlight any delays in the patient pathway • The Hospital Discharge Service: Policy & Operating Model is now fully embedded across the northern Lincolnshire system • All wards now have senior consultant presence at board rounds before 10am, work to now focus on the effectiveness of board rounds and ensuring every patient has a plan with an EDD • All wards are now able to report if and when a patient no longer has a criteria to reside in an acute hospital bed by completing web v and this is being monitored on a daily basis by matron staff and several engagement sessions have been held with nursing staff • 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 • The trust is taking part in the the ward/board round collaborative with NHS E/I a medical ward from the Scunthorpe & Grimsby site have been nominated • Large process mapping and engagement exercise taken place to develop a improvement plan for the whole discharge process concentrating on board rounds, the use of our discharge lounges and timely discharge • Our staff are familiar and using the new terminology around if a patient meets the criteria to reside in an acute hospital bed, this has empowered our care navigators to ask the questions why not home, why not today.	• 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 • Although there have been significant improvements for senior presence on all wards before 10am there is a vast amount of work that now needs to take place to improve the effectiveness of board rounds to ensure every patient has a plan • Significant pressures on partner organisations for home care, this has resulted in some discharge delays and more placements to temporary care homes	• Continued pressures on the acute workforce resulting in delay in decision making and timely discharge • Continued IT system & reporting improvements required to ensure all data is captured and reported accurately by our IT systems

Electives and Cancer

Highlights	Lowlights	Risks
• Volume of patients waiting longer than 104 days in Cancer is improving since July 2020. • The number of RTT 52 week plus waiters continues to decrease and the current number waiting is 469 • Overall out-patient attendances for new patients continue to deliver above plan and the April to August position is showing 102% delivery with Surgery at 107% and Family Services at 106% of the plan • Throughout Q1 the overdue follow-up position has slightly deteriorated and has reduced further during August. Each specialty is working up plans to deliver their share of the maximum 9000 waiters as at the end of March 2022 • The use of the Independent Sector continues to support the Trust and additional capacity has been agreed with St Hughs during Q2 to support long waiter backlog patients with 330 transferred to date in Q1. Work is due to commence with a new provider in Scunthorpe to provide ENT & General Surgery support also, due to be mobilised at the beginning of October. Medinet has been mobilised in September to support Ophthalmology with additional capacity. • Processes in place to record, track and monitor risk stratification for all patients at all points in the pathway • Inpatients Live Risk Stratification at 99.8%	• Volume of patients waiting longer than 104 days in Cancer is 31 (trust wide – all tumour sites except Breast & Gynaecology (21st September2021)) • For follow-up attendances the Trust are delivering 87% of the plan. A number of specialties are working up plans to continue and increase use of external providers to support with delivery of the plan along with ensuring all available capacity is being utilised to full utilisation • For the April to August comulative position, elective performance against plan continues to be under delivering at 80% for in-patients and 89% for daycases. A number of specialties are experiencing an increase in Priority 2 and urgent patients who are more complex. • Plans are being put in place to risk stratify all open Outpatient episodes • Risk stratification in ophthalmology at SGH.	• Workforce risk around significant vacancy gap • Workforce risk around carried over annual leave • Potential wave 3 of COVID-19 • Capacity to deliver risk stratification for Outpatients • Challenges to delivery of the elective recovery plan with a current risk to theatre staffing

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)202

DATE OF MEETING	5th October 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Shaun Stacey, Chief Operating Officer
CONTACT OFFICER	Graham Jaques, EPR & Business Continuity Manager/Operations Centre Manger
SUBJECT	NLaG Winter Planning and Potential COVID-19 3rd Wave 2021/22
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Approved at TMB 5th July 2021
EXECUTIVE SUMMARY	This paper is NLaG's Winter Planning and Potential Covid-19 3rd Wave 2021/22 response.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	SO1-1.6 The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
	✓				

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Operations

NLAG WINTER PLANNING AND POTENTIAL COVID-19 3RD WAVE 2021/22

Reference:	DCM567
Version:	1.0
This version issued:	28/07/21
Result of last review:	N/A
Date approved by owner (if applicable):	N/A
Date approved:	05/07/21
Approving body:	Trust Management Board
Date for review:	July, 2022
Owner:	Graham Jaques, EPR & Business Continuity Manager/Operations Centre Manger
Document type:	Miscellaneous
Number of pages:	12 (including front sheet)
Author / Contact:	Ashley Leggott, Emergency Planning Manager and Local Security Management Specialist / Stacy Kirby, Emergency Planning Officer

Contents

1.0 Introduction

The overarching aim of the trusts response for any winter is to ensure patient and staff safety. The ongoing Covid-19 pandemic has brought challenges in providing patient care due to the restrictions created by zoning which effectively reduces our capacity. As we head into winter these challenges could become more difficult as the trust manages a variety of infectious conditions. It is expected there will be continued high attendances at our emergency departments and an increased demand on our inpatient capacity due to the expected seasonal influence on Covid-19 infection rate and acuity, and the normal winter pressures of frailty/chronic conditions /higher acuity/flu and D&V.

The challenges created by winter is not only affected by increased incidence of infectious diseases but also non-infectious conditions that are exacerbated during the winter months such as asthma, chronic obstructive pulmonary disease (COPD), ischaemic heart disease, myocardial infarction and stroke. Cold winter temperatures contribute to increases in cardiorespiratory disease and increase the survival time of respiratory viruses.

The expected impact of Covid-19 throughout the coming winter is somewhat unknown. There has been a good uptake of the Covid-19 vaccine locally and a further booster is expected as part of the seasonal flu campaign, this may however be offset by the continued emergence of new variants where the efficacy of the current vaccine is undetermined.

Winter 2020/2021 saw a reduction in admissions for patients with long term conditions which could be attributed to the impacts of national lockdowns and shielding. As lockdown measures are eased it is expected that the number of these admissions will rise above pre-pandemic levels.

2021/2022 will be increasingly difficult due to five main risks affecting health services nationally:

- Other viral illnesses e.g. Influenza A, Influenza B, Norovirus and Respiratory Syncytial Virus will be circulating which will increase demand on the trusts isolation facilities and an additional increased risk of losing capacity by closing bays when patients are exposed to viruses.
- Having the ability to segregate Covid-19 patients and other infectious diseases will restrict the use of our capacity.
- Following the previous suspension of routine clinical care it is likely to result in an increased number of poorly-managed chronic conditions or undiagnosed diseases creating additional hospital pressures.
- Reduced workforce due to sickness or isolation requirements.
- European Union Exit impact on goods, services and borders.

2.0 Local Systems Resilience

Locally Systems Resilience is a collective responsibility of the local A&E Delivery Board.

It is vital that the Trust together with the wider Northern Lincolnshire System:-

- Focus on admission avoidance schemes and ambulatory care pathways
- Create the capacity to meet increased demand
- Link the Trust Winter Plan to the System wide escalation plan
- Manage patient flow through maintaining optimum length of stay

- Embed the national Discharge Policy and provide health and care assessments outside the hospital setting
- Robustly performance manage the system to maintain quality, safety and patient experience

Set out within the NHSE/I North East and Yorkshire Region- Incident Management Escalation and Mutual Aid Plan to Support Systems across the region (December2020). The following principles have been developed. These principles underpin the way NEY will approach the management of escalation and the consideration of mutual aid. It is important that our four local ICS's are working to similar levels of escalation when managing urgent and elective activity across local trusts. This is to ensure that:

- **Principle 1**: No trust or system is placed under disproportionate pressure compared with others across the North East and Yorkshire when there is an ability to mitigate potential risks to patient outcomes.
- **Principle 2**: All capacity in the region is mobilised to deliver surge capacity that maintains optimum access to urgent and emergency care to all patients who require it.
- **Principle 3**: Patients have equitable access to urgent planned care and are not disadvantaged by significant differences between Trusts and systems in local availability of beds, critical care, staff and other resources.
- **Principle 4**: As much planned care, for those in greatest need, should be delivered and when capacity is limited this should be used as equitably as possible so that no patient population is disadvantaged.
- **Principle 5**: Staff are not placed under sustained, high levels of strain disproportionately between systems or trusts.

If the Trust in need of mutual aid or operating at OPEL 4 a regional exception report (Annex A) will have be completed and submitted before 11am daily until de-escalation to NHSE/I- england.eprrney@nhs.net

3.0 Key Pressures

The key pressures posed by winter include:

- Availability of Point of Care testing for Covid-19 and Influenza.
- Zoning challenges.
- Increased demand on isolation facilities at both sites.
- Ageing infrastructure of HDU at DPOW with little ability for segregation.
- Staff fatigue.
- Maintaining an increased elective capacity.
- Risk of concurrent emergencies i.e. Adverse Weather, Evacuation and increasing operational pressures OPEL 3 / 4.
- Avoidable ED attendances.

- ED disposition utilised by ambulance crews where alternative pathways would be more appropriate.
- Patients not being discharged when they no longer meet the criteria to reside.

In managing these pressures this winter, the overriding objectives are to:

- Utilise the summer months to realise, prepare and implement schemes that will support the organisation through the coming winter.
- Improve patient flow within and out of NLAG during Winter 2021/22 to cope with variations in demand and capacity.
- Improve clinical outcomes and patient experience through reduced waits for assessment, diagnostics, treatment and discharge.
- Improve staff job satisfaction and morale.
- Consistent achievement of operational targets.
- Adherence to patient and staff safety/ quality standards e.g. IPC
- Plan and resource initiatives appropriately; this will be achieved through effective communications, teamwork, coordination, assessment and decision making.

3.1 Cold Weather Plan

The Cold Weather Plan for England is a framework to support the protection of the population from the harm to health from cold weather. It aims to prevent the major avoidable effects on health during periods of cold weather in England by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately. It recommends a series of steps to reduce the risks to health from cold weather for:

- the NHS, local authorities, social care, and other public agencies
- professionals working with people at risk
- individuals, local communities and voluntary groups

All organisations are expected to register with the Met Office Cold Weather alert scheme and ensure that there is an organisational cascade process to ensure the alerts and alert levels are recognised and responded to in a timely manner. Furthermore, organisations are expected to review the national Cold Weather Plan for England and consider the recommendations for planning and the fit with the organisations own surge & escalation and/or business continuity planning. This arrangement is already established within the organisation with each member of the Emergency Planning Team registered.

In addition NLaG receive MET Office civil contingency weather alerts which gives a forecasted warning of any impending adverse weather that could impact on staff ability to travel to and from work and within Community Services.

4.0 Demand's experienced Pre Covid-19 and Current

The numbers attending the emergency department have continued to increase exponentially, from 2017 where the average daily attendance was circa 170 per site to last winter where each site saw in excess of 250 patients. Last year the introduction of the Urgent Treatment Centre co-located alongside the emergency department team allowed patients who were not acute emergencies to be streamed through to be seen by a multi-disciplinary team led by a GP although this coincided with an increase in walk-ins to the ED. The UTC is no longer operating from DPoW. A similar solution currently being referred to as 'primary care hubs' is in development. This was hoped to be live by end of April across NEL however there is no go live date at present. The aim is that by winter these should be directly bookable slots from both 111 and ED.

In November 2019 the acute assessment unit for medicine was introduced where patients could be seen for assessment, or their condition observed rather than waiting within the emergency department. By autumn 2020 this developed into the Integrated Acute Assessment Unit (IAAU) for all specialities alongside Same Day Emergency Care (SDEC) which is a chair based alternative to hospital inpatient stays.

During winter 2019/2020 an orthopaedic hot clinic was piloted which enabled patients to be seen and reviewed and return for review, again rather than waiting in the emergency department. The Grimsby Orthopaedic hot clinic (Scunthorpe data is unavailable) shows a total of 154 new patients attended between December 2019 and April 2020. The success of the Hot clinic in 2020 will be replicated for Winter 2021.

In line with the Hospital Discharge Service: Policy and Operating Model and based on the criteria to 'reside in hospital' as developed with the Academy of Medical Royal Colleges, acute hospitals must discharge all patients who no longer meet these criteria as soon as they are clinically safe to do so. The Discharge to Assess model is supported by a programme of work to ensure the policy is embedded within the trust and the whole northern Lincolnshire system, once fully embedded the trust will see effective MDT daily board rounds on every ward with early decision making resulting in identifying discharges proactively and reducing length of stay.

The Single Point of Access (SPA) and Community Response Team (CRT) are key enabling services in supporting the Medicine and Surgery Divisions to reduce demand by coordinating the response of the wider health and social care community by;

- meeting the needs of patients in the community where they would otherwise require hospital admission
- avoiding admission for patients who are presenting in need and
- reducing length of stay for patients when they can be safely cared for the in the community.

The SPA and CRT Model was enhanced in March 2020 to include a GP role to provide senior clinical decision making within the service and therefore further expanding the level of complexity that patients can present with whilst still being cared for in the community. The CRT GP responds to an average of 500 patient referrals each month and the most recent data demonstrates that for 87% of these it has been clinically determined that an avoidable and inappropriate hospital admission was prevented by their involvement.

The SPA operates 24 hours a day, 365 days a year and accepts referrals from GP Practices, NHS 111 and Ambulance services and in doing so reduces the demand for the Medicine and Surgery Divisions through providing an alternative care pathway for patients who would otherwise present to Urgent and Emergency Care Services.

Further work is being undertaken to work more closely with ambulance services increase the number of referrals sent by them in order to further reduce the number of unnecessary attendances to ED where alternative dispositions would be more appropriate and a better experience for patients.

5.0 Covid-19 Zoning 2020/2021

During the initial response to Covid-19 the numbers of patients attending the emergency department dropped substantially – however since the beginning of May these numbers have been increasing and it is has frequently peaked around 250 ED attendances at both sites from the latter part of August and has continued throughout the winter months. Although ED performance had started to improve pre-Covid-19 the pressures that we are now seeing due to increased activity is making achieving the ED performance standard very challenging.

The prevalence of Covid-19 has continued to reduce nationally and regionally throughout this year, probably attributable to the effects of lockdown and the uptake of the Covid-19 vaccination. As of 17th May 2021 there was one patient diagnosed with Covid-19 within our hospitals and no complete ward designated as a red zone.

The principle of containing the outbreak in the smallest possible footprint will remain in place and under daily review by the Operational Management Team and the Infection Prevention and Control Team. Any new admissions diagnosed with Covid-19 will be cared for in A1, DPOW and ward 17, SGH. If the trust experiences an increasing number of patients with Covid-19, a timely decision to re-establish red zone wards on the affected site will be required. Due to the previous experience of the medical and nursing teams, and the oxygen provision capability within the estate, the initial red zone wards will be ward C5, DPOW and ward 17, SGH. The table below highlights the trigger points for an escalating situation by site noting that GDH will remain a "green" to support the elective work program.

Specialist areas will continue to cohort within their own area e.g. Paediatrics, Maternity and ICU.

Covid-19 escalation	DPOW	SGH
3 or less patients	Ward A1 side rooms (C5 side room if higher level of oxygen required)	Ward 17 2 bedded bay plus 1 side room
3 – 6 patients	As above plus 3 side rooms C5	As above plus 3 side rooms IAAU b
> 6 patients	Consider re-introduction of red ward on C5	Consider re-introduction of red ward on ward 17
> 20 patients	Consider re-introduction of 2nd red ward on C2	Consider re-introduction of 2nd red ward on ward 16

A program of works to refurbish ward 25 has been scoped during May to increase the number isolation facilities within the ward footprint. It is expected to achieve 17 side rooms

within a previous 28 bedded ward. Although this will reduce overall capacity it will protect the remaining bed space within the hospital by reducing bay and ward closures during outbreaks. This will replicate the capability on the DPOW site provided by ward A1. It is expected this ward will become operational by November 2021.

The organisation has not yet fully restored its current elective activity to pre pandemic levels and its current programme requires maintaining throughout winter. A review of the capacity at DPOW ward B4, B6 and B7 to support an increase in activity will be undertaken and returning SGH ward 27 to an operational ward by moving SDEC to the Day Surgery Unit will increase the bed base at the SGH site to increase elective activity when theatre E returns operational in July 2021. All wards providing elective care will be protected green zones.

Goole Hospital (GDH) is identified as a green site and used primarily for elective care so where possible any positive Covid-19 patients are not managed here, all elective cases are swabbed prior to their admission. GDH is also in a position to support all Goole and other North Lincolnshire Residents with its step up/step down ability, these patients are accepted following a negative admission and day 3 swabs as a minimum to minimise the likelihood introducing Covid-19 to the hospital site.

6.0 NLAG Winter Planning

The Trust's approach to winter planning has been formed by a working group consisting of representation from each division that will meet at a fortnightly interval. This will allow an organisational and system approach to winter planning bringing oversight, decision making and authority to implementation of the NLAG Winter Action Plan for 2021/2022. The Group will also give consideration to any emerging issues and concerns which have a direct or indirect impact to the whole systems Winter Plan. Escalation from this group will be by exception to the Chief Operating Officer to maintain executive oversight.

6.1 Group Membership

- **Chair:** Head of EPRR
- Emergency Planning Manager
- IPC Lead
- Head of Patient Flow
- Triumvirate for Surgery and Critical Care
- Triumvirate for Medicine
- Triumvirate for Family Services
- Triumvirate for Community and Therapy
- Triumvirate for Clinical Support Services
- Representative from Medical Directors Office
- Representative from Estates and Facilities

- Representative from Communications and Marketing Team
- Representative from Procurement
- Representative from Path Links
- Representative from Strategy and Planning
- Representative from Finance

6.2 Action Log

The action log is maintained by the Emergency Planning Officer. Directorates/Divisions will be required to send updates to the Emergency Planning Officer to include in the action log and this will circulated to the attendees prior to the next meeting.

Annex A

Organisation COVID-19 exception report

Organisation information			
Organisation code			
Organisation name	Northern Lincolnshire and Goole Foundation Trust		
Organisation type	Acute Hospital		
Date		Time	
Completed by	Name: Title:		
Single point of contact number	03033306344		
Single point of contact email address	nlg-tr.covid19@nhs.net		
Authorised for release by	Name: SHAUN STACEY Title: CHIEF OPERATING OFFICER		

Clinical Service Impacts	
Services which are only being maintained through business continuity plan invocation	
Services that are operating as normal but will need business continuity invoking to remain in operation in the next 24 hours	
Specific capabilities that are suspended	
Issues in other organisations and social care caused by COVID-19 preventing normal operations	
Non-clinical COVID-19 impacts	
Non-clinical services that are operating on business continuity and issues within your organisation regarding: • Supply Chain • Human resources (e.g. availability of staff/agency issues)	

Notification of requests to the National Equipment Loan Programme
This section should **only** be used to escalate a need for additional equipment arising **now or in the next 7 days**. Please do not use this section to inform us of longer-term strategic equipment needs (such as those required to reach maximum surge capacity). For each request, please include the following information: • What device or equipment is needed? Be specific as to type and quantity. Would any equivalent device be acceptable? • Please confirm that mutual aid has been explored and exhausted. You must include a brief commentary. • Please confirm that patient transfer has been considered and is not a suitable / available option. You must include a brief commentary as to why. The national team will need to understand whether there is capacity locally and across the wider geography.
None required

Notification of critical consumable supply shortages
This section should only be used to escalate a critical need for additional consumables, including PPE, arising **now or in the next 7 days**. You must first escalate to the National Supply Distribution Response (NSDR) service for consumables/some medical devices and pursue alternative suitable replacement products. Confirmation is also required that regional mutual aid has been actioned: your locality director or operational delivery network is available to support you with this request. If you have completed both these steps, and are still in critical need, you **must** include the following information below: • NSDR reference number • Make, model and quantity of consumable items • How many days' supply you have left • Information on all local assistance routes exhausted • Delivery address and 24/7 contact number
None required

Other context information	
Any other information that you as Incident Director (Strategic Commander) deem relevant for the NHS England and NHS Improvement region to be aware of including societal issues impacting on the organisation	
Key risks and mitigating actions	**Emergency departments attendance and staffing shortages within medical team**, high – mitigations **High demand for Critical Care beds** **Requirement for Mental Health** **Community Nursing** **Nurse/Doctor staff shortages** r **Hospital Discharge flow** – **Paediatrics/Neonates** –
Forward look – issues anticipated for the following time periods	
24 hours	
48 hours	
72 hours	
Recovery	
Communications	
Communications issues for regional escalation	
Exception reporting	
Exception report due	Daily as required by 11am
Submission to	england.eprrney@nhs.net

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)203

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Gill Ponder, Chair of Finance & Performance Committee
CONTACT OFFICERS	N/A
SUBJECT	F&P Committee Highlight Report – August & September 2021 – PERFORMANCE
BACKGROUND DOCUMENT (if any)	Minutes of meeting
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	Performance and Estates and Facilities matters to highlight to Trust Board from the meetings held on 25 August and 29 September 2021 were: • Concerns about A&E performance and ambulance handover times. Further changes planned in October. • Planned Care 52 week waits recovery on track. • Cancer performance continued to miss the 62 day standard. • Assurance on management of asbestos and medical gases.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable	SO1 1.2 SO1 1.3 SO1 1.4 SO1 1.5 SO1 1.6 SO3 3.1 SO3 3.2 SO4				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	✓

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5 October 2021
Report From:	Finance & Performance Committee 25 August & 29 September 2021

Highlight Report:

- A&E performance continued not to meet the 4 hour standard, despite reduced length of stay and improved flow. The 111 first initiative had not reduced demand. Changes to the front door model would be made in October, with senior clinicians streaming patients to the right place for treatment. That model had worked well in other locations. The Trust intended to proceed at risk after discussion with CCG's, as funding had not yet been secured.
- Planned Care recovery on track to clear patients waiting over 52 weeks by 31 October. The Trust had the best 52 week and 104 day performance in the region due to ring-fencing capacity and minimising cancellations.
- Cancer performance continued to miss the 62 day target due to high demand and shortage of specialist clinicians. Extra capacity to meet diagnostic demand would be created by retaining the staffed mobile units at a significant, unbudgeted cost and by doing more diagnostics in the community.
- Asbestos surveys of all sites would inform an updated management plan.
- A detailed action plan on medical gases was in place after a report from the Authorised Engineer. The next report to the Committee would focus on progress with delivering those planned actions.

Confirm or Challenge of the Board Assurance Framework:

The Committee carried out a Deep Dive into the BAF Strategic Risk– SO1 – 1.2 (The risk that the Trust fails to deliver constitutional and other regulatory performance targets).

The current risk score was 20 and there was a robust discussion about whether the risk of harm to patients warranted that score. Mitigations were in place, including Risk Stratification, Discharge to Assess, changes to the model of delivering urgent care and increased diagnostic capacity, but these had not yet delivered enough benefits to reduce the score. The Committee asked when benefits would be seen and suggested a target risk score for the year where it was not possible to move from the current score to the final target score in one year. It was felt that that would enable the Committee to gain assurance against the planned risk reduction trajectory and the mitigation of the risk to patients.

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(21)204

DATE OF MEETING	Tuesday 5 October 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Maurice Madeo – Deputy DIPC, Ellie Monkhouse, Chief Nurse/DIPC
CONTACT OFFICER	As above
SUBJECT	Annual Infection Prevention & Control DIPC report
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Quality & Safety Committee
EXECUTIVE SUMMARY	• 28 cases of Hospital Onset Healthcare Associate C.difficile cases which is 23% reduction to last year. • Only x1 hospital onset case of MRSA bacteraemia in December. There was a 20 month gap between cases. • 19% reduction in E.coli bacteraemia cases. • Good performance with orthopaedic primary hip & knee surgical site infections. • Managing the second wave of the pandemic a challenge due to infrastructure deficiencies and limited testing ability and novel virus. • Continuation of the Incident Control centre with excellent clinical engagement and innovative ways of working. • IPC Board assurance framework informally assessed by CQC and deemed satisfactory.

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

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

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

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

INFECTION PREVENTION & CONTROL TEAM
ANNUAL REPORT
TO THE
DIRECTOR OF INFECTION PREVENTION & CONTROL

2020-21

Written by M. Madeo Deputy DIPC / Assistant Chief Nurse on behalf of the DIPC Ellie Monkhouse Chief Nurse.

Contents:

Table and Figures

Executive Summary

This report is a record of activities relating to the prevention and control of healthcare associated infection (HCAI) in Northern Lincolnshire and Goole NHS Foundation Trust during the year April 2020 to March 2021.

The main focus this year has been to continue the work around nosocomial infections and antimicrobial stewardship. However with the unexpected emergence of SARS CoV-2 and variants, managing the pandemic has been the main focus of attention for the team and Trust for the last 12 months. The team continue to work closely with facilities colleagues to best direct cleaning resources and instigate appropriate cleaning regimes to help manage the pandemic. Work also continues with the capital team in the design of new builds to take into account the latest evidence around containment of SARS CoV-2. The management of COVID-19 has been a substantial challenge and pull on limited IPC team resources. With the establishment of the incident control centre this allowed the pandemic to be managed in a proactive robust manner with excellent engagement from clinical staff.

Overall there have been a number of achievements in the past twelve months, which include:

Performance

- Only 1 lapse in care / practice associated with C.difficile infection from cases reviewed which is a reduction from the previous year. Due to the pandemic multidisciplinary reviews were suspended and undertaken by the IPC team.
- 28 cases of Hospital Onset Healthcare Associate C.difficile cases which is well within the allocated trajectory and 23% reduction to last year.
- Only x1 hospital onset case of MRSA bacteraemia in December. There was a 20 month gap between cases.
- Reduction in Gram negative blood stream infections which remains a challenge, however we have achieved a 19% reduction in E.coli bacteraemia cases.
- Good performance with orthopaedic primary hip & knee surgical site infections although cases reduced due to pandemic response.
- Use of medical devices such as PVC and urinary catheters remains broadly the same.
- Antimicrobial IV usage is difficult to compare due to the pandemic response.
- Below peers for number of Hospital onset COVID-19 cases.

Governance

- The development of WebV COVID-19 icons to identify current swab status
- Implementation of SARS CoV-2 monitoring tool to help operational team and update service leads.
- Developed systems using Power BI to feedback ward / dept performance against KPIs.
- Undertook the Infection prevention and control board assurance framework assessment which showed overall good compliance
- Undertaken point prevalence surveillance across acute adult wards.

- Had a virtual CQC Infection Prevention and Control Assessment Engagement call to review the BAF which was deemed satisfactory.

Training / Education

- Due to the pandemic face-face training replaced by virtual and on the spot donning and doffing / fit testing preparation.
- CPD team and seconded staff into IPC assisted manage the FFP3 fit testing requirements with around 2500 fit tested.

Areas for further improvement and support include:

There remain a number of challenges for the Trust that needs to be considered going forward which have been magnified with the emergence of the coronavirus pandemic.

The lack of single rooms across the trust is partly been addressed at DPOW through the opening of A1 and reconfiguration of the C floor wards. However SGH continues to be a challenge due to the historic closure of the Coronation wards and loss of 11 single rooms. As previously mentioned the incidence of respiratory virus for various socioeconomic reasons appears to be much higher within Northern Lincolnshire, as such impacts on the SGH site. It was noted during the pandemic at times the prevalence in the community within NL was 3-4 times higher than North East Lincolnshire.

There is no High Dependency Unit at SGH which causes issues when there needs to be escalation of respiratory patients, especially if no capacity on ICU to manage patients. The HDU at DPOW is also not currently fit for purpose due to only having x1 single room, which has posed a challenge during the pandemic. This situation is compounded due to the oxygen limitations (output) across the wards making management of patients requiring high level of oxygen more of a challenge.

As part of the estates strategy, future builds will now take into consideration the IPC requirements including enhanced ventilation, oxygen demands and isolation capacity. This will help the Trust prepare for future COVID-19 waves and future infection challenges. Adequate mechanical ventilation is now seen as being essential to help mitigate the risk of airborne pathogens to help protect staff and patients and not solely rely on the use of PPE. This is critical within areas that are undertaking AGPs such as respiratory wards and critical care settings. Currently we do not have this functionality within the Trust.

The Trust purchased some redirooms which allowed us the opportunity to try and contain suspected and confirmed cases of COVID-19 within the admission zones to compensate for the lack of isolation capacity. These have been of great use especially during the second wave of the pandemic where we saw high daily cases of COVID-19 admissions.

There continues to be a lack of Consultant Medical Microbiologists onsite 5 days a week. During the pandemic one of the part time Consultant medical microbiologists was appointed the main COVID lead for the Trust and undertook this role on a full time basis remotely which was well received. Once this comes to an end post lockdown there will be a significant gap that will impact on the delivery of a proactive service with antimicrobial stewardship ward rounds and attendance of key meetings.

Introduction

This report is a record of activities relating to prevention and control of healthcare associated infection (HCAI) in North Lincolnshire & Goole Hospitals NHS Foundation Trust during the year April 2020 to March 2021. Healthcare associated infection remains a top priority for the public, patients and staff and remains one of the Trust's strategic objectives. Avoidable infections are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources and impact on antimicrobial resistance pressure. Investment in infection prevention and control remains both necessary and cost effective.

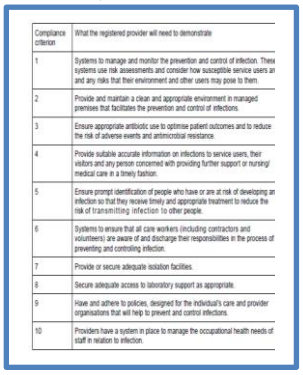
The purpose of this report is to inform patients, public, staff, the Trust Board of Directors, Council of Governors and Clinical Commissioning Groups (CCG) of the infection prevention and control work undertaken in 2020-21 and provides assurance that the Trust remains compliant with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health, 2015). This report is structured using the criteria in the Health and Social Care Act 2008 – Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance which sets out the criteria against which a registered provider's compliance with requirements relating to cleanliness and infection control will be assessed by the Care Quality Commission (CQC).

Infection prevention and control is the responsibility of everyone in the healthcare community and is only truly successful when everyone works together. Success is the product of everyone getting everything right first time, every time. This annual report shows how we are performing, where we do well and where we would like to do better. Due to the COVID-19 pandemic much of the normal IPC activities had to be prioritised as such most of the annual report will be focused on the management of the pandemic and lessons learnt.

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

Infection Prevention and Control Workforce arrangements

The Trust's arrangements for the prevention and control of infection are contained within the document, *Infection Prevention & Control Strategy: Overview of the Trust Approach and Arrangements for Infection Prevention & Control* [IC/SP3], which is held by the Directorate of Governance & Assurance/Trust Secretary. This document details the responsibilities of various parties within the organisation and their governance and management arrangements. While the Chief Executive has the final responsibility for all aspects of infection control, the functional responsibility lies with the Director of Infection Prevention and Control (DIPC) who is currently the Director of Nursing. The deputy DIPC for IPC oversees the day to day activities of the IPC team and delivery of the IPC Strategy 2020-22 incorporating the annual work plan.

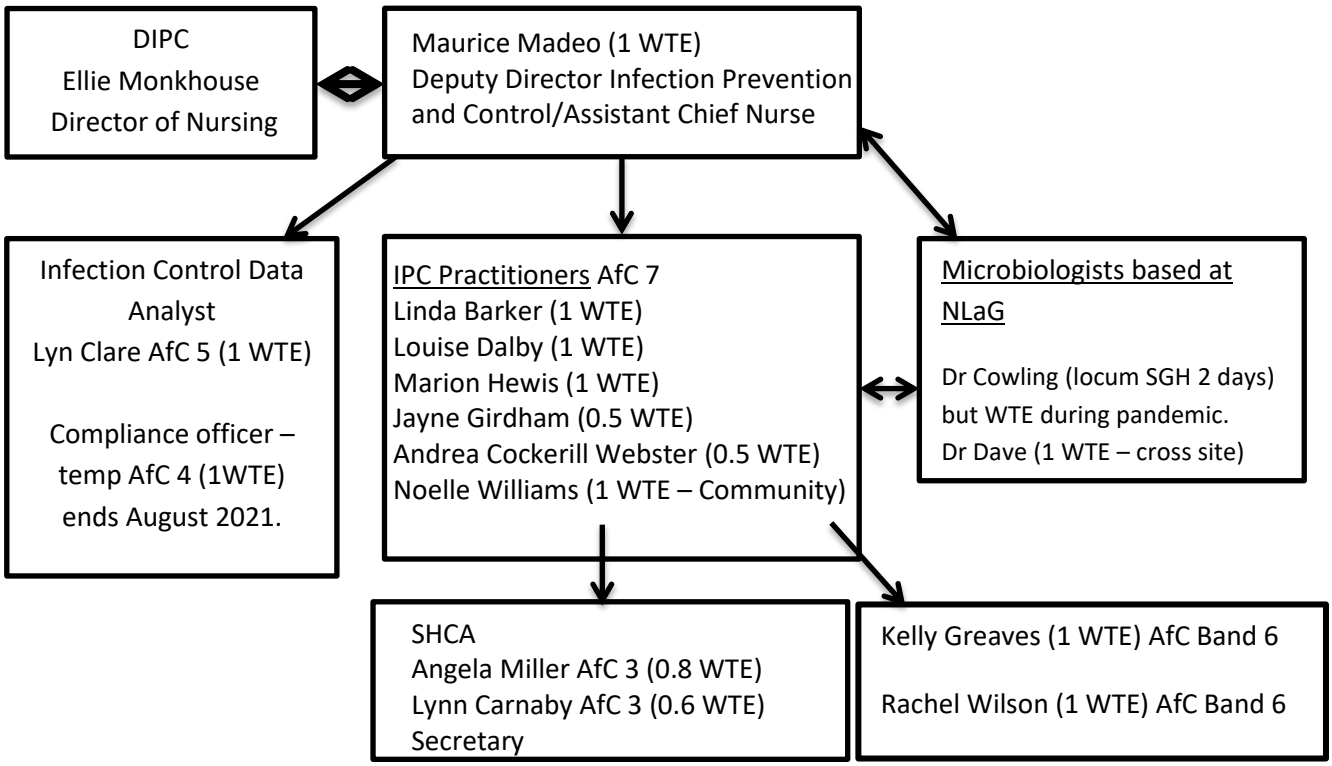


Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs of staff in relation to infection.

The number of consultant microbiologists available within PathLinks continues to have challenges with recruitment. This has left the

availability of onsite consultant microbiologists severely stretched minimising the amount of ward rounds especially during the pandemic and attendance at relevant meetings. During the COVID-19 pandemic we were fortunate to acquire the services of a WTE Consultant Medical Microbiologist, to provide the Trust and IPC team remote additional support during this pandemic. This has been very much appreciated and valuable during the early phases of the pandemic where there was much anxiety within certain staff groups.

Infection Prevention & Control Team at March 2021



The infection control service is provided 7 days a week with an on- call service available to cover the weekends and Bank holiday periods. All nurses who provide on call advice service have completed a programme of study and are experienced infection prevention and control specialists. There is also 24/7 consultant medical microbiologist cover through Path Links.

Infection Prevention & Control Committee

The IPC committee oversees and directs all infection prevention and control activity in the Trust, is responsible for ensuring appropriate implementation of national guidance and that infection prevention and control policies are in place, regularly reviewed and compliance audited. During the pandemic there was a close working relationship with the Incident Control Centre, where the Deputy DIPC and Consultant Microbiologist were core members. The ICC met on a daily basis and was able to review and agree new national guidance and provide strategic direction in an efficient timely manner.

The annual infection prevention & control programme and IPC strategy are endorsed by the Infection Prevention & Control Committee and updates are received on a periodic basis. The committee membership includes representatives from Occupational Health (co-opted), Consultant Microbiologist, Senior Infection Prevention and Control nurses, senior divisional nurses or representatives, Consultant Pharmacist, Antimicrobials, CCG representatives, Estates / facilities, medical director or deputy and others co-opted as required. The attendance at IPCC has been variable as expected due to competing pressures and obviously the pandemic. The establishment of the Incident Control Centre during the COVID-19 incident helped to cascade key messages and the Deputy DIPC was a key member of this group.

Surveillance of Healthcare Associated Infection

One of the main elements of Infection Prevention workstream is undertaking active surveillance. Surveillance is more than just the recording or reporting of infections. Data is collected in accordance with strict definitions and protocols to ensure consistency. Some surveillance data are only reported internally and other data are reported externally either as part of mandatory or voluntary surveillance schemes. However, the most important element of surveillance is feedback to clinicians in a timely manner. Feedback prompts review of, and where necessary, planned improvements to clinical practice. There are a number of mandatory surveillance activities that are routinely undertaken to meet Public Health England requirements and this is growing year on year with increasing demands on the team and information team.

MRSA Bacteraemia

Nationally, there remains a zero tolerance for preventable MRSA bacteraemia cases. Thus, once again the Trust had a target of zero avoidable hospital-acquired cases. As in previous years, every case of MRSA bacteraemia must undergo a rigorous Post Infection Review Process to help identify any obvious root causes and learn lessons. I am pleased to report the Trust only detected 1 hospital onset MRSA bacteraemia case in December and has since not had any further cases.

Table 1 MRSA bacteraemia cases since 2006

Year	Trust apportioned	Total
2006/2007	29 (60.4%)	48
2007/2008	22 (66.7%)	33
2008/2009	11 (57.9%)	19
2009/2010	3 (18.8%)	16
2010/2011	8 (50.0%)	16
2011/2012	4 (57.1%)	7
2012/2013	2 (40.0%)	5
2013/2014	5 (55.6%)	9
2014/2015	1 (16.7%)	6
2015/2016	0 (0.0%)	3
2016/2017	3 (75%)	4
2017/2018	1 (33%)	3
2018/2019	0	2
2019/2020	1	7
2020/2021	1	1

Overall the Trust has performed very well compared to many other Trusts within the region as can be seen in the Yorkshire and Humber PHE data below.

Figure 1 Total Number of MRSA Bacteraemia Hospital Onset Yorkshire & Humber up to February 2021

Quintiles: Low High Not applicable

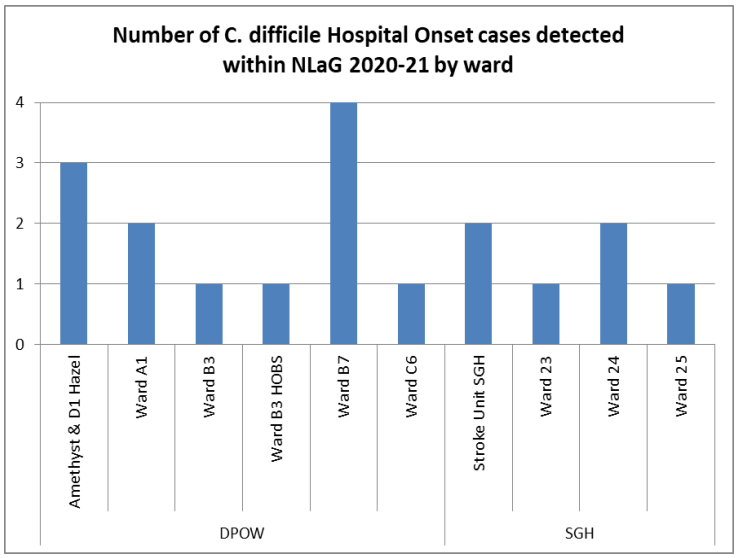
Recent trends: – Could not be calculated → No significant change ↑ Increasing ↓ Decreasing

MRSA bacteraemia all cases counts and 12-month rolling rates, by acute trust and month (Persons, All ages) New data Feb 2021 — Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	695	2.4	-	-
acute trusts	–	68	2.3*	1.8	2.9
Bradford Teaching Hospitals	→	11	6.5	-	-
Doncaster and Bassetlaw Hospitals	→	10	4.5	-	-
Leeds Teaching Hospitals	→	18	3.5	-	-
United Lincolnshire Hospitals	→	8	2.3	-	-
Airedale	→	2	2.2	-	-
Sheffield Teaching Hospitals	→	9	2.2	-	-
Barnsley Hospital	→	3	2.1	-	-
Calderdale and Huddersfield	→	3	1.7	-	-
The Rotherham	→	1	0.8	-	-
Hull and East Yorkshire Hospitals	→	2	0.7	-	-
Northern Lincolnshire and Goole Hospitals	→	1	0.5	-	-
York Teaching Hospital	→	0	0.0	-	-
Harrogate and District	→	0	0.0	-	-

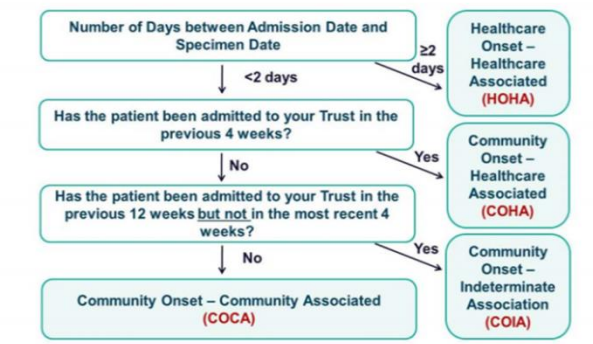
Clostridioides difficile (formerly known as Clostridium difficile) Infections

Figure 2 Breakdown of C.difficile cases by ward



Clostridioides difficile infection (CDI) remains an unpleasant, and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups especially those who have been exposed to antibiotic treatment. *Clostridioides difficile* is a bacterium that releases a toxin which causes colitis (inflammation of the colon), and symptoms range from mild diarrhoea to life threatening disease. Asymptomatic carriage also occurs. Infection is often associated with healthcare, particularly the use of antibiotics which can upset the bacterial balance in the bowel that normally protects against *C. difficile* infection. Infection may be acquired in the community or hospital, but symptomatic patients in hospital may be a source of infection for others.

The *C.difficile* objective guidance continued the use of lapse in care as a performance indicator. A lapse in care would be indicated by evidence that policies and procedures consistent with local guidance or best practice were not followed. There was also a change in the classification of a healthcare onset or community onset case. This reduced the number of days to identify hospital onset healthcare associated (HOHA) cases from ≥3 to ≥2 days after admission. The introduction of the Community Onset Healthcare Associated (COHA) category also will assign cases to the Trust where the patient has been an inpatient in the trust reporting the case in the previous four weeks. In 2019/20 the Trust has been allocated a trajectory of no more than 36 cases combining the HOHA and COHA as such we adopted this trajectory for 2020/21.



The trust had a CDI objective of no more than 36 cases and ended the year on 28 reported cases which is well within the allocated trajectory and 23% reduction to last year. There was 1 lapse in practice / care detected from the Post Infection Reviews undertaken with the main issues around antimicrobial prescribing

The SGH site had 11 cases of CDI and DPOW 17. Due to the reconfiguration of wards during the pandemic there were no obvious issues with significant cases detected within any wards or linked cases. The IPC team routinely submit positive stool samples for ribotyping to the reference laboratory to help establish the presence of virulent strains of C.difficile and also monitor if there is a possible relationship between cases. It was pleasing to report there were no clusters or outbreaks of C.difficile infection. Overall the trust is performing well compared to Yorkshire & Humber data for CDI rates in patients over 2 years of age for all England acute trusts based on 100,000 bed days.

Figure 3 Total Number of C.difficile Hospital Onset Yorkshire & Humber upto Feb 2021

Quintiles: Low High Not applicable

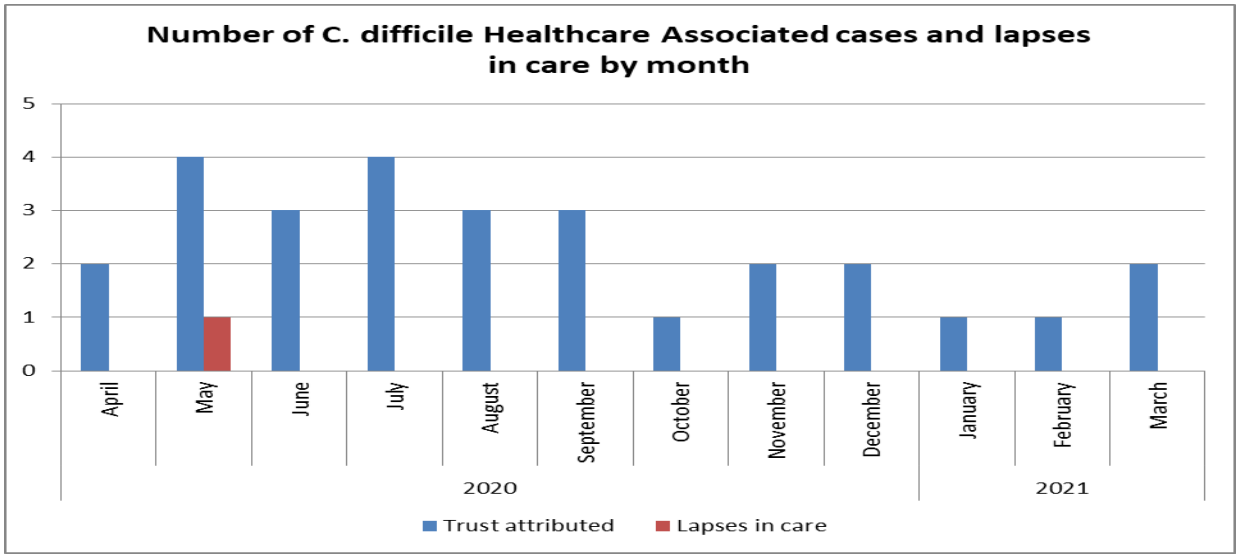
Recent trends: – Could not be calculated → No significant change ↑ Increasing ↓ Decreasing

C. difficile infection counts and 12-month rolling rates of hospital onset-healthcare associated cases, by reporting acute trust and month (Persons, 2+ yrs) New data Feb 2021

Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	4,844	17.0	-	-
acute trusts	–	560	18.7*	17.2	20.3
Sheffield Teaching Hospitals	→	112	27.5	-	-
Calderdale and Huddersfield	→	40	22.8	-	-
Leeds Teaching Hospitals	→	114	22.4	-	-
Harrogate and District	→	16	20.8	-	-
York Teaching Hospital	→	49	19.5	-	-
Airedale	→	16	17.7	-	-
Hull and East Yorkshire Hospitals	→	47	16.8	-	-
Doncaster and Bassetlaw Hospitals	→	37	16.5	-	-
United Lincolnshire Hospitals	→	55	16.1	-	-
The Rotherham	→	20	15.9	-	-
Bradford Teaching Hospitals	→	22	13.1	-	-
Barnsley Hospital	→	14	9.6	-	-
Northern Lincolnshire and Goole Hospitals	→	18	8.9	-	-

Figure 4 Number of C.difficile cases

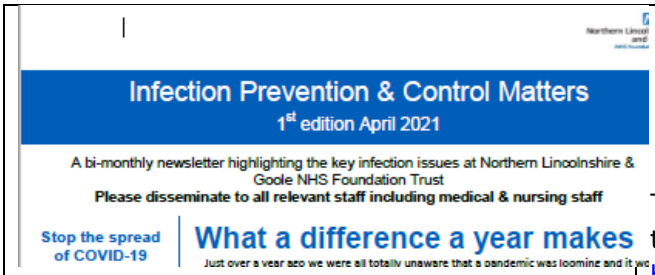


The distribution of cases over the year does not show any abnormal trend.

Post Infection Review

Following a case of Healthcare Onset Healthcare associated C.difficile infection a PIR is undertaken with relevant clinical staff to ascertain if there have been any deviations from best practice. However due to the ongoing pandemic situation the structure was amended. The IPC team undertook a thorough review of the case and if there were any obvious lapses in practice / care then a PIR meeting was held if possible. The one lapses detected was associated with the use of antimicrobials e.g. prolonged courses.

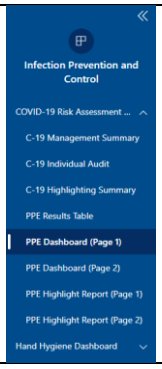
Some of the initiatives introduced to reduce the risk of nosocomial infections



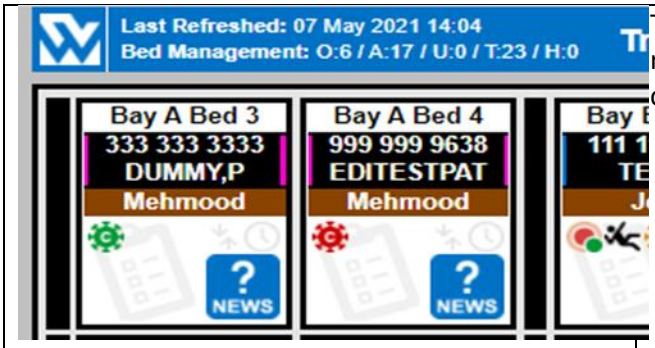
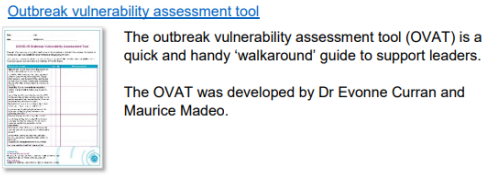
The IPC team managed to launch a newsletter to help promote latest news http://nlgnet.nlg.nhs.uk/infectioncontrol/Documents/Link%20Network/infection%20control%20matters%201st.pdf

The IPC Blog is regularly updated to provide bite sized information to staff https://ipc427.wordpress.com/

As part of the COVID pandemic response we had additional support from our nursing colleagues to help with donning and doffing / PPE training. They wore a visible jacket to allow staff to easily spot them on their rounds. The majority of high risk staff were fit tested for reusable FFP3 masks. >2500 fit tests were undertaken during the pandemic.



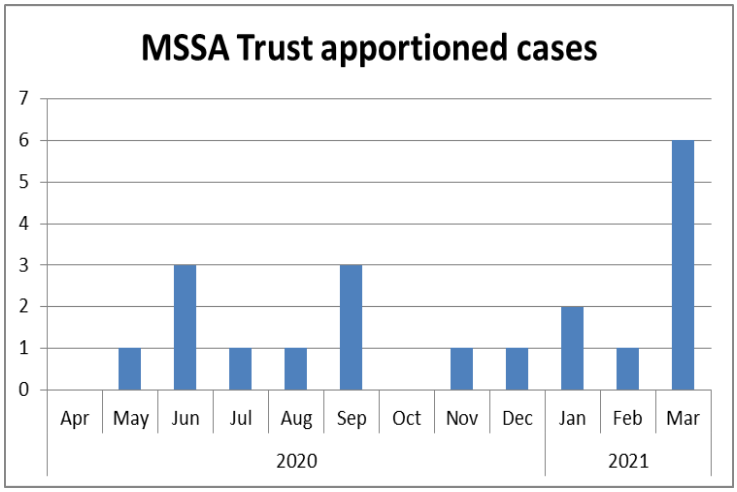
The implementation of bespoke audits to help ensure best practice was in place during the pandemic – including PPE and IPC Board assurance audits with dashboards for staff. Infection Prevention and Control Power BI App

	The development of the COVID flags and reswab list to improve day 3 and 6 swabbing compliance.
	The IPC team undertook a number of surveys to establish staff feedback on how they thought the pandemic was managed and lessons to be learnt. This was undertaken on the back of the tool developed and adopted by NHSE/I. Full report – here.

Staphylococcus aureus bacteraemia

Staphylococcus aureus is a bacterium commonly found colonising the skin and mucous membranes of the nose and throat. Although approximately a quarter of the population carry this organism harmlessly, it is capable of causing a wide range of infections from minor boils to serious wound infections and from food poisoning to toxic shock syndrome. In hospitals, it can cause surgical wound infections and bloodstream infections. When *Staphylococcus aureus* is found in the bloodstream it is referred to as a *Staphylococcus aureus* bacteraemia. The reporting of Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias became mandatory from January 2011. Prior to that only voluntarily collected data was available.

Figure 5 MSSA Trust apportioned cases



The number of trust apportioned MSSA bacteraemias detected during the current year is shown in Figure 5. The definition of Trust-Acquired vs Community-Acquired is based on the positive blood culture sample being collected on or after the 3rd day of admission. All actions taken to minimise MRSA bacteraemias will have the effect of minimising MSSA bacteraemias. The number of cases detected deemed healthcare acquired compared to the previous year have generally remained static. The majority of MSSA bacteraemia cases are detected within 2 days of admission and in many

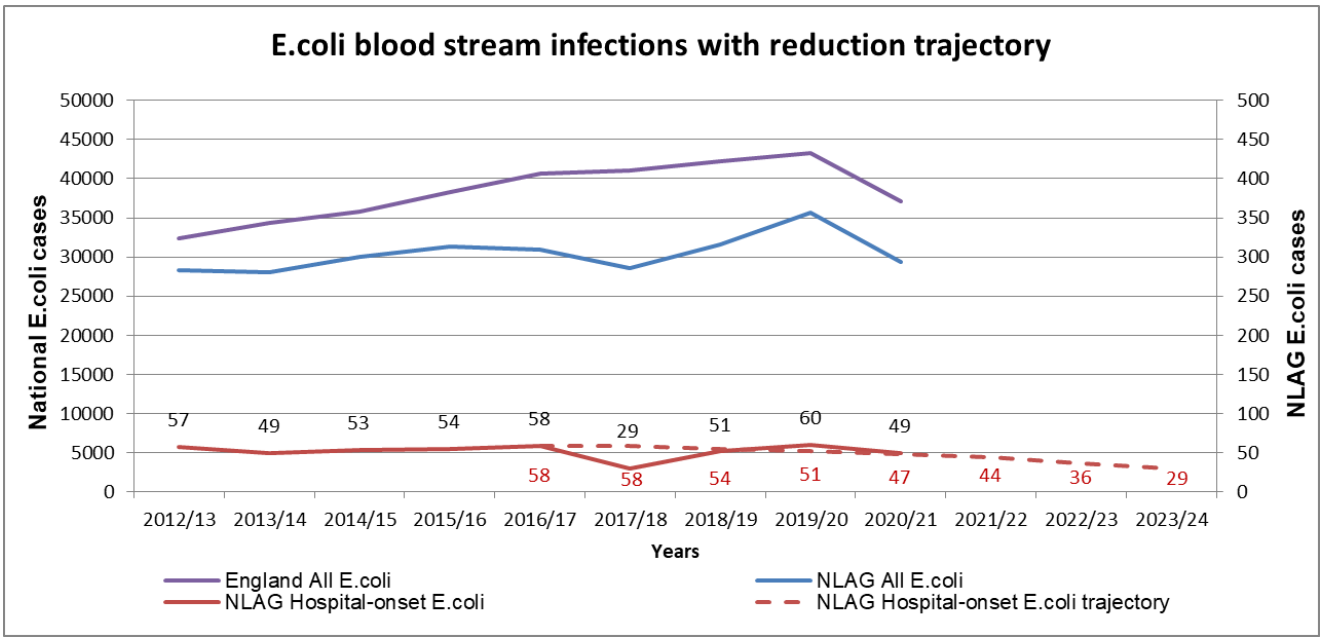
cases the source is not always obvious despite a review by the IPC team. There are many causes for MSSA infections and there are generally no obvious trends at present.

Gram negative blood stream infections inc E.coli.

Halving the numbers of healthcare-associated Gram-negative bloodstream infections (GNBSIs) by 2024 is a key government ambition, announced as a key action in Lord O'Neill's Review of Antimicrobial Resistance (AMR). In 2017 we saw the implementation of a new national ambition to reduce the incidence of healthcare-associated Gram negative bacteraemias caused by Escherichia coli, Klebsiella spp. and Pseudomonas aeruginosa by 50% (compared to baseline year April 2017 to March 2018) by April 2024.

Locally the number of E.coli bacteraemia cases remains a significant burden for patients.

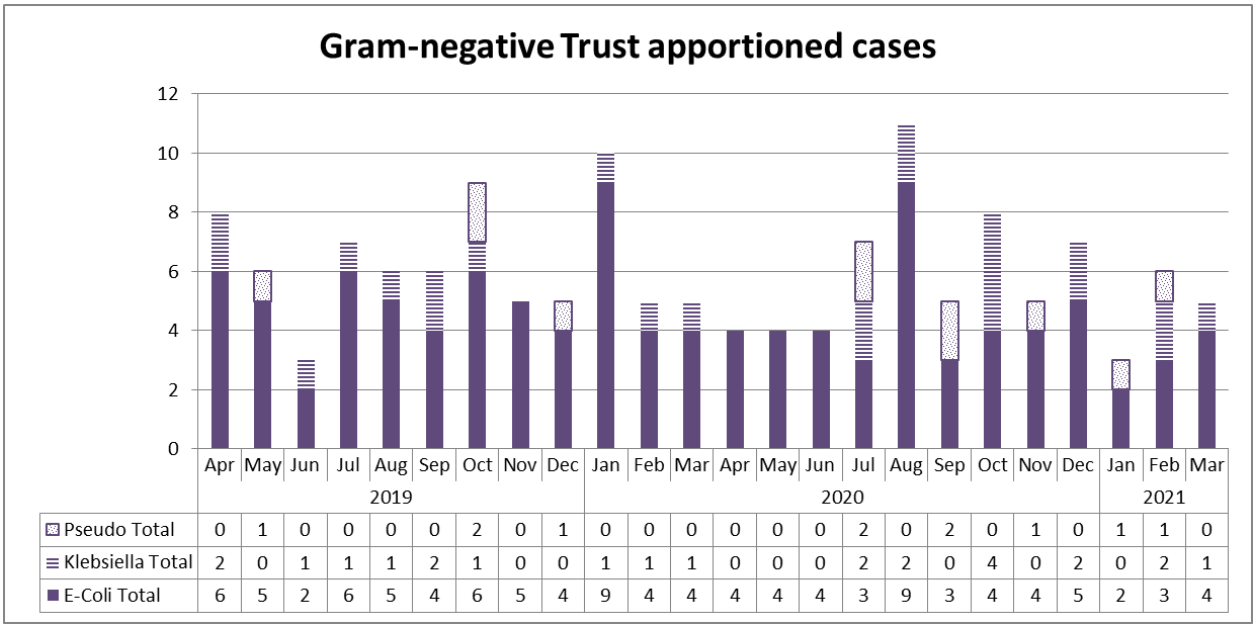
Figure 6 E.coli blood stream infections with reduction trajectory



The number of E.coli blood stream infections detected after day 2 of admission has decreased from 60 to 49 which is a 19% reduction. The number of cases detected is very dependent on the presenting patient condition and timeliness of the blood culture. There is seasonal variation with generally more cases during the spring and summer period would also have had some impact on the number of cases presenting with urogenital issues exacerbated by dehydration. The Trust reported 382 cases which is a combination of Healthcare Onset and Community Onset cases of which 49 were deemed Healthcare Onset (13%). As can be appreciated with this number of cases reported with around 87% of E.coli blood stream infections detected within 2 days of admission, many of the required interventions will require a health economy approach if a long lasting reduction is to be made. The necessary actions should take into consideration the age profile of these patients (Fig 11) where the average age of gram-negative patients is 70.3 years. Due to the age profile a significant number will have numerous co-morbidities and risk factors e.g. dementia, increasing their risk of infection. Therefore measures such as hydration, removal of urinary catheters, appropriate diagnosis

and treatment of urinary tract infections. Improved surgical management are some of the key priorities for secondary and primary care which may have been adversely affected due to the pandemic.

Figure 7 Trust apportioned Gram Negative Cases



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2019									2020												2021		
Pseudo Total	0	1	0	0	0	0	2	0	1	0	0	0	0	0	0	2	0	2	0	1	0	1	1	0
Klebsiella Total	2	0	1	1	1	2	1	0	0	1	1	1	0	0	0	2	2	0	4	0	2	0	2	1
E-Coli Total	6	5	2	6	5	4	6	5	4	9	4	4	4	4	4	3	9	3	4	4	5	2	3	4

In addition to E.coli the Trust reports the number of Klebsiella and Pseudomonas aeruginosa blood stream infections.

Pseudomonas aeruginosa is a Gram-negative bacterium often found in soil and ground water. P. aeruginosa is an opportunistic pathogen and it rarely affects healthy individuals. It can cause a wide range of infections, particularly in those with a weakened immune system. These infections are sometimes associated with contact with contaminated water. In hospitals, the organism can contaminate devices that are left inside the body, such as respiratory equipment and catheters. P. aeruginosa is resistant to many commonly-used antibiotics.

The trust detected 30 cases of Pseudomonas aeruginosa with 7 Healthcare Onset, which was similar to previous years.

Klebsiella species belong to the family Enterobacteriaceae. Klebsiella species are a type of gram negative rod shaped-bacteria that are found everywhere in the environment and also in the human intestinal tract (where they do not cause disease). Within the genus Klebsiella, 2 common species are associated with the majority of human infections: Klebsiella pneumoniae and Klebsiella oxytoca. Both species are commonly associated with a range of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis.

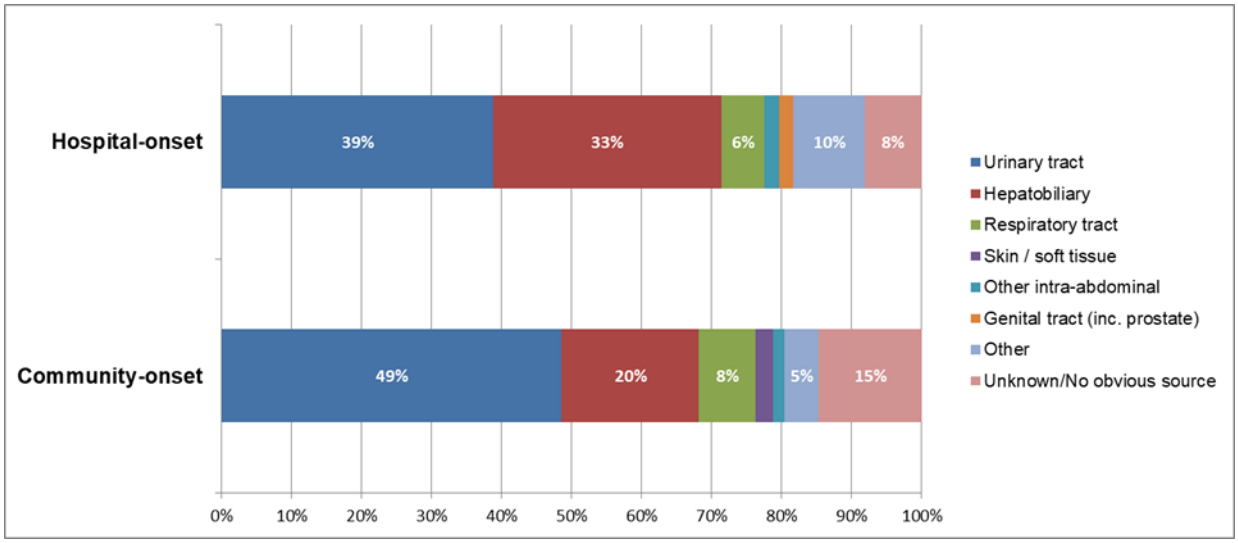
In healthcare settings, Klebsiella infections are acquired endogenously (from the patient's own gut flora) or exogenously from the healthcare environment. Patient to patient spread can occur via contaminated hands of healthcare workers or less commonly by contamination of the environment. There were 62 cases of Klebsiella with 13 Healthcare Onset which is similar to the previous year.

Table 2 Hospital onset E.coli bacteraemia cases 2020-2021

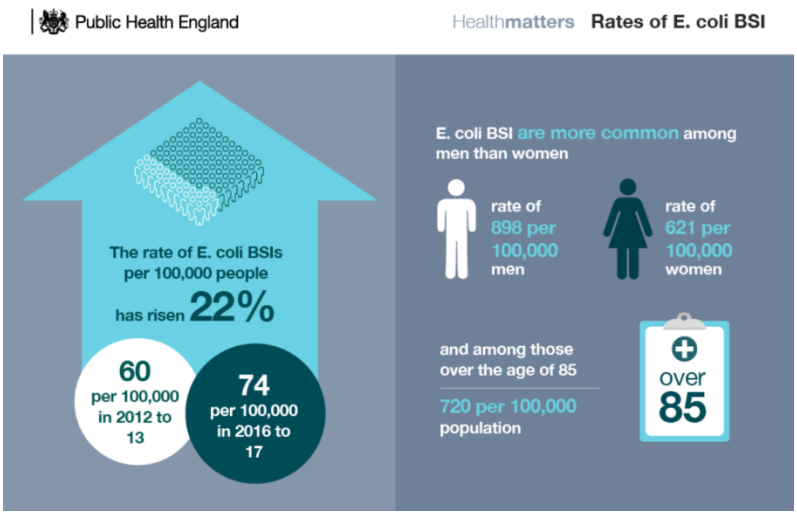
Row Labels	2020/21 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 Total
E-Coli													
DPOW													
Acute Assessment Unit - DPOW	0	0	0	0	0	0	0	0	0	0	0	0	0
Amethyst & D1 Hazel	0	0	0	1	0	0	0	0	1	0	0	1	3
Holly Ward	0	0	0	0	0	0	0	0	0	0	0	0	0
ITU	0	0	0	0	0	0	1	1	0	0	0	0	2
Laurel Ward	0	0	0	0	0	0	1	0	0	0	0	0	1
Stroke Unit DPOW	0	0	0	1	2	0	0	0	0	0	0	0	3
Ward A1	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward B2	1	0	0	0	0	0	0	0	0	0	0	0	1
Ward B3	0	0	0	0	0	0	0	1	0	0	0	0	1
Ward B4	0	0	1	0	0	0	0	0	0	0	0	0	1
Ward B6	0	0	0	0	1	1	0	0	0	1	0	0	3
Ward C1 Glover	0	1	0	0	1	0	0	0	0	0	0	0	2
Ward C2	0	0	1	0	0	0	0	1	1	0	1	1	5
Ward C5	0	1	0	0	2	0	1	0	1	0	0	0	5
Ward C6	0	0	0	0	0	0	0	0	0	0	0	0	0
DPOW Total	**1**	**2**	**2**	**2**	**6**	**1**	**3**	**3**	**3**	**1**	**1**	**2**	**27**
GDH													
Goole Neuro Rehab Centre	0	0	0	0	0	0	0	0	1	0	0	0	1
Ward 3 GDH	0	0	0	0	0	1	0	0	0	0	0	0	1
Ward 5/6 GDH	0	0	0	0	0	0	0	1	0	0	0	0	1
GDH Total	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**1**	**0**	**0**	**0**	**3**
SGH													
Acute Assessment Unit - SGH	0	0	1	0	0	0	0	0	0	0	0	0	1
Central Delivery Suite	0	1	0	0	0	0	0	0	0	0	0	0	1
Stroke Unit SGH	0	0	0	0	0	1	0	0	0	0	0	0	1
Ward 16	1	0	1	0	0	0	0	0	0	0	0	1	3
Ward 17	1	0	0	0	0	0	0	0	0	1	0	0	2
Ward 18	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 19	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 22	0	0	0	0	0	0	0	0	1	0	0	1	2
Ward 23	0	0	0	0	1	0	0	0	0	0	1	0	2
Ward 24	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 25	1	0	0	1	0	0	0	0	0	0	0	0	2
Ward 26	0	1	0	0	0	0	0	0	0	0	0	0	1
Ward 27	0	0	0	0	1	0	1	0	0	0	0	0	2
Ward 28	0	0	0	0	0	0	0	0	0	0	1	0	1
Ward 29	0	0	0	0	1	0	0	0	0	0	0	0	1
SGH Total	**3**	**2**	**2**	**1**	**3**	**1**	**1**	**0**	**1**	**1**	**2**	**2**	**19**
E-Coli Total	4	4	4	3	9	3	4	4	5	2	3	4	49

Examination of the main source of E.coli infection locally in the stack chart would suggest the urinary system and hepatobiliary are the main predisposing risk factors and this is where targeted interventions are to be directed e.g. avoid / removal of urinary catheters, streamlined surgical pathways. The national picture in the infographic is not too dismilar to our local position.

Figure 8 Common causes of E.Coli bacteraemia in cases detected in NLaG in 2020-2021



It is acknowledged that there has been good reduction in E.coli hospital onset bacteraemia cases detected over the last year; this may be the consequence of the pandemic. Much more needs to be done to ensure the number of cases is kept as low as possible and best practice is embedded across the whole health economy.



Given the risk factors for gram negative reduction are so generalised and as yet not fully understood, it is important as a Health economy we adopt measures that are within our control. All cases of Hospital Onset Gram negative infections are reviewed to identify the source of infection if known and identify if any lapses in care / practice have occurred. Where a lapse has been identified a review meeting is held with the ward manager and Matron to help avoid future cases.

As a trust our rate of E.coli bacteraemia is comparible to many other trusts however we always strive for improvement in reducing the number of cases.

Surgical Site Infection Surveillance

The Department of Health introduced mandatory surveillance of certain categories of surgery in 2004. It is a requirement that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period (3 months) in the financial year. The categories are:

- hip replacements
- knee replacements
- repair of neck of femur
- reduction of long bone fracture

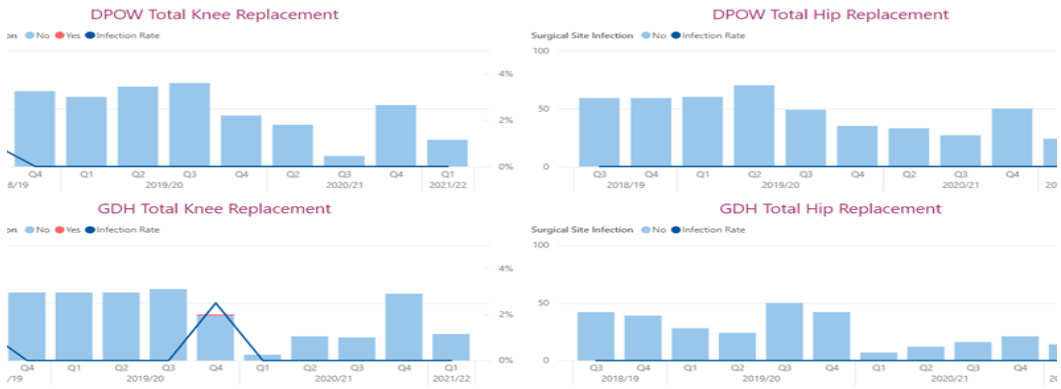
The Infection Prevention and Control team in conjunction with our orthopaedic colleagues undertake continuous surveillance of primary total hips (THR) and primary total knee (TKR) at DPOW and GDH hospital sites.

Table 3 Orthopaedic hip and knee replacement infection rates – April 2019 – March 2021

	All Hospitals	Grimsby			Goole		
	National Rate	No. Operations	No. Infections	% Infection	No. Operations	No. Infections	% Infection
Hip Replacement	0.5%	324	0	0.0%	201	0	0.0%
Knee Replacement	0.4%	343	0	0.0%	326	1	0.3%

Overall the infection rates remain within normal parameters, however due to the small denominator the infection rate can quickly become skewed. When a surgical site infection is detected a thorough RCA is undertaken to identify if there were any deviations from best practice. In the cases reviewed there were no significant deviations from best practice identified. As a team we undertake a very robust method of monitoring patients fully for the whole year. Due to the pandemic situation and zoning of clinical areas elective surgery has been reduced therefore the throughput of cases will be impaired compared to previous years. The 1 SSI detected found no lapses in care or practice and the organism detected was MSSA.

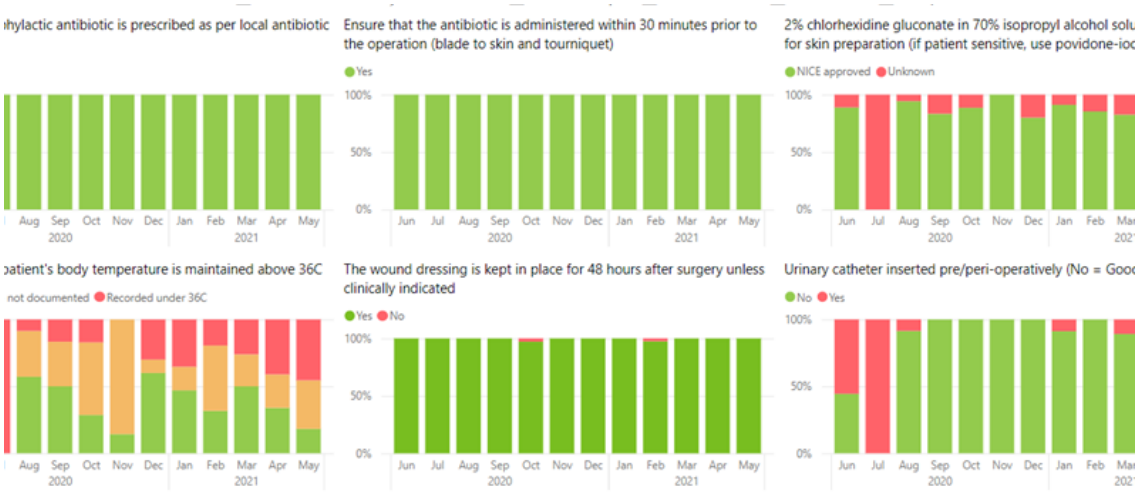
Table 4 Surgical Site Infections 2018 - 2020



As part of the surveillance process the team also ensure theatres are adopting best practice in accordance with the High Impact Intervention surgical site prevention bundle. Now that sufficient

data has been collected a dashboard has been produced and shared with Theatre colleagues to ensure the high standards of practice are maintained.

Figure 9 Surgical Site High Impact Intervention Feedback

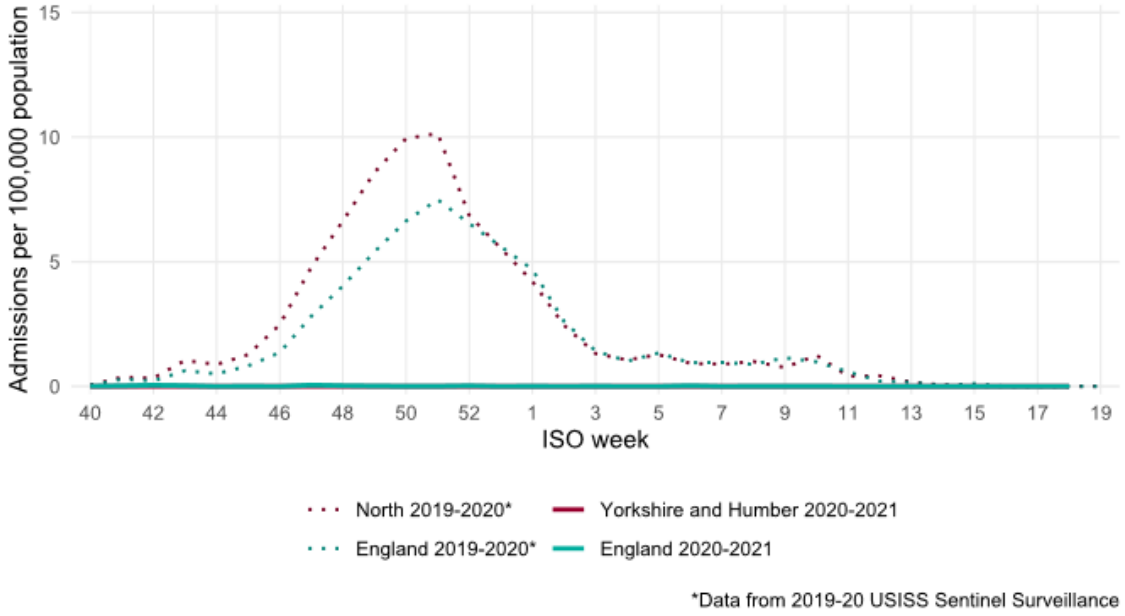


The main issues noted are around normothermia. The high impact data is fed back to the divisions to review and implement any actions required.

Influenza / Viral respiratory disorders

Due to the social distancing measures and lockdown the Trust and generally across the NHS there have not been any significant cases of influenza

Figure 10 Number of Influenza cases detected within Yorkshire & Humber



One of the best ways to protect vulnerable patients and front line staff from influenza virus is the influenza vaccine. There was an ambition for organisations to achieve a front line worker uptake of at least 100%. NLaG achieved a respectable 65% uptake in front line workers using a peer vaccination approach. Although a drop to previous years this may have been as a result of the low prevalence of influenza circulating and staff focusing on the coronavirus vaccine.

Table 5 Influenza vaccination uptake by frontline workers

Season	Dr	Nurse	AHP/STT	Support	Total
2017-18	83.7%	65.5%	67.1%	80.5%	72.6%
2018-19	77%	76%	98%	75%	78%
2019-20	77%	68%	67%	65%	67.6%
2020-21	57.33%	63.27%	73.54%	61.61%	64.32%

Point Prevalence Surveillance

As part of the ongoing review process the IPC team began to undertake a modified version of the national Point Prevalence Surveillance twice a year where possible. The main advantage of utilising this approach is that it enables the team to gain an immediate insight into the practices on the ward re invasive devices, antimicrobial prescribing and management of patients with infections. All patients within the ward are reviewed and staff are then provided with a verbal resume and this is followed up with a written report usually the same day. Divisions are provided with a dashboard that is available on the HUB site to help support any changes in practice. Due to the pandemic the usual rounds of surveillance had to be put on hold until the covid-19 infections subsided and wards reverted back to some form of normality. As such the PPS was undertaken in the last quarter of the financial year. The IPC team managed to undertake surveillance on 26 wards across the 3 hospital sites with 484 patients monitored. The mean age of patients was 70 years with a range of 17-98 years.

The overall hospital onset infection rate was 4.1% which is a drop from the baseline of 6.4%. It was noted that the number of antimicrobials prescribed had risen to 45% compared to the recommended standard of around 30% and this is an increase from the baseline of 34%. This may be a result of the pandemic where most patients admitted with signs of a chest infection were generally prescribed an antimicrobial, which many required intravenous administration. As such there has also been a large increase in the use of peripheral venous cannula devices to 61% compared to 39% baseline value. There is an urgent requirement to review the current usage of antimicrobials and those administered intravenously so that invasive devices can then be removed in a timely manner. It was pleasing to note the majority of PVC had an appropriate assessment and dressing was clean, intact and secure.

Carbapenemase-producing Enterobacteriaceae

The management of patients with an antibiotic resistant organism is an increasing priority nationally. The emergence of Carbapenemase-producing Enterobacteriaceae (CPEs) is predicted to pose significant challenges nationally in the near future. Carbapenem antibiotics are a powerful group of B-lactam antibiotic used in hospitals. Until recently they have been able to be used to treat infections when other antibiotics have failed. Emerging resistance patterns have rendered in some cases Carbapenems ineffective. Public Health England have issued toolkits for use in either acute or community settings to enable the early detection, management and control of CPE. A Trust policy is in place to support and guide staff to provide safe and effective management of patients colonised or infected with resistant bacteria and minimise the risks of transmission in patients.

Last year there were 2 cases detected x1 NDM and x1 OXA-48.

2. Provide and maintain a clean and appropriate environment for managed premises that facilitates the prevention and control of infections.

Facilities Service update **(written by Keith Fowler – associate director facilities)**

The Hospital Support Assistant (H.S.A) remains a relatively new concept within Healthcare cleaning services. The role combines a multi-skilled ward and department based service enhancing the patient experience with excellent standards of cleaning, nutrition and hydration and ward support functions.

Building upon the service with enhanced cleaning practices embedded during 2019 – 20, our cleaning feedback, audits, CQC inspections, patient experience and team engagement provided a high level of assurance around our support services.

2020–21 presented the biggest ever challenge to face our NHS in the form of a global pandemic. The coronavirus (Covid–19) challenged our cleaning service beyond any expected or planned levels of support service delivery. The H.S.A staff group demonstrated a level of courage and response to the increased demands for effective cleaning which was truly unbelievable. The challenges around PPE use, segregations, zoning and additional safety practices to keep everyone safe was a changing platform, and tested the whole teams resilience and grit.

Staff worked more hours, in hot uncomfortable PPE, ensuring wards received enhanced frequencies of cleaning, and ensuring we were helping our clinical colleagues to prevent cross contamination and ensure the highest standards of infection prevention and control were achieved.

The team reacted to create enhanced working rotas, service changes to achieve compliance with increased cleaning frequencies, and took forward plans for the wider hospital sites to take on the challenge. We trained in enhanced PPE, recorded and reassured the training principles, adapted labour resource and thrust forwards the Trust cleaning response to Covid–19.

Emotions were mixed, and the team were supported, supportive, and built upon relations in wards where staff pulled together in the fight against Covid 19. The numbers of positive patients treated were at times reaching our limits of capabilities, and the H.S.A role and service reacted to this at peak times, alongside supporting deep cleaning areas when reopening to non-positive patients. The service enabled the operational response to the pandemic.

Our cleaning remains to the highest standards possible, and lessons learned combine with enhanced cleaning levels throughout the sites to assist a return towards activity levels and operational delivery prior to the pandemic. The H.S.A cleaning service has demonstrated the model remains to be a service of excellence and efficiency, and the Facilities services team, in partnership with the Infection Prevention & Control team will continue to ensure a response to any future challenges is robust, capable and keeps our patients, staff and visitors safe from the coronavirus.

Facilities Services have already commenced a detailed gap analysis of the newly released National Standards of Healthcare cleanliness (2021), working to understand the impact of this revised standard against our H.S.A role and domestics functions. Investment commenced in late 2020 to update our auditing tool, and the team are building upon this updated version to ensure compliance with the revised standards but, also include the new departments recently opened as a result of the Capital Investment Programme. The team anticipate the revised standards to be embedded during 2021.

IPC Environmental Audits

The IPC team undertake a yearly environmental audit of clinical areas and if required repeat the process depending on findings. The majority of the IPC areas of concern have now been incorporated within the Ward Assurance Tool (WAT) and Matron audits. Therefore the IPC audit acts as an independent validation and is triangulated with the WAT.

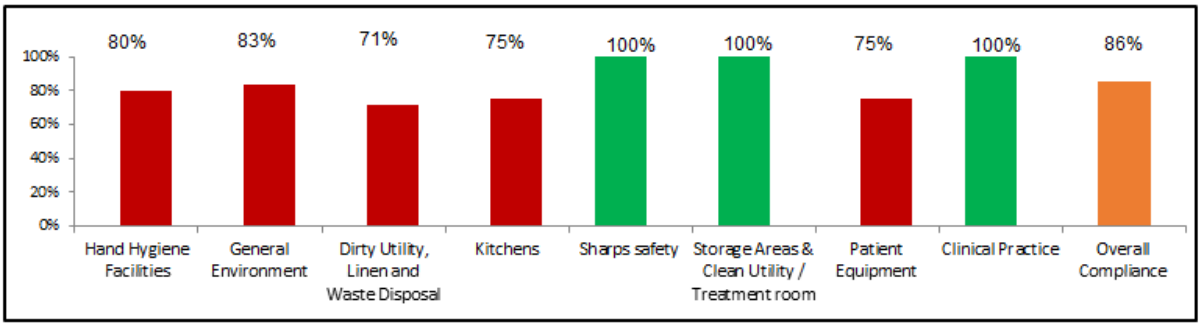
The average scores per section are highlighted below. The main areas for future improvement are generally associated with environmental fixture and fittings such as floor and wall condition. Any items that are potential patient safety concerns are dealt with by estates and facilities in a timely manner.

Figure 11 IPC Environmental Audit Tool Feedback Form

Infection Prevention and Control Environmental Audit

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Site:	**DPOW**
Location:	**Rainforest Ward**
Date:	**20/01/2021**
Observer / Auditor:	**Andrea Webster-cockrill**



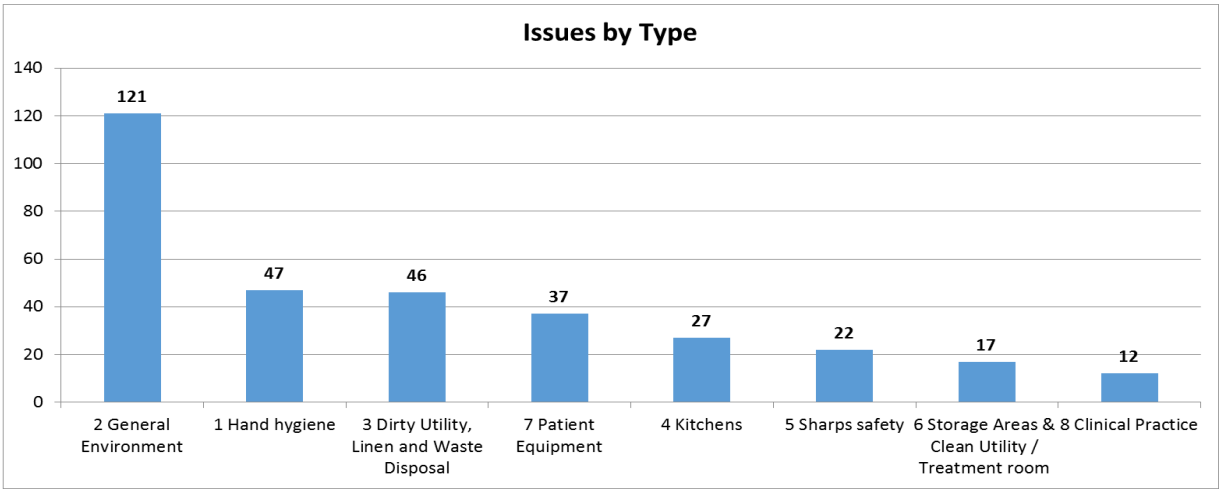
1. Hand Hygiene Facilities		
1.1	Is hand rub available at the point of care e.g. bed area/cubicle/side room/clinical area?	Yes
1.2	Is soap in a dispenser readily available in a working condition next to the wash hand basins?	Yes
1.3	Are there sufficient wash hand basins within the clinical setting to facilitate effective hand washing?	Yes
1.4	Are the wash hand basins free from clutter and used appropriately?	No
1.5	Are patients offered the opportunity to clean their hands prior to mealtimes and after using the commode?	Yes
1.6	**Community Only:** Are individual hand sanitiser bottles available and used if deemed appropriate?	
Compliance		**80%**

Comments: Sluice hand basin blocked by laundry bags and rubbish bag and box.

Table 6 IPC Environmental Audit Scores

IPC Environmental Audit 2020/21									
Compliance by Ward and Division									
Row Labels	1 Hand Hygiene	2 General Environment	3 Dirty Utility, Linen & Waste Disposal	4 Kitchens	5 Sharps Safety	6 Storage Areas & Clean Utility/ Treatment Rm	7 Patient Equipment	8 Clinical Practice	Overall
Community	100%	81%	93%	83%	95%	88%	82%	93%	90%
DPOW	89%	80%	82%	85%	78%	86%	86%	86%	84%
GDH	100%	94%	92%	94%	79%	97%	87%	96%	92%
SGH	98%	91%	86%	94%	82%	96%	86%	95%	91%
Grand Total	95%	85%	87%	88%	83%	90%	85%	91%	88%

Figure 12 Number of IPC Environmental Audit Issues by Type



With the introduction of 15 steps accreditation and Monthly ward manager audits; these have been designed to incorporate again pertinent IPC related questions. As part of the 15 Steps process a member of the IPC takes part in this process which allows expert opinion to be included in the review process. As can be seen the main issues identified in the IPC audits tend to be related to the estate of the building. Various capital scheme projects have been submitted for national funds to help address some of these issues which has seen ward 29 transformed into a ward.

Decontamination

A member of the Infection Prevention and Control team attends the decontamination group. This group oversees decontamination issues including the function of the Synergy run HSDU. The committee is responsible for ensuring that reprocessing systems are revalidated as required and dealing with problems by exception. It serves as a conduit between equipment reprocessing departments and the IPCC.

Water Safety Group

The Deputy DIPC and Consultant microbiologist are members of this group to help ensure relevant guidance is adopted to help reduce the risk of waterborne infections such as Pseudomonas and Legionella. The group has implemented a number of standard operating procedures to ensure the

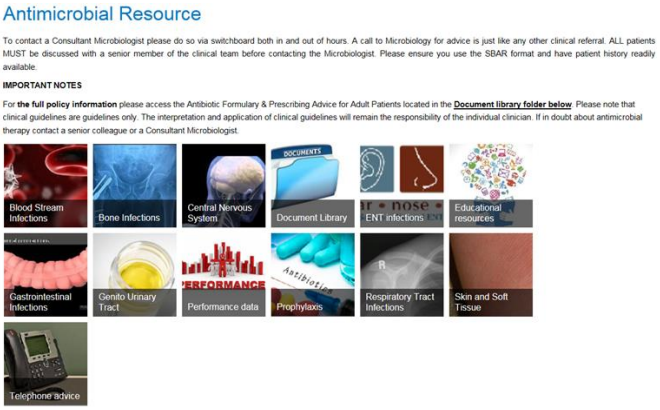
daily flushing of little used outlets and their correct cleaning / maintenance including the use of L8 guard.

Pseudomonas Water Testing

In 2012 the Department of Health issued national guidance for managing Pseudomonas within the water system of hospitals in-particular the augmented care units. These high risk units have a regular water check depending on results and where Pseudomonas or legionella species are identified discussion takes place with the IPC team on measures required to mitigate the risk. There is a robust ongoing program within the clinical settings to ensure flushing is undertaken within little used outlets and that wash hand basins are used appropriately. The L8 guard reporting system is working well and generally achieving a good level of flushing compliance.

3. Ensure appropriate antibiotic use to optimise patient outcomes and resistance

Antimicrobial Stewardship



Antimicrobials stewardship is the prudent, use of antimicrobials. This is a multi-disciplinary effort and all healthcare professionals are encouraged to facilitate good prescribing practices.

Slowing the development of micro-organisms' resistant to antimicrobials, increasing the longevity of our available agents and minimising the occurrence of healthcare acquired infections is a national and international priority.

In terms of total antibiotic reduction the Trust has noted significant reductions in antibiotic use throughout all areas during COVID-19. However in regards to daily doses used per 1000 patients, usage has increased during the COVID-19 pandemic Trustwide in Medicine and Surgery & Critical Care. Targets have not been met in the Medicine at Goole and Surgery and Critical care at DPOW and SGH. This may be due to a difference in the demographics of patients being treated before the pandemic, to those after it started; i.e. those who were not sufficiently ill to require admission to hospital for IV antibiotics post-pandemic commencement may have avoided visiting the hospitals altogether or more antibiotics may have been used to treat patients with COVID-19 pneumonia, despite very few of these being likely to have secondary bacterial pneumonias. It was not possible to identify and audit these patients accurately. Conversely, the Trust will have admitted very few patients for elective procedures requiring antibiotic prophylaxis.

Antimicrobials Stewardship Strategy

The Trust's Antimicrobials Stewardship Strategy, released in January 2020, incorporates all elements of the national Tackling antimicrobial resistance 2019 – 2024: The UK's five-year national action plan, in order to ensure that our Trust is compliant with those elements in its local healthcare context, including:

Minimising infection, by:

- Having zero tolerance of avoidable infections in healthcare settings;

- Optimising the use of effective vaccines;
- Minimising infection transmission in the environment;
- Promoting good infection control practices.

Providing safe and effective care to patients, through:

- Practising good antimicrobials stewardship;
- Encouraging that all decisions involving the use of antimicrobials are informed by a diagnostic test, clinical decision support tool or other relevant data;
- Prescribing and administering the appropriate antimicrobials agents *promptly*, to reduce harm from sepsis;
- Using data more effectively, to achieve optimum prescribing of recommended agents.

Supporting the sustainable supply and access to quality assured antimicrobials

- Through appropriate contracting activities.

Demonstrating appropriate use of antimicrobials, through:

- Real-time monitoring of use, via reports from the Trust's electronic Prescribing and Medicines Administration System and associated systems;
- Collection and display of appropriate antimicrobials consumption data, made freely available to all, for discussion and to develop better antimicrobials prescribing habits amongst clinicians.

Engaging patients, carers and the public, through:

- Effective communication with patients, carers and the public about their antimicrobial medicines and optimum use, to treat primary infections effectively, whilst avoiding healthcare acquired infections and antimicrobial resistance.

Antibiotic audits and point-prevalence surveys

The Consultant Pharmacist, Antimicrobials, Deputy Director of Infection Prevention and Control and Quality and Audit Department co-ordinate appropriate antimicrobials audits and point prevalence surveys to examine and inform whether antimicrobials are being used appropriately within the Trust, for example:

- Adherence to surgical prophylaxis guidelines;
- Adherence to IV to oral switch guidance, per speciality;
- Adherence to dosing and therapeutic drug monitoring guidelines for antibiotics with a narrow therapeutic index.

Education and Training

Training on Antimicrobial Stewardship and antimicrobials medication is provided Trust-wide in a number of ways:

- On-line and face-to-face mandatory training;
- Twice yearly antimicrobial stewardship sessions, on new doctors' induction sessions;
- "Key messages on antimicrobials prescribing;" Antimicrobial Stewardship sessions on the FY1 doctors' core training programme;
- Pharmacists' monthly Antimicrobial Stewardship sessions

- Annual Grand Round presentations for doctors on both main sites, on Antimicrobial Stewardship, to coincide with World Antibiotics Awareness Week and European Antibiotic Awareness Day;
- Pre-registration Pharmacist activity, during World Antibiotics Awareness Week and European Antibiotic Awareness Day, including running stands to communicate with Trust staff and patients, on the prudent use of antibiotics;
- Delivery of influenza and pertussis vaccination training sessions for Trust peer and patient vaccinators;
- Additional information and expert advice on aspects of the use of antimicrobials in clinical trials.

Table 7 Antibiotic average monthly percentage difference from 2018 calendar year baseline

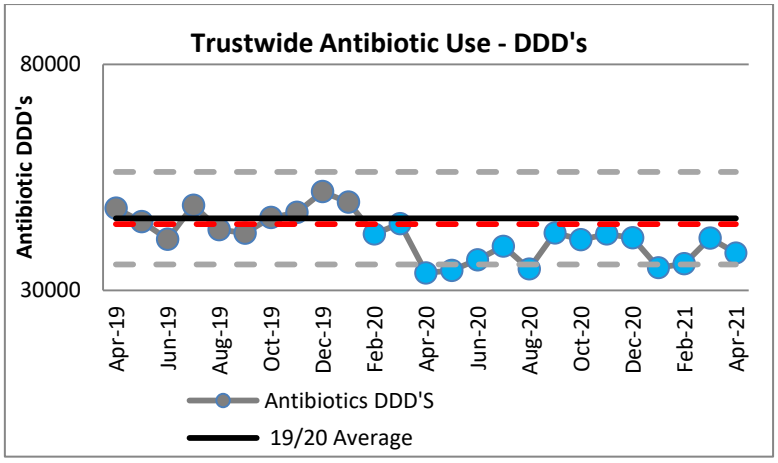
DDDs

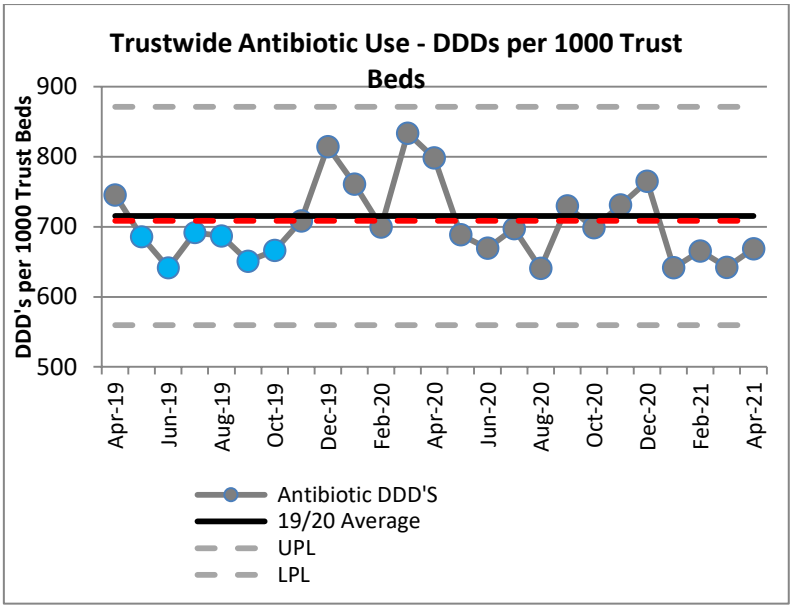
	Trustwide	Medicine	Surgery & CC	Family Services
Trustwide	**-15.96%**	-13.20%	-10.47%	-49.52%
DPOW	-13.49%	-8.63%	-7.86%	-51.43%
SGH	-15.92%	-13.49%	-8.45%	-47.44%
GDH	-69.18%	-81.09%	-44.13%	N/A

DDDs per 1000 Trust Beds

	Trustwide	Medicine	Surgery & CC	Family Services
Trustwide	**-7.52%**	-4.48%	-10.99%	-30.20%
DPOW	-10.24%	-8.43%	0.51%	-27.08%
SGH	-9.94%	-5.88%	-26.16%	-36.57%
GDH	46.27%	8.41%	3.50%	N/A

Figure 13 Trustwide Antibiotic use





Antimicrobials Guidance and Review

The Consultant Pharmacist, Antimicrobials co-ordinates these functions in a number of ways:

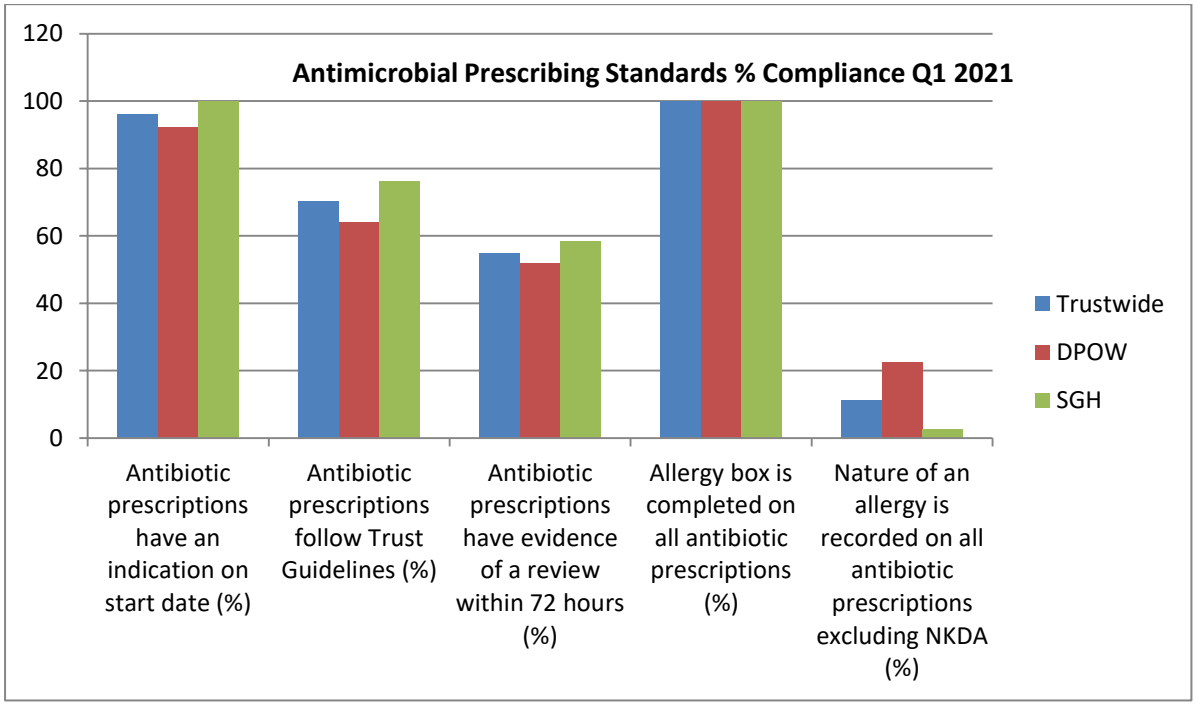
- Collaboration in the review, maintenance and development of the Path Links Antimicrobials Formulary and Prescribing Advice, for both adults and children, to ensure that it is fit-for-purpose locally and also meets relevant national guidance, such as the NICE and Royal Colleges guidance on the management of infections;
- Antimicrobials stewardship ward rounds in specific areas, in conjunction with the Consultant Microbiologists and Lead Nurse Infection Control;
- Provision of detailed antibiotics history reviews for patients identified as being community or hospital onset, hospital acquired infections and participation in post-infection reviews of those patients;
- Provision of monthly Specific Process Charts (SPCs), the Antibiotic Prescribing Quality Standards Dashboard and any additional information to Divisional Governance Groups and Clinical Directors, for consideration of and action, as necessary on local antimicrobials consumption trends. The Antibiotic Prescribing Quality Standards Dashboard (completed quarterly for all patients prescribed an antimicrobial) shows there is room for improvement in our prescribing practices.

Table 8 Percentage of patients prescribed an antibiotic on the day of data collection during Q1

	2021/22 (Q1)
% of patients prescribed an antibiotic	47.5%
% of patients prescribed an antibiotic DPOW	43.9%
% of patients prescribed an antibiotic SGH	51.5%

Note: Q1 2021/22 based on April 21 bed occupancy data at midday divided by 30 days

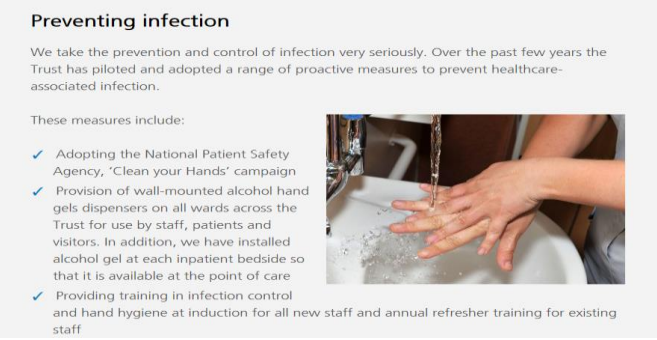
Figure 14 Percentage of compliance to antimicrobial standards Q1 2021



4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing / medical care in a timely fashion.

Patient Information

The trust has an IPC www website with information for the general public. There are a variety of guides for common healthcare associated infections.


Preventing infection

We take the prevention and control of infection very seriously. Over the past few years the Trust has piloted and adopted a range of proactive measures to prevent healthcare-associated infection.

These measures include:

- ✓ Adopting the National Patient Safety Agency, 'Clean your Hands' campaign
- ✓ Provision of wall-mounted alcohol hand gels dispensers on all wards across the Trust for use by staff, patients and visitors. In addition, we have installed alcohol gel at each inpatient bedside so that it is available at the point of care
- ✓ Providing training in infection control and hand hygiene at induction for all new staff and annual refresher training for existing staff

The intranet HUB has a multitude of information leaflets for patients that can be quickly printed off by staff as required as well as quick reference guidance on 'how to' manage patients with infections. The IPC team designed a specific leaflet for patients and staff to help manage the pandemic and encourage the wearing of face masks in patients.

5. Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment or care to reduce the risk of passing on the infection to other people.

MRSA colonisation

As a result of the pandemic the laboratory had to prioritise the types of samples it was processing to help keep on top of the Coronavirus testing. As a result only high risk patients and clinical settings were swabbed for MRSA during the peak of the pandemic.

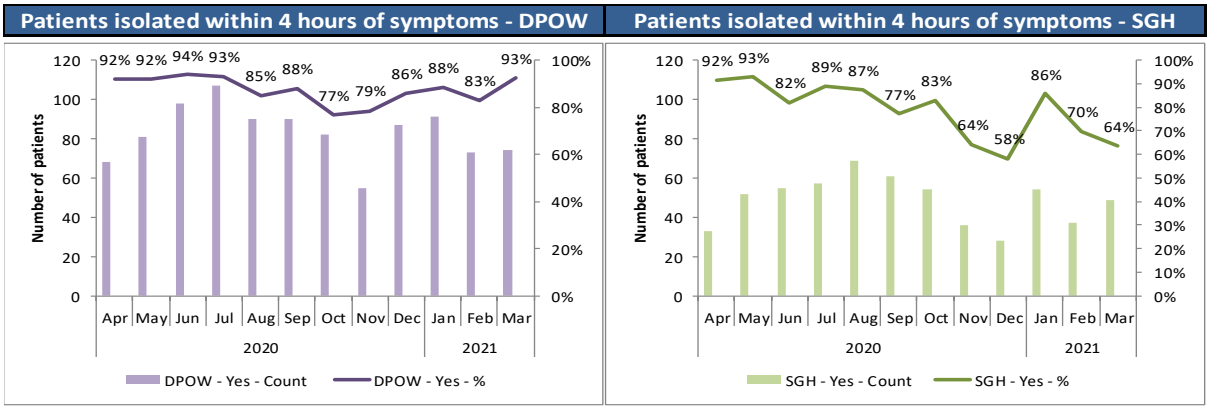
The bulk of MRSA isolates come from routine wound swabs and from swabs taken specifically to look for the presence of the organism (screening swabs). Most patients, from whom the organism is isolated, are not infected but rather merely colonised, i.e. harmlessly carrying the organism. It is very difficult to look at the raw data and determine how many patients are in fact infected but the rule of thumb is that infections account for less than ten percent of isolates.

The MRSA screening criteria within the trust was modified in 2014/15. This was in accordance with national recommendations where targeted screening rather than blanket screening was encouraged. If an MRSA colonisation is detected within a high risk environment a rapid review is undertaken to ensure best practice is maintained and any lessons learnt are shared.

Patients with Unexplained Diarrhoea

As part of the C.*difficile* reduction strategy the IPC team monitor patients who have had a faecal sample submitted to the laboratory for suspected infection. One of the main key performance indicators is patients presenting with type 5-7 stools should be isolated within 4 hours of symptoms. Again during the height of the pandemic the priority for single rooms were patients with suspicion of COVID-19 infection meaning this posed some difficulties at times. The adoption of the Redirooms certainly allowed us to minimise the overall impact.

Figure 15 Patients with diarrhoea and time to isolation



In approximately 86% of cases this was achieved at DPOW site but only on 77% of the time at SGH. Due to the limited number of single rooms currently available across the main hospital sites, especially at SGH this will continue to pose challenges especially during the

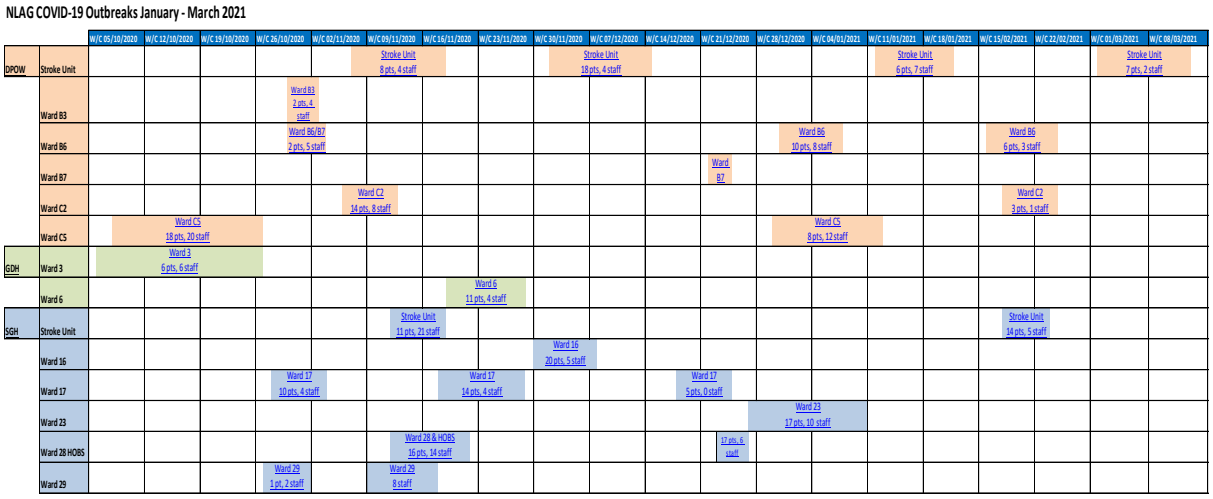
peak winter season. Work continues with Strategy and Planning and part of the winter resilience to enhance additional isolation capacity across the Trust including Scunthorpe site. Part of the enhancement has seen the installation of architectural wallsz including ward 23.

The IPC team also review whether the stool sample submitted is deemed appropriate based on clinical information. Staff are given feedback if samples are deemed inappropriate to help improve practice and reduce pressure on single rooms. There is ongoing education and stool sampling and correct management of patients with diarrhoea is part of the IPC yearly roadshows.

Outbreaks

Outbreaks occur when there are two or more linked infections which may or may not be preventable. Usually, these events are, by definition, unpredictable. Historically this has mainly been associated with viruses such as Norovirus or Influenza. However with the emergence of SARS CoV-2 we have mainly been dealing with numerous outbreaks associate with this virus and fortunately no outbreaks related to other traditional winter viruses.

Figure 16 Wards and bays closed for outbreaks of confirmed COVID-19 outbreaks.

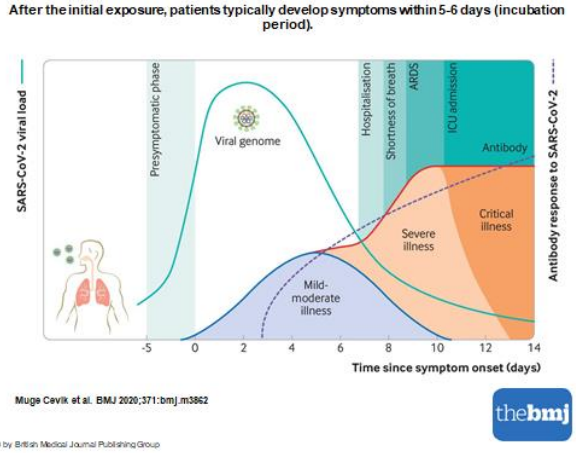


COVID-19 pandemic response

Due to the vast amount of activity undertaken in preparing and managing the COVID-19 outbreak the operational content will be covered in the phase 2 and 3 response documents produced by directorate of operations. This section will only focus on the pertinent IPC aspects of the pandemic.

The COVID-19 pandemic in the United Kingdom is part of the worldwide pandemic of coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The virus reached the UK in late January 2020. As of 24 March 2021, there have been 4.4 million cases confirmed and 127,543 deaths overall among people who had recently tested positive.

SARS-CoV-2 is spread primarily via respiratory droplets during close face-to-face contact. Infection can be spread by asymptomatic, pre-symptomatic, and symptomatic carriers. The average time from



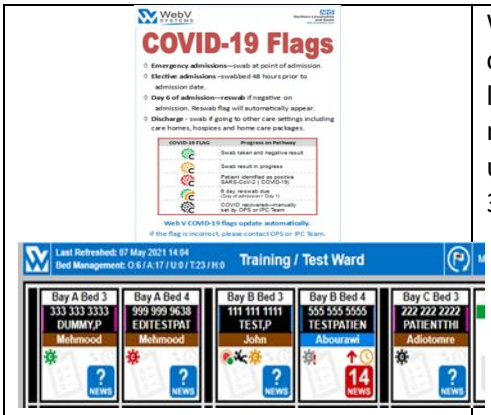
exposure to symptom onset is 5 days, and 97.5% of people who develop symptoms do so within 11.5 days. The most common symptoms are fever, dry cough, and shortness of breath. Diagnosis is made by detection of SARS-CoV-2 via reverse transcription polymerase chain reaction testing. Manifestations of COVID-19 include asymptomatic carriers and fulminant disease characterized by sepsis and acute respiratory failure. Approximately 5% of patients with COVID-19, and 20% of those hospitalized, experience severe symptoms necessitating intensive care. More than 75% of patients hospitalized with COVID-19 require supplemental oxygen.

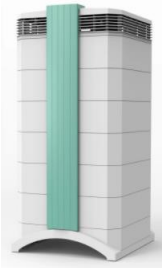
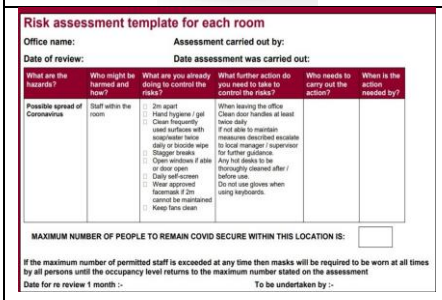
On 23 March 2020, the UK went into lockdown. The governments imposed a stay-at-home order banning all non-essential travel and contact with other people, and shut almost all schools, businesses and gathering places. Those with symptoms, and their households, were told to self-isolate, while those with certain illnesses were told to shield themselves. The NHS was asked to make additional capacity for possible surge of cases. This resulted in a number of wards being identified as being the COVID-19 wards to manage positive cases, initially this was C5 and C6 with A1 at DPOW and Ward 22, 25 and 18 at SGH. Part of the surge preparation, clear zoning was instigated across the Trust to ensure patient pathways were deployed based on the patient COVID status or presentation of possible COVID like illness.

Green Zone	Covid free
Yellow Zone A	Patient Covid status unknown - Asymptomatic
Yellow Zone B	Patient Covid status unknown - Symptomatic
Red Zone	Covid positive patients

The COVID wards were changed in November due to the oxygen demands with influx of patients requiring high volumes of oxygen therapy. As such ward 17 was upgraded to improve its oxygen delivery hence ward 22 migrated into this area and C6 migrated to C1.

Measures implemented to assist with the management of COVID-19 infections.

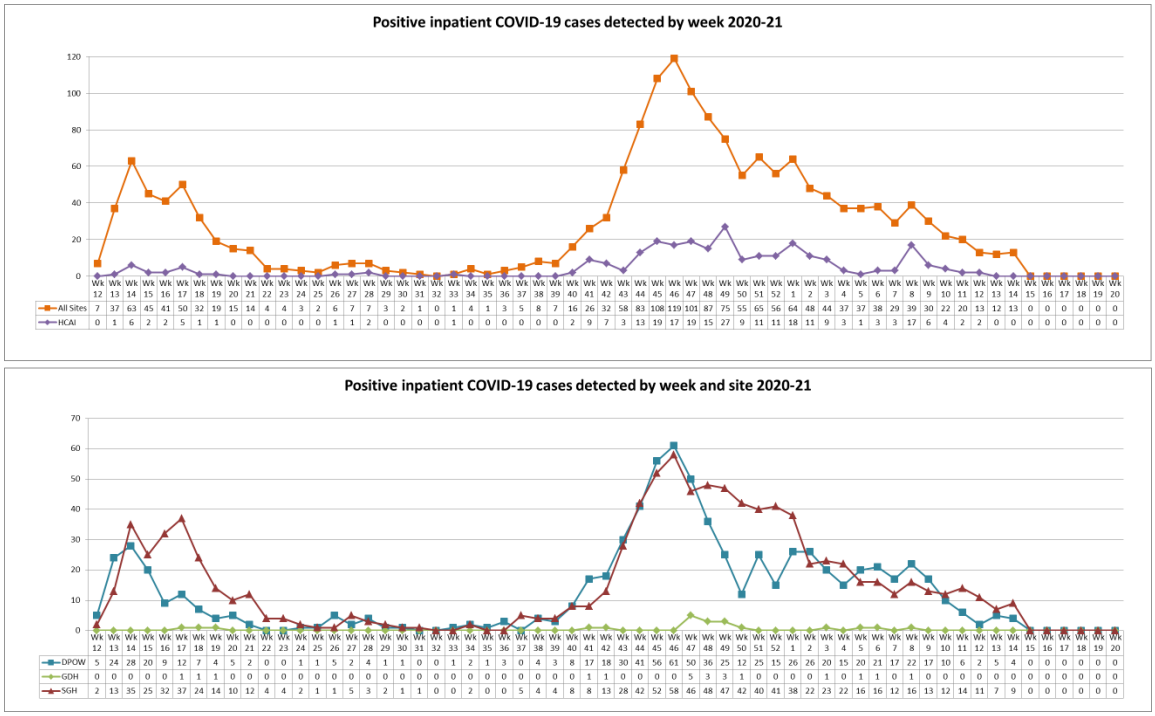
	Working closely with WebV programmers some new coronavirus icons were developed. These were automatically linked to swab results and when received by the laboratory making the movement of patients safer and preventing unnecessary swabs. This was particularly useful when the day 3 swab came into being in December.
	The Trust purchased 30 Redirooms which are pop up isolation PODS. These were received in December and implemented within the admission areas such as IAAU and short stay wards. Although there were some beds lost due to the size of the POD it has helped to enhance the isolation capacity across the Trust and certainly helped to reduce the nosocomial infection rate especially with the emergence of the B117 (Kent) variant in December 2020. This particular variant was reported to be up to 70% more transmissible

	than the original SARS CoV-2 variant.
	The Trust also purchased a number of Cubiscreens. These are plastic curtains that are used to help provide a visible barrier between patients. These help to prevent patients mingling and will protect against droplets but not airborne particles.
	Within certain high risk units the Trust also purchased a number of air scrubbers. These help to reduce the amount of airborne contaminants by filtering the air and passing it through a HEPA filter. Depending on the room size is equivalent to 12 Air changes per hour. These were deployed within HDU, ECC SGH and COVID wards to help reduce risk to patients and staff from airborne particles.
	As part of the social distancing implementation process all areas were asked to risk assess all rooms using the HSE guidance. The assessment was then placed in a visible area e.g. on the door. This was periodically updated to take into account the shielding changes and increasing numbers of staff, ward moves etc. Staff were also asked to undertake a declaration that they would not attend work with any possible signs of COVID. During the pandemic staff were asked to undertake a personal risk assessments to determine if their current area of work was safe for them and what additional mitigations were required e.g. PPE. A panel was instigated by HR to review cases scoring high on the RA tool.
	COVID-19 antibody testing was rolled out in the Trust in summer which saw a phenomenal uptake. Site / % Positives / Total Tested SGH / 15% / 1663 GDH / 12% / 179 DPOW / 6% / 1848
	In June the updated IPC guidance advocated all patients / visitors and staff to don a face mask. In order to support this initiative a PPE audit was introduced to support the implementation. A PPE and COVID BAF dashboard are available for staff to gauge their performance.
• Outbreak vulnerability assessment tool  The outbreak vulnerability assessment tool (OVAT) is a quick and handy 'walkaround' guide to support leaders. The OVAT was developed by Dr Evonne Curran and Maurice Madeo.	Outbreak vulnerability Tool adopted by NHSE

During the first wave of the pandemic there were real difficulties in testing patients and staff due to lack of capacity locally and nationally. As a result the number of infected cases cannot be seen as a true reflection. The trust initially was sending swabs to approved laboratories which impacted on turnaround times and management of patients. The laboratory began testing in house for SARS CoV-2 in April with limited capacity to begin with. The use of rapid PCR testing (30 minutes) was not available until November and volumes of test kits were small to begin with.

As can be seen in the charts below the laboratory detected 2056 positive SARS CoV-2 swabs. In total approximately 80% of the positive cases were admitted. When broken down by sites this saw SGH have 942, DPOW 750 and GDH 21 cases who were positive and admitted.

Figure 17 COVID-19 cases detected by site and allocation



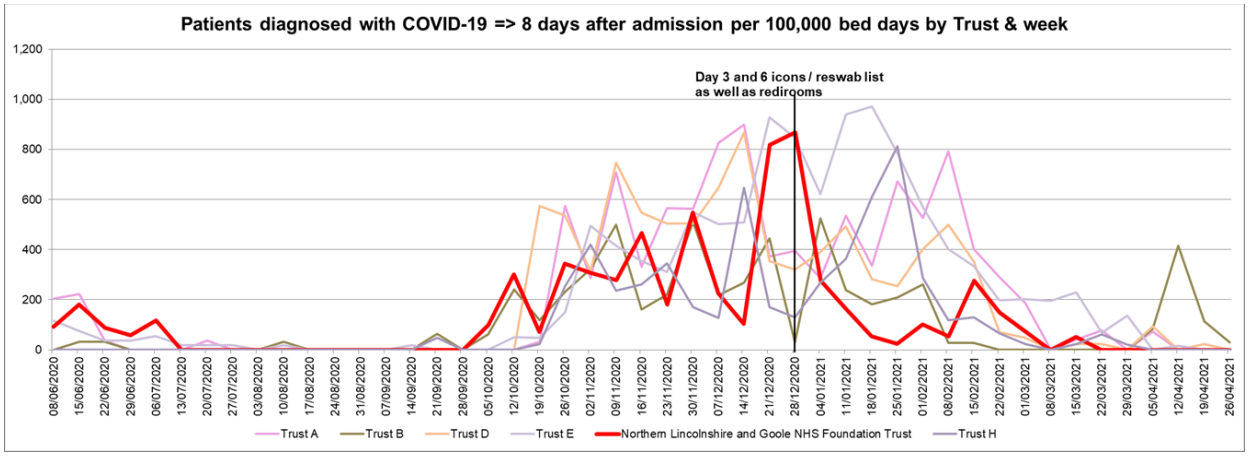
Scunthorpe hospital has had more cases detected over the course of the pandemic which made the management difficult due to the old infrastructure and movement of staff and wards to accommodate the surge of cases. The implementation of the Redirooms and plastic screens helped to mitigate some of these issues.

As part of the learning process during the pandemic the team held outbreak meetings where indicated or undertook post infection reviews using a SBAR tool for hospital onset cases. Due to the scale of numbers involved, the main focus was on reviewing definite hospital onset cases to help identify any key themes or trends. The main reason for possible spread noted was patients detected COVID positive later in their admission journey e.g. admission swab negative but day 3 or 6 positive, which would invariably increase the risk of cross infection to other patients if not isolated. As part of the review process a selection of patients that unfortunately died within 28 days of COVID detection were selected for a structured judgement review which had input from the Deputy DIPC and Consultant Medical Microbiologist and acute care physician. All hospital onset cases >day 15 had a

mini RCA undertaken to identify any lessons to be learnt. The main themes detected varied depending on the time of the infection:

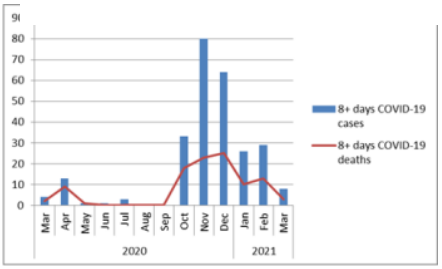
- Possible staff to patient transmission (Before lateral flow testing became available for asymptomatic staff)
- Admission swab negative (could be false negative) which may have exposed other patients in bay / ward, especially pertinent when no day 3 swab was recommended.
- Aerosol generating procedure – helping to disseminate the virus in presumed negative patient in a bay.
- Delay in detecting positive cases due to swab turnaround time or failure to swab on time– increasing exposure to susceptible patients.

Figure 18 Comparison of NLaG COVID-19 cases with local peers based on 100,000 bed days



One of the consequences of the pandemic is unfortunately hospital onset COVID with resulting mortality within 28 days of detection. As with the majority of NHS Trusts we unfortunately experienced a significant number of patients that died during the pandemic that will have acquired the infection whilst in our care. This is now part of a national enquiry to determine lessons learnt and better planning for any future pandemics. Given the complexity of the pandemic it was inevitable hospital onset cases would occur despite best efforts taken to minimise them.

Figure 19 Number of deaths >8 days (exc pillar 2)



6. Ensure that all care workers are aware of their responsibilities in preventing and control of infection.

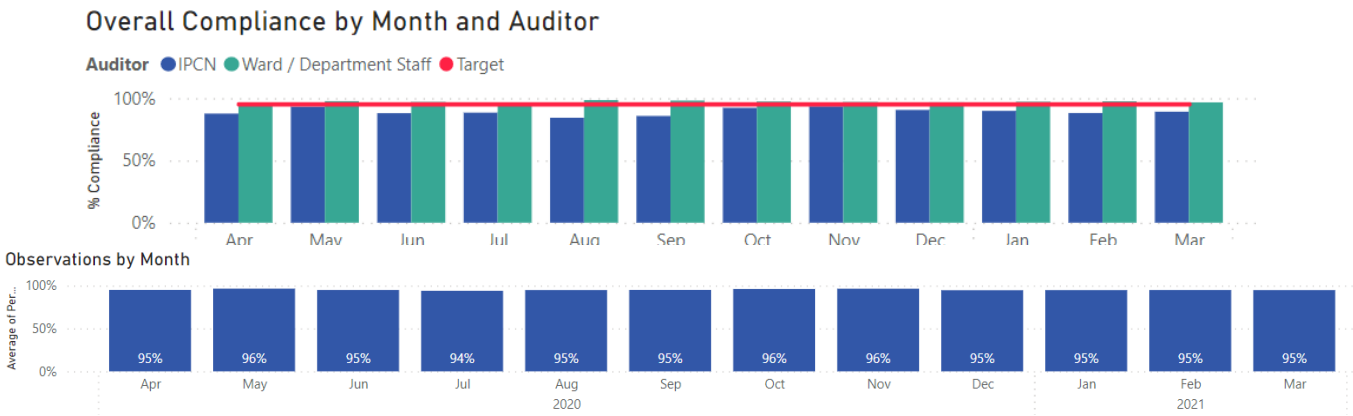
Hand Hygiene

Hand Hygiene remains a fundamental component in the prevention of nosocomial infections. The IPC team continue to promote hand hygiene compliance incorporating the WHO five moments tool. Hand hygiene compliance including bare below the elbows is an expectation for all clinicians. Ward staff continue to record opportunistic hand hygiene observations on a monthly basis and these are supplemented by IPCN observations to provide some quality assurance. Areas that are found

deficient are provided with a feedback plan and remedial actions worked through with the ward manager and if required the Matron.

A WebV hand hygiene App was launched in February 2019 allowing staff to use the smart phones on wards / depts. to record compliance. Results are displayed in an interactive dashboard so that all areas can view their compliance with each of the WHO five moments. Overall hand hygiene compliance remains good. Total observations for 2020/21 were 8354: 2084 IPCN observations and 6270 Ward/Department Staff observations.

Figure 20 Hand Hygiene overall compliance scores



Isolation Facilities

As previously mentioned SGH site is more compromised due to the lack of isolation rooms. The opening of Ward 29 has improved the infrastructure for surgical patients and has the additional benefit of adequate mechanical ventilation.

The lack of isolation capacity is highlighted on the Board Assurance Framework as a risk which may impact on the management of infectious patients, however this has been mitigated considerably with the introduction of the Redirooms and future capital schemes enhancing isolation capacity.

7. Secure adequate access to laboratory support as appropriate.

Microbiology Laboratory (report by Nick Duckworth Laboratory manager)

A slightly busier year than expected. Covid-19 samples arrived from the first week in February which were initially tested by PHE before on-site testing started at Scunthorpe on 3rd April. Microbiology were part of the ME2 network response along with Nottingham, Leicester, Derby, Chesterfield, Kings Mill, Kettering & Northampton who all worked together through the ME2 Ops team comprising all 8 lab managers plus a lead and support team. Until December 3 meetings each week were held, plus additional meetings during operational difficulties. Contact between managers was also by WhatsApp to allow for rapid contact and support across the network. Although work was moved

around initially between sites to allow for delays to implementation & analyser failures, by the autumn this method had been ditched as being too staff intensive and introduced further delays and problems into the system. The ME2 Ops group has been viewed as a very successful operation and we have shared lessons learnt with the ME2 board. The microbiology staff have volunteered for extra Covid-19 shifts and/or swapped shifts to enable us to provide 24/7 Covid-19 cover and although one or two ME2 sites did manage to provide some 24/7, we remain the only lab providing this level of service throughout.

Routine work dropped considerably during April as Path Links Microbiology Directorate introduced the RCPath testing guidance for the pandemic to ease staffing pressures and to allow extra safety measures to be put in place to protect staff. BAU finally came back with a vengeance in mid-February 2021.

The UKAS surveillance visit in March 2021 went very well with only 2 improvement actions which was viewed by Path Links management as an incredible achievement under normal operating conditions, let alone the pandemic.

The tender for MALDI-TOF has finally gone out through the NHS Framework at the beginning of May 2021 and we hope to complete this and have it service by late summer. This will make a significant improvement to the identification of organisms and turnaround time, which should benefit sepsis management in particular.

The major challenge now is to obtain NLAG Trust agreement for several business cases for extra staff for both Covid-19 testing and routine work as we are now, in common with other labs, struggling to meet demand safely.

8. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

Infection Prevention and Control Policies

There are an extensive number of policies, guidelines and how to documents that are maintained by the IPC team in a timely manner. Recent policies updated can be seen below.

Table 9 Policies updated within last year

Name of Policy	Date for review
Decontamination of Medical Equipment Prior to Inspection Service or Repair Policy	23/03/2022
Sharps injury and body fluid exposure management	01/09/2021
Surveillance Policy	04/05/2022
Hand Decontamination Policy	24/06/2022
Varicella Zoster Virus Protocol	11/08/2022
MRSA Policy	17/02/2024
Isolation Policy	01/05/2022
Safe Use and Disposal of Sharps Policy	08/11/2022
SARS Policy / SARS CoV-2 (PHE guidelines)	04/08/2021
Viral Haemorrhagic Fevers & Other Hazard Group 4 Agents (VHF Policy)	20/11/2022
Medical Devices Policy	06/01/2023
Transmissible Spongiform Encephalopathy Agents – (TSE Policy)	17/01/2023

9. Have a system in place to manage the occupational health needs of staff in relation to infection.

The Occupational Health team have undergone changes within the last year with the senior nurse leaving the service. The team have played a crucial role in the delivery of the influenza vaccines and the also helped to implement a successful support service during the pandemic. The lead nurse has an open invite to the Infection Prevention & Control Committee.

Training and Education

The IPC team continue to make education of staff one of its key priorities. There are a wide variety of educational portfolio materials available for clinical and non-clinical staff to help maintain their mandatory training requirements.

The materials include:-

- Surewash machines
- Workbooks for clinical and non-clinical staff updated into flip books
- Link practitioner programme
- Ward based training
- Care Camp
- Induction
- Clinical updates
- Junior Doctors / HYMS training
- IPC blog site for staff and students

Over 6000 members of staff have undertaken some form of IPC training.

Count of Competency Match	Column Labels	
Row Labels	Yes	Grand Total
208|LOCAL|Antimicrobial Stewardship|	1386	1386
208|LOCAL|Infection Control - 3 Yearly|	589	589
208|LOCAL|Infection Control - No renewal|	1309	1309
NHS|MAND|Infection Control - 1 Year|	3312	3312
Grand Total	**6596**	**6596**

There was also approximately 2500 staff fit tested for the appropriate FFP3 mask. This process also incorporated a resume on donning and doffing.

Community & Therapies Services – information provided by Noelle Williams IPCN

Overview

2020/21, the year of the Covid-19 pandemic has been a year of challenge for all IPC teams throughout the UK. The Community Infection Prevention & Control team were no exception to this. The team remains a sub set of the Acute Trust IPC team, with dual input across both acute and community interfaces in the provider only role. The team also continues to deliver the IPC service for Goole hospital.

The Community Infection Prevention & Control (IPC) team comprises a 1.0 wte Band 7 CNS IPCN and a 0.8 wte Band 3 AHCA (this includes sequestered time to the SSI prevention strategy).

The work of the Community IPC team has been significantly impacted by the COVID-19 pandemic from mid-January 2020. Initially with the management of potential cases of SARS-CoV-2 infection as a high consequence infectious disease (HCID), and then as significant numbers of cases were managed in Community and the Trust, the team were called upon to support the Acute Hospitals. The Band 3 AHCA went into shielding between 28/2/2020 until 30/6/2020 and the Band 7 was placed on sick leave from 17/11/2020 until 07/12/2020.

Demonstration of activity and input/acknowledgement of on-going challenges, related to infection prevention and control continue to be discussed within the Community & Therapy Governance meetings which are held monthly; remotely since the advent of the pandemic. Minutes from this meeting including actions and issues continue to be forwarded to the Infection Control Committee and are available to view via the Hub. Where attendance has not been possible a formal report has been submitted for discussion.

Support to commissioned services has continued throughout this financial year and has notably increased during the Covid-19 pandemic. A named nurse for Commissioning IPC service has now been appointed.

Face to face mandatory training has not been possible during this year so work booklets have become the medium of choice.

Surveillance organisms

Performance against the objectives set for surveillance organisms improved overall in the year 2020/21 with all objectives achieved as can be seen in the table below.

Table 10 Comparison of North Lincolnshire performance against CAI surveillance organisms for 3 years

Organism	2018/19	2019/20	2020/21
	Performance	Performance	Performance
MRSA	1	3 ↑	0 ↓
C.difficile	20	15↓	10 ↓
E.coli	106	165 ↑	125 ↓
MSSA	43	41 ↓	31 ↓

CPE	1	0	0 =

Audit

Prior to the COVID 19 pandemic, community services had launched the '15 Steps' audit programme as alluded to in the previous annual report, this included Community IPC as a core auditor. This was to supersede the previous community audit. With the advent of the pandemic this was naturally postponed. Issues with community environments were, this year reviewed on need until such time as the annual audit programme could be reinstated. Board Assurance Framework (BAF) Covid risk assessments were however undertaken for all community venues as soon as the team were relieved from acute only duty.

Hand hygiene audits continue to be recorded annually on OLM as a practical assessment for all Community & Therapy staff. Monthly point of care audits remain requested of those staff groups in group clinical environments; namely the chronic wound management team, podiatry teams, MacMillan Home Health care teams and Dental clinics. These audits are available to view via the IPC hub dashboards. The annual hand hygiene assessment for all Community clinical staff remains the significant audit for assurance.

Community & Therapy Link Practitioner Forum

There was no Link practitioner forum during the period under scrutiny due to the Covid 19 pandemic All IPC guidance appertaining to Coronavirus/Covid 19 remains accessible on the Trust Hub. A Bulletin newsletter was provided quarterly to update Link Practitioners on the current developments.

Decolonisation Service

The decolonisation clinic, closed during the Covid 19 pandemic and remains so at the time of writing this report. Any decolonisation treatments required during this year have been secured entirely via the primary care route. Table 2. below demonstrates the would be accesses to the clinic for both identified MRSA patients and for out of area accesses in comparison to the prior 2 years .

Table 11 MRSA decolonisation events

Period	No. of MRSA patients treated	No. of Out of Area accesses
2018/19	42 ↓	20 ↓
2019/20	20 ↓	2 ↓
2020/21	0/21	0/1

Activity and Engagement

FIT Testing

The community IPC team assisted in the delivery of FIT testing sessions to Community &Therapy staff plus acute Medical and nursing staff as was required throughout the year.

Preparation of the Covid Swabbing Teams

The Community IPC team delivered training and advice to the Community swabbing teams – ensuring good practice for donning and doffing of PPE and the swabbing technique required.

Care Home Support

May to July 2020 Community IPC were seconded 2 days per week to assist the commissioners and local authority to provide face to face PPE training and infection control advice to a number of North Lincolnshire care homes whom had been identified as 'hotspots' . These homes were struggling with Covid -19 outbreaks and required the support to better manage the situation within.

During this period 19 Care home were visited and training provided to all available staff. Of these 19, 3 were provided with multiple visits to provide further support.

Community IPC also supported a number of North Lincolnshire GP practices during this period with advice for restarting urgent minor procedures.

PPE Roadshow

August 2020 the Community IPC team joined forces with the acute team to provide education, information and advice specifically around the topic of PPE practice. Education packages and quizzes were utilised to ensure that all staff were both aware and understanding of the practice required.

The community prize was won by a Speech & Language Therapist (who did not wish her photo to be shared)

Glossary

MRSA	Meticillin resistant Staphylococcus aureus is a bacterium that is resistant to commonly used antibiotics such as flucloxacillin.
C.difficile	Is the organism most frequently identified as the cause of antibiotic-associated diarrhoea
Bacteraemia	The presence of bacteria in the blood
Colonisation	The presence of a bacteria on or in the body without causing infection
ESBL	Extended-Spectrum Beta-Lactamases are enzymes produced by bacteria, making them resistant to broad-spectrum antibiotics.
PIR	Post Infection Review is a systematic review of an event to determine if any deviation from best practice and lessons to be learnt.
Antimicrobials	Antibiotics
Dashboard	Is a way of presenting data in a visual format.
Carbapenemase-producing Enterobacterales	Resistance to carbapenem antibiotics

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Safeguarding Annual Report

Lynn Benefer

Deputy Head of Safeguarding

Statutory Responsibilities

- **Safeguarding everyone's responsibility**
- New Governance and reporting arrangements
- Met key responsibilities in relation to NHS standard contract for Safety and Safeguarding Legislation
- CCG commissioning arrangements/ Section 11 responsibilities

- **Key Achievements**
- Appointment of senior roles within the team / integrating vulnerabilities team

- **Next Steps**
- On going safeguarding work across the ICS/ collaborative working

Covid 19

- **Business as usual approach- remained**
- Training
- Learning Disability Mortality cases
- Vulnerability Ward rounds
- Rise in Domestic Abuse incidents
- Increase in ECC attendances young people MH concerns
- CLA Team have good oversight of vulnerable young people

- **Key Achievements**
- CP-IS

- **Next steps**
- Re-set training
- CP-IS inpatient

Liberty Protection Safeguards

- Good oversight of activity and DOLS
- Code of Practice and LPS work stream
- Large scale change - April 2022
- Responsibilities for Trust Board
  - NLaG responsible body for authorisation
  - New training
  - Governance
  - Referral pathways and authorisation
  - Policies

Key Risks

- Unlawful deprivation of liberty

Next Steps

- Further update for Board once Code becomes available
- New work stream reporting to VOB

NLG(21)205

DATE OF MEETING	Tuesday 5 October 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Vicky Thersby, Head of Safeguarding
SUBJECT	Annual Safeguarding Report
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Vulnerabilities Oversight Board - approved Quality and Safety Committee - approved
EXECUTIVE SUMMARY	This Annual Report provides an overview of the national and local context of safeguarding and vulnerabilities and associated agendas related to safeguarding adults and children. The report highlights the key performance activity and informs the Trust Board of how its statutory responsibilities are being met and of any significant issues or risks and how these are mitigated. There are a number of priorities for 2021-22 linked to associated safeguarding agendas which will be monitored though the Vulnerabilities Oversight Board. Safeguarding Adults and Children is a trust key priority and the Safeguarding and Vulnerabilities team have continued to work throughout the pandemic ensuring that both our patients and staff have been supported The Team has seen a number of new posts which will enhance the delivery and quality of care our patients receive The Mental Capacity (Amendment) Act received Royal Assent in May 2019 and introduces the Liberty Protection Safeguards to replace DoLS. The Minister of State announced post pandemic that they now aim for full implementation of LPS by April 2022, with some provisions, covering new roles and training coming into force ahead of that date. Once fully implemented NLaG will be responsible for authorising the deprivation of liberty. Overall responsibility will sit with the Trust Board of Directors. • During 2020-21NLaG will need to consider the implications for both acute and community services once the public consultation commences on the

	Codes of Practice anticipated shortly. • Staff will need to be trained and aware of what the new LPS constitutes along with implementing new referral pathways and authorisation processes Trust wide.

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

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

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

Safeguarding Annual Report

2020 – 2021

FOREWORD

Safeguarding is a statutory responsibility of all NHS organisations as detailed under the Care Act (2014), and the Children Act (1989/2004). Legislation and guidance are built upon the principle that the welfare of the most vulnerable in our society is paramount and that all statutory services consider and promote the needs of children, families and adults at risk.

North Lincolnshire and Goole NHS Foundation Trust (NLaG) is committed to ensuring that safeguarding its patients, staff and the wider community is given the highest priority in all that the Trust does.

Safeguarding work across the Trust is underpinned by NLaG's values by demonstrating our behaviours:

- Kindness
- Courage
- Respect

Safeguarding is an integral part of core business and is a shared responsibility. We work together with multiagency partners across the Districts of North Lincolnshire, North East Lincolnshire and East Riding to improve the lives and protect the most vulnerable in our society from harm.

CONTENTS

INTRODUCTION

The 2020-2021 annual report provides the Trust Board with an overview of the national and local context of safeguarding and areas of practice included in safeguarding across the Trust. The report will show performance activity and inform the Trust Board of how its statutory responsibilities are being met and of any significant issues or risks, and how these are mitigated.

This report is a combined Children and Adults Safeguarding and Vulnerabilities Report that describes all areas of safeguarding activity. The report describes how the Children and Adults Safeguarding and Vulnerabilities Team work together to demonstrate to the Trust Board and external agencies how North Lincolnshire and Goole NHS Foundation Trust discharges its statutory duties in relation to:

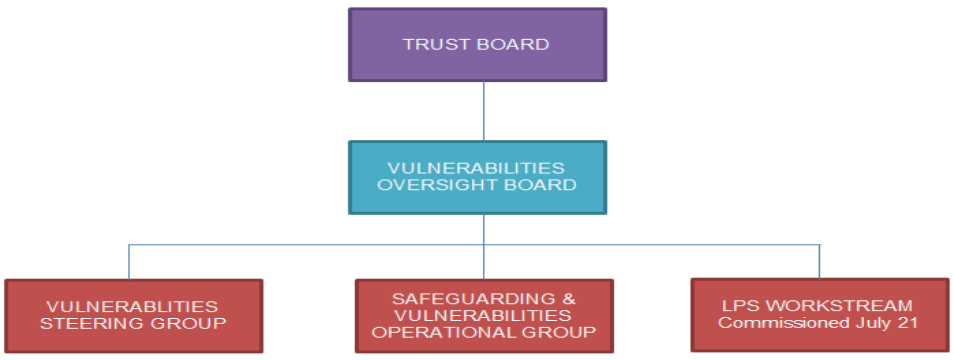
- The Children Act (1989)
- The Sexual Offences Act (2003)
- Female Genital Mutilation Act (2003)
- Children Act (2004) - Statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11
- Domestic Violence and Victims Act (2004)
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007
- Registration standards, Health and Social Care 2008 (Regulated Activities) Regulations 2014: Regulation 13
- CQC national standards of quality and safety - Outcomes 7-11: Essential standards of quality and safety
- Safeguarding Vulnerable People in the NHS- Accountability and Assurance Framework (2013)
- Care Act (2014)
- Counter- Terrorism and Security Act (2015)
- Working Together to Safeguard Children (2018)
- Adult Safeguarding: Roles and Competencies for Health Care Staff (First Edition: August 2018)
- Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (Fourth edition: January 2019)
- The Coronavirus Act 2020

GOVERNANCE ARRANGEMENTS

All staff have a statutory responsibility to safeguard and protect those who access our care regardless of their position in the Trust. However, some defined named safeguarding roles exist for safeguarding.

- The Executive Lead for Safeguarding Children and Adults is the Chief Nurse; this responsibility is delegated to the Deputy Chief Nurse.
- The Safeguarding and Vulnerabilities Team and Named and Designated Professionals provide both strategic support and direction to the governance and safeguarding arrangements within NLaG, and operational advice and support to all trust staff.
    - The Trust has in place a Named Doctor for Safeguarding Children at both sites, Named Midwife's, Named Adults Professional and Named Nurses for Safeguarding Children.
    - Following the retirement of the Named Doctor at DPoW both the clinical lead and Designated Doctor are assisting with this role until the new applicant is in post
    - Designated Doctors for Safeguarding Children and Looked After Children are employed by NLaG, and as well as their Trust roles also link with other Designated Colleagues in the CCG as part of their role.
    - The Trust attends the Local Child Death overview panel meetings with representation from the SUDIC Paediatrician and paediatrics.

Our internal arrangements ensure that Safeguarding remains core Trust business. More formally the Safeguarding Operational Adults and Children's Forums that reported directly to the Safeguarding and Vulnerabilities Oversight Board last year have now been re-structured to become the Safeguarding and Vulnerabilities Operational Forum which meets bi-month.ly. The Learning Disability and Dementia Steering group will report to the VOB along with a newly commissioned LPS work stream This Board is aligned directly and reports to the Trust Board. Direct alignment to the Trust Board ensures clear lines of reporting and accountability.



During 2021-21 the Safeguarding team are working closely with CCG Safeguarding Colleagues to develop opportunities to work more collaboratively across the Humber Coast and Vale.

Integrated working across the health partnership arrangements could provide opportunities to represent each other at meetings, share training resources, policies etc. We æprogressing with task and finish groups in 2021 to support CCG colleagues to review and look at joint working arrangements.

PREVENT

The Counterterrorism and Security Act (2015) places a duty on NLaG to have; *'due regard to the need to prevent people from being drawn into terrorism.'*

NLaG have met its statutory responsibilities in relation to ensuring

- Prevent training is delivered in line with the Prevent Competencies Framework (2017)
- The Policy is in place in the Trust.
- Quarterly Prevent data is submitted.
- Partnership links with Local arrangements and meetings are attended.
- Fulfilling the requirements of the NHS Contract.
- Prevent leads are in post.

Key Achievements

PREVENT champions have been identified within the safeguarding team who regularly attend regional PREVENT meetings and training.

The Safeguarding team have provided 100% attendance at Channel Panel meetings.

100% PREVENT returns within time frame to NHS Digital.

Provide assurance to the CCG via the quarterly report.

referrals during the COVID pandemic.

The Trust was on a trajectory to obtain 100% PREVENT compliance by Q3 2020/21 however due to COVID we saw a slight dip in these figures. The figures have started to climb steadily again going into 2021.

Priorities in 2021-22

- Review the Prevent Policy
- Review and Implementation of new Prevent Training and Competencies Framework 2021.

ADULT SAFEGUARDING

Following the introduction of the Care Act (2014) implemented in April 2015; adult safeguarding has been on a statutory footing. NLaG saw a number of changes last year to its Safeguarding Adults team. A new Named Professional and Specialist Practitioner started in post in March 2021. The Named Nurse for Adults is a statutory post and interim arrangements were in place to ensure continuity of service with the Named MCA DoLS lead. NLaG has met our statutory, regulatory, and contractual Safeguarding Board requirements and obligations, by ensuring there are robust governance arrangements, policies and procedures, and support mechanisms in place to ensure these requirements are met.

There has been continued commitment from the Safeguarding team to attend and contribute to the local authority partnership safeguarding board subgroups as well as participating in multi-agency audits where appropriate. The Interim Head of Safeguarding attending the strategic boards for North and North East Lincolnshire.

Key achievements 2020 – 2021

- Safeguarding Adults Policy updated
- Maintained attendance to Safeguarding Board and Subgroup meetings.
- Developed flow charts for ward and departments to follow when safeguarding concerns are identified, including 7-minute briefings.
- Reviewed training in line with the Adult Intercollegiate Document.

Priorities in 2021-22

- Continue to embed 'Making Safeguarding Personal' and work with partners to put patients at the heart of what we do by embedding this culture.
- Work with adult social care to ensure that referrers receive feedback from concerns raised, and a consistent approach to referral thresholds is achieved.
- Embed staff knowledge and understanding relating to falls and referrals into safeguarding procedures.
- Attending falls huddles
- Review the Absconding Policy and flow charts
- Develop the Adults Supervision Policy and implement a supervision and implementation strategy for the Trust
- Review and update the Safeguarding Adults Hub Pages
- Allegations Policy (to include LADO and PiPoT)
- Develop safeguarding champions
- Promote the 'Pressure Ulcers and the interface with a Safeguarding Enquiry: When to raise an Adults Safeguarding Concern' (DH 2018).

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SAFEGUARDING WEEK AND OTHER PROMINENT DAYS

The safeguarding team promoted and shared links with Trust colleagues for NE Lincs safeguarding week. This included a host of different webinars focusing on understanding thresholds, how to make safeguarding children referrals and changes to the CSC front door.

The safeguarding team also shared links to safeguarding webinars held by N Lincs as well as East Riding Safeguarding Partnerships.

Priorities 2021-22

- Continue to be involved in safeguarding weeks and promotion of training and study days
- Lead and contribute to Safeguarding Month in July and Domestic Abuse month in October

VULNERABLITIES (Learning Disability and Dementia)

Our Vulnerabilities team is led by our Lead Nurse for Vulnerabilities. We appointed Holly O'Connor this year to provide strategic and operational responsibility. This year the vulnerabilities team joined our safeguarding team to continue collaboratively supporting our most at risk patients. There are overlapping responsibilities in safeguarding our most vulnerable patients, but also ensuring that we follow safeguarding procedures when a person becomes at risk or results in abuse or neglect occurring. The Equality Act (2010), states that there is a duty to make reasonable adjustments for those in society who are placed at a disadvantage due to their disability. We ensure our vulnerable patients have reasonable adjustments made to support and care needs to ensure they have the same access to health care as everyone else.

Our responsibilities include implementing national guidance on Learning Disability and Dementia, providing support and advocacy to inpatients on both adult and children's wards, and in outpatients as required regarding clinical decision. All our patients are vulnerable and we prioritise supporting our clinical staff in complex cases utilising the wider remit and scope of the Mental Capacity Act (2005) and the principles surrounding this. Externally we have strong links with our partners in the CCG, North East/North Lincs Partnership Boards, and Carer Support forums. Our Senior Nurse for Vulnerabilities is part of Steering groups across NLaG influencing change in areas such as Transition, End of Life, Mortality Improvement, Patient experience and the new ED building design considering our LD/Dementia patients and for example low stimulus lighting and clocks. The Lead Nurse for Vulnerabilities regularly meets with the Safeguarding team and Chief Nurse Directorate.

Learning Disability

The NHS Long-term Plan includes providing the right care for children with a learning disability, improving the recognition of carers and the support they receive, and progressing on care for people with dementia. The Learning Disability Improvement standards for NHS Trusts (2018) are crucial in measuring the quality of care provided to people with a learning disability and/or autism. By protecting and respecting rights and fostering inclusion and engagement we can improve and meet those standards required to ensure the outcomes

created by people and families/ carers are met. This approach to improve the quality of care places patient and carer experience as the primary objective, as well as recognising the importance of how the NHS listens, learns and responds in order to improve care. Our vulnerability nurses are crucial to ensuring these standards are met within NLaG.

LeDeR Reviews

Learning form Lives and Deaths – People with a learning disability and autistic people (LeDeR) policy (March 2021)

The process for LeDeR reviews is changing in June 2021 to include people with autism. As the NHS moves in to its new arrangements though 2021-22 local integrated care systems will become responsible for LeDeR reviews being completed and actions are implemented toimprove the quality of services for people with an LD. LeDeR reviews look at key episodes ofall health and social care the person received. A structured judgement review is also completed. A revised LeDeR process is being put in place this year with changes to the training required to complete these reviews. The new process will include an initial review and then a decision is made as to whether a focused review is required. This has oversight of our Lead Nurse Vulnerabilities.

COVID 19

There were 11 Disability mortality cases that occurred in the second wave of the Covid 19 pandemic between October and December 2020. All of these cases were reviewed by the Lead Nurse for Vulnerabilities. There were no patient safety concerns that required escalation.Care for these patients was appropriate and consistent with care of patients without a learning disability.

Apr 20	May 20	Jun 20	July 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 20	Feb 20	Mar 20
0	1	0	0	0	1	1	5	5	1	2	0

Transition of young people into adult services can be complex and difficult for the young person and families; this should be undertaken over time and start as early as 12 years old as it may take several years for complex young people. The ‘Ready, Steady, Go’ programme involves identifying and supporting young people and their families to move into the adult healthcare arena. Our transition Steering Group and Learning Disability and Complex Care Transition Nurse is leading on developing a transition pathway. If Transition is handled well means a better patient/carer experience, reduce admissions, patient safety, and a better process of working between primary and secondary care.

Dementia

We are undertaking the National Audit for Dementia in August 2021 this is voluntary but we have not taken part in any National Audit for Dementia over the last few years due to Covid 19 (none were produced by them).We have put a wish into the Health tree foundation for a Dementia Bus to come to NLaG The initiative is intended to give NHS staff the opportunity to experience what it is like for someone living with dementia by completing a series of basic daily activities while wearing dark sunglasses, headphones and multiple-layered gloves. The Dementia Nurse Specialists regularly take part in the Vulnerability rounds within NLaG. We promote the use of IMCA’s in these rounds Kate Scott our Dementia Nurse Specialist Nurse

has also supported in the roll out and teaching of the trusts supportive care policy and the AFLOAT tool. The Dementia strategy had recently been updated The Dementia training is going to be changed to Vulnerabilities training and cover a patient journey including patient safety, falls, pressure ulcers, MCA and DoLS and nutrition. Every year we celebrate Dementia week across the trust show casing all the work we do. Recently the Vulnerabilities team did a sky dive and raised money for Dementia friendly wards. We are part of development plans for Dementia friendly areas. In the new ED departments we have Dementia friendly clocks, pastel colours, appropriate signage and low stimulus lighting.

Covid 19

Has been particularly challenging for both our Dementia and Learning Disability agendas. The Specialist Nurses within both teams have maintained a high level of visibility throughout and heavily supported patients when relative/carer contact was minimal. Lack of Community support also meant that we provided increased support for patients who were inpatients and at outpatient appointments. We have supported trust wide as a team in advising on reasonableadjustments and the Avoiding Falls Level of Observation Assessment Tool (AFLOAT); aiming to reduce unnecessary harm. The Vulnerability rounds have continued and extra support for promotion of best interests meetings, DOLS applications and facilitating earlier discharge where possible. Most providers stopped coming into our Hospital so therefore our call volume increased also. We have continued to reiterate key messages from the Chief Nurses Directorate such as the visiting policy. We have taken this opportunity to stream line our referrals onto Web V and also promote and encourage the stage 2 capacity assessment on Web V.

Key Achievements

- Development of the AFLOAT tool and Supportive care policy
- Leading the Vulnerabilities ward rounds
- Reset of Vulnerabilities steering group and Champions
- Relaunch of red bag scheme at DPOW
- Complete the National Audit (trust wide)
- Development of a Vulnerabilities dashboard
- Increased our numbers of staff who can complete LeDer reviews across NL/NEL
- Celebrated Learning Disability week in 2020- service Users were unable to participate this year. Every year we celebrate LD week across the Trust show casing all the positivework we do. Often we hold events during that week and invite service users in. Unfortunately due to Covid the last 2 years we have been unable to do this.
- Implemented the changes to the LeDeR process

- **Key Priorities 2021-22**

- Develop and embed a Transition Pathway / Policy working in collaboration with Children's services
- Audit the use of RESPECT forms with Learning Disability patients
- Flag on our PAS systems patients with Learning Disability and Dementia to improve identification of vulnerable inpatients and attendance at outpatient appointments
- Progression of a 'Changing Places' facility at SGH
- Vulnerabilities round form – to then collate data
- Develop a Carers strategy
- Recruitment of Vulnerability Champions
- Secure the Learning Disability and Transition Nurse
- Update the Learning Disability and Dementia Strategy
- Combine the LD and Dementia training to Vulnerability training
- Priorities Develop and embed a Transition Pathway / Policy working in collaboration with Children's services
- Audit the use of RESPECT forms with Learning Disability patients
- Complete the National Audit for Dementia
- Community and Therapies engagement – improving links between primary and secondary care.
- Relaunch and lead Dementia training as Vulnerabilities training half day session for front line staff responsible for the delivery of care to our patients.

MENTAL CAPACITY AND DEPRIVATION OF LIBERTY SAFEGUARDS

NLaG is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and Deprivation of Liberty Safeguards (DoLS, 2009). MCA DoLS training is delivered mainly via online packages (since the beginning of the pandemic) however all key staff working with adults who are band 7 and above are expected to complete the level 3 Safeguarding Adults training (this includes an MCA/DoLS module) to achieve full compliance.

NLaG MCA DoLS lead and Specialist Practitioner are part of the Safeguarding Team and the point of contact for advice and support in relation to MCA/DoLS.

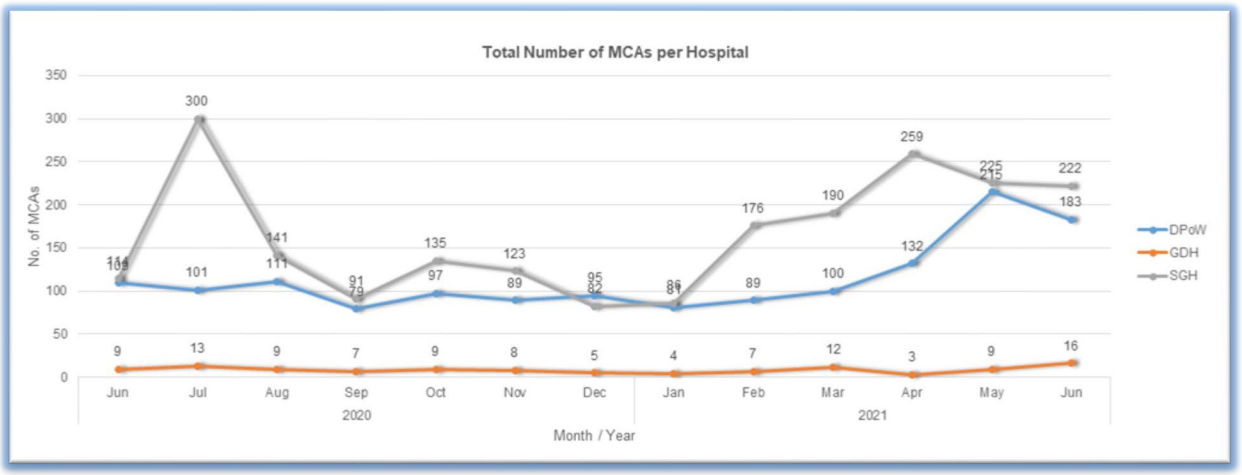
The Safeguarding Team continues to work closely with DoLS managers from our Local Authority partners to support consistency of applications across the Trust. The team now quality assures all DoLS applications before they leave the Trust. (This is anticipated to assist us with our move over to Liberty Protection Safeguards (LPS) in April 2022)

DOLS applications

Year	NEL	NL	Total	Average Per month
2014-15		14	14	1
2015-16	2	30	32	5
2016-17	170	51	221	2.6
2017-18	219	30	249	20
2018-19	255	109	364	30
2019-20	259	155	414	34
2020-21	294	164	458	38

**We have seen a steady increase in the numbers of applications year on year. This data provides assurance and oversight that DoLS awareness is improving across the Trust.*

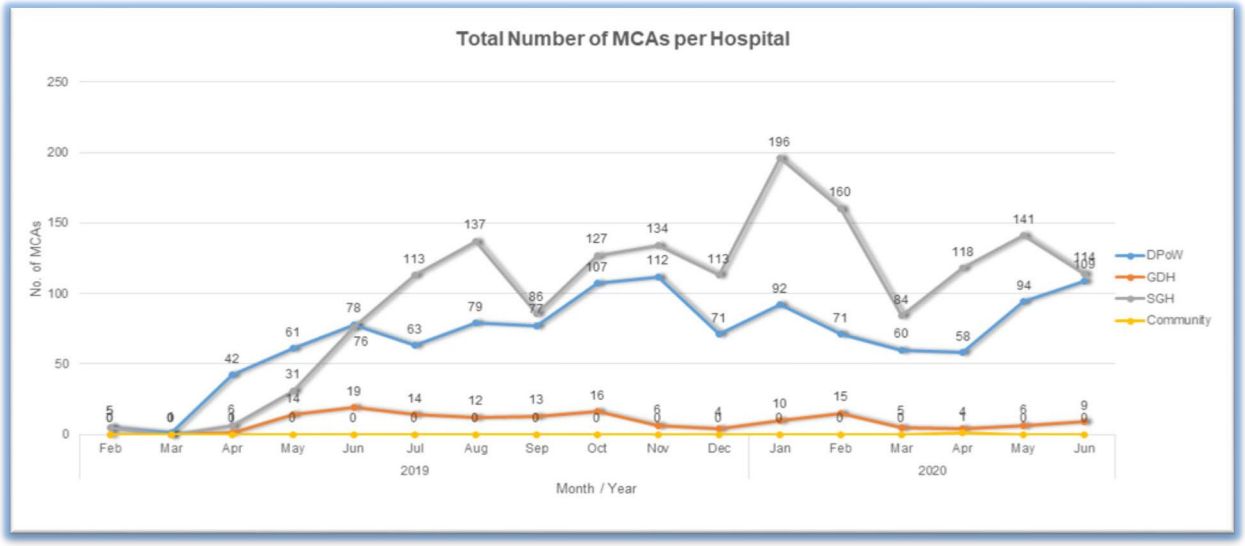
Mental Capacity Assessments



This graph shows the number of city assessments carried out and recorded on WeBV from June 2020 to June 2021 (it is important to note that this will not reflect all assessments carried out as some will be documented directly in the patient's notes).

We can see from the graph, that the numbers dropped from July 2020 to January 2021 this could be due to a number of factors influenced by the pandemic.

2019-2020 figures for comparison. We know from our data that both the DoLS and Mental Capacity figures are influenced by the team walking around the wards and promoting them. We have more work to do to get us to where we need to be.



Key Achievements

- DoLS data is recorded and shared at the Nursing Metrics meeting and Vulnerabilities Oversight Board.
- Our training compliance is now at 80% MCA and 87% DoLS
- We are now quality assuring all DoLS applications before they leave the Trust.
- We provide bespoke training, we have recently completed some sessions delivered to GNRC around the completing of mental capacity assessments with challenging patients.
- We have recently launched our electronic Best Interest Tool in partnership with WeBV we believe that this will improve the documentation of best interest discussions/meetings which will in turn help us to meet our legal responsibilities around the MCA.
- Continued work embedding knowledge and skills in all areas regarding MCA/DoLS. We do this by working closely with the wider Vulnerabilities Team.
- Reviewed the Mental Capacity and Deprivation of Liberty Policy

Priorities 2021-22

- To continue to support wards in completing their own DoLS applications
- To continue to support staff to embed MCA into practice
- To monitor closely the progression of the Bill and link with other Local NHS Trusts around implementation and plans for embedding LPS.
- Work with legal services department to ensure plans for new systems are embedded.
- Review the MCA DoLS Policy when the LPS are implemented.

MENTAL CAPACITY (AMENDMENT) BILL

Background

The Mental Capacity (Amendment) Act received Royal Assent in May 2019 and introduces the Liberty Protection Safeguards to replace DoLS. The purpose of the Bill is to provide a simplified legal framework and authorisation process which is accessible, clear, deliver improved outcomes for people deprived of their liberty and place the person at the heart of decision making.

The Minister of State announced post pandemic that they now aim for full implementation of LPS by April 2022. Some provisions, covering new roles and training, will come into force ahead of that date.

Implications for NLaG

- Hospitals (the responsible body) will be responsible for authorising the deprivation of liberty (it will no longer be the Local Authorities responsibility, but the Hospital Manager.
- Referral pathways and authorisation process will need to be considered.
- For the responsible body to authorise any deprivation of liberty, it needs to be clear that:
    - The person lacks capacity to consent to the care arrangements
    - The person is of unsound mind
    - The arrangements are necessary and proportionate

    All 3 of the above criteria must be met

- The deprivation can be used in a variety of settings (i.e.) those who live at home and have respite care and a day centre.
- Staff will need to be trained and aware of what the new Liberty Protection Safeguards constitute as well as what an objection is including how to refer to an Approved Mental Capacity Practitioner (AMCP) – acting as a form of mediation prior to a Court of Protection Appeal.

Priorities 2021-22

- Consider implications for NLaG Acute and Community Services once the public consultation commences regarding to MCA and DoLS Code of Practice.
- Provide detailed report to Board of Directors regarding Liberty Protection Safeguards, implications of the Bill and Codes of Practice.
- Review Team resources to implement the new LPS scheme including training, new processes, and expertise.
- Commission a Liberty Protection Safeguards Work stream for oversight and assurance that all aspects are covered prior to implementation next year.

MENTAL HEALTH

NLaG have continued to work in partnership with our mental health providers across North (RDASH) and North East Lincolnshire (NAVIGO) and Lincolnshire Partner Trust (Young Minds Matter- DPOW) to ensure that our patients presenting with acute general health needs who have mental health concerns are treated holistically throughout their stay and receive the right care, at the right time in the right place. The lead Nurse for Mental Health is responsible for strategic and operational oversight of all mental health patients and pathways throughout the trust and works collaboratively with the safeguarding and vulnerabilities team to ensure our patients are kept safe.

Going forward the Lead Nurse for Mental Health will meet quarterly with RDASH and NAVIGO and reports internally (6 monthly) to the Quality and Safety Committee and to the Quality Safety Committee meeting, and the Quality Governance Group.

Key Achievements

- Developed pre-recorded training for staff around Mental Health Act
- A Samaritans link in patient phone lines
- Established regular internal MH teaching in the Trust
- Legal guidance teaching resulting from police led right care right person model (RCRP)
- Development of policies, guidance with partners or with their consultation
    - Conveyance at SGH of mental health patients (DCM 535)
    - Conveyance for patients with mental health needs in ECC SGH (DCM 536)
    - Managing mental health patients in ED for adults (DCM 538)
    - Managing mental health patients under 18 a quick guide (DCM 537)
    - MOU between police, NLAG and organisations (DCM 553)
    - Policy for the prevention of self-harm including attempted suicide for patients over the age of 18 (DPOW)(DCP 345
    - Policy for the prevention of self-harm including attempted suicide for patients over the age of 18 SGH) DCP 344
    - SOP for detention under the MHA 1983 NAVIGO and NLAG (DCR 198)
    - SOP for detention under the MHA RDASH and NLAG (DCR 060)
    - Treatment of patients with a mental health disorder in an acute and general hospital setting (DCP 378)

Priorities 2021-22

- Mental health strategy for the Trust
- A Mental Health Pathway (Goole District Hospital)
- Continue suicide prevention work
- Embedding compliance with the Sections of the MHA
- Establish links with higher education systems (student nurse training - Hull University)
- Working closely with the Adult Named Nurse focusing on patients with an underlying MH disorder and self-neglect.
- Capturing mental health patient experience
- Review the formal agreements with RDASH and NAVIGO

- Continue to progress compliance with the NCEPOD standards and recommendations where applicable suicide prevention; liaison mental health (treat as one); children and young people's mental health.
- Explore pathways for joint working to ensure children and young people do not havedelays in waiting for appropriate services

SAFEGUARDING MENTAL HEALTH AND MIDWIFERY

As part of our commissioning arrangements and Intercollegiate Document standards NLaG is required to provide Named Midwives to support our maternity services for safeguarding children and vulnerable women and families. Our Named Midwives have robust oversight of complex work at both SGH and DPOW who support our midwives, midwifery support workers and health care assistants with complex cases both antenatal and postnatally where there are concerns that relate to both adults and children. Our Named Midwives both support midwives and mothers in the most complex cases.

High risk women with a diagnosed mental illness, such as bipolar, schizophrenia, previous puerperal psychosis and/ or severe depression are referred to the perinatal mental health midwife for close partnership working where safeguarding oversight is required, and appropriate referrals and signposting to appropriate external agencies

Mental ill health, both in the ante natal or post-natal period can have a negative impact upon the attachment between the mother, baby and family unit, which may result in safeguarding issues.

Key achievements

- Promoted the ICON within the maternity services
- Continued to provide supervision and maternity specific safeguarding training (Day 1 Mandatory Training) to midwives and NICU virtually and face to face throughput Covid.
- ICON information and documentation to reflect these touch points has been added to the perinatal institute hand held post-natal notes
- Developed a pre-birth pathway in NE Lincs with partners in social care and early year's providers, ensuring a robust referral and communication pathway to ensure unborn babies are born with a safe plan from social care and the appropriate support is in place. This has received interest from a local MP who wishes to attend and see first-hand how this process is improving our practice.
- Increased referrals in to children's social care since the development of the MARF multi agency referral form from midwifery services.
- Worked collaboratively with the vulnerabilities and adult safeguarding professionals to support the care of our most vulnerable pregnant women with additional learning needs.

- Actively participated in the Domestic abuse strategy delivery group working closely with the safeguarding children's partnership and partner agencies to improve the quality and provision of support for those at risk of domestic abuse.
- Safeguarding midwives have attended strategy meetings, case conferences, core groups with social care and other agencies throughout Covid, supporting midwives to do the same.
- Worked closely with the specialist perinatal mental health midwife for NLAG to discuss women who have complex mental health needs and safeguarding concerns.
- Robust links with named midwives in other provider organisations and attended Regional and National Named Midwife Forums.
- Developed Electronic family files on web V where safeguarding information is recorded
- Used virtual technology to continue deliver training and supervision
- Safeguarding leads within the Midwifery COC teams

- **Priorities 2021-22**
- Develop and implement a cascade safeguarding supervision model within midwifery
- Audit the effectiveness of the ICON rollout
- Develop a Learning Disability and Pregnancy guideline for Midwives.
- Health Visitor liaison form to be implemented electronically in North Lincs in order to align the process with North East Lincolnshire following the pilot within NE Lincs.

CHILDREN AND YOUNG PEOPLE

NLAG is fully committed to the principles set out in the government guidance 'Working Together to Safeguard Children - 2018,'the Children Act 1989/2004 and to joint working with both the North Lincolnshire MARS and North East Safeguarding Children Partnerships.

NLaG work closely with are three neighbouring local authorities, North and North East Lincolnshire, East Riding and Lincolnshire. Links to their policies are including in NLaG's safeguarding policy as well as highlighted to staff via supervision and training. NLaG safeguarding team ensure that policies are aligned with multiagency procedures when developed or updated and hyperlinks are inserted to assist professionals when accessing the policies.

NLaG's safeguarding responsibilities are effectively discharged by the provision of day to day advice, supervision, support and promoting good professional practice. This includes identifying the training needs of all staff and volunteers in relation to safeguarding children and delivering a comprehensive mandatory programme of training, which includes key safeguarding messages from research, safeguarding incidents, and safeguarding children practice reviews / learning lessons reviews and lines of sight.

Covid 19 Challenges

The Covid 19 Pandemic has brought its own challenges for vulnerable children and young people. They have been less visible to professionals during periods of national lockdowns

and school bubble isolation. Home for some children is not a safe place and this year the team have focused on monitoring all attendances to the accident and emergency department of 0-17 years and ensuring we follow up and refer onwards to other support services as required and though the multi-agency safeguarding children procedures.

Key achievements

- Continued to provide safeguarding children supervision to ECC, paediatric, midwifery and NICU teams ensuring that they adhere to IPC safety measures
- Developed and distributed 5 safeguarding newsletters which have covered topics such as LADO / PiPoT, MARAC, thresholds, neglect and legal orders to supplement staff's safeguarding training.
- Disseminated updates from NE Lincs, N Lincs and East Riding children's services with NLaG staff and promoted multi agency virtual training.
- Continued professional development virtually to maintain level 4 Safeguarding Competencies.
- Benchmarked NLaG against the RCPCH standards for safeguarding paediatric medicals and action plan in development.
- Updated policies ensuring that they are in line with any new or revised guidance both in house and interagency working with the CCG. Policies and guidance updated 2020/21 include: Safeguarding Children Guidance, CCE Guidance, Failure to Be Brought and Guidance for professionals when requesting a safeguarding paediatric medical assessment
- Implemented a SOP for CP-IS in both Accident and Emergency Departments
- Instigated a new daily update and communication between Paediatric Ward and Safeguarding team at DPOW for inpatients (Pilot project)
- Provided support to NLaG staff where domestic abuse has been identified
- 100% attendance at MARAC meetings.
- A new streamlined electronic process of screening and sharing ECC attendances with the child health teams
- All quarterly reports have been returned within the timeframe to the CCG
- Improved and developed Paediatric liaison data bases which enable the team to identify themes and trends and has shown an increase in attendances for children over the pandemic period. This has identified an increase in attendances of mental health concerns for children and young people
- Completed Section 11 Audit requests for East Riding, North Lincs and North East Lincs Safeguarding children Partnerships.
- Worked collaboratively with NLaG legal team where cases become complex.
- Joint working with the Deputy Head of Surgery to embed a streamlined process of notifications to the team of attendances at 'Hot Clinics'.

- **Priorities 2021-22**
- Develop an audit programme

- Embed the actions from the medical report audit and the identified actions from the safeguarding paediatric medical standards (RCPCH 2019)
- Review of the liaison professional's role to include increased support to paediatric safeguarding medicals by providing background health information to the examining paediatrician.
- Review the Failure to be Brought policy
- The roll out of CP-IS in paediatrics.
- Develop Web V safeguarding communication templates
- Multi-agency audit of Children/Young people attendances SGH

THE SUDIC (Sudden Death in Childhood) ARRANGEMENTS

Since April 2008 Local Safeguarding Partnerships have been required to review the deaths of all children in their area as outlined in 'Working Together to Safeguard Children 2018.' The Child Death Overview Panel is made up of senior representatives from multi-agency partners, and from 2021 is being chaired by senior representatives in midwifery and paediatrics from NLaG. The panel covers arrangements across North and North East Lincolnshire.

Guidance in 2018 outlines the duties of the new Child Death Review (CDR) partners, the Local Authority and the Clinical Commissioning Group (CCG), the processes to be followed when responding to, investigating, and reviewing the death of any child, from any cause. The statutory partners must ensure CDR arrangements are in place to review all deaths of children who are normally resident in the local area and as appropriate for any non-resident child who has died in their area. It runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP).

The purpose of a review is to:

- ensure that lessons are learnt from child deaths, that learning is widely shared and that actions are taken - locally and nationally
- to reduce preventable child deaths in the future.
- Identify cases giving rise to the need for a serious practice review
- matters of concern affecting the safety and welfare of children in the area
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the local area

Our SUDIC (Sudden Death in Childhood) nurse Trust wide ensures that NLaG fulfils its requirements to maintain this joint agency response (JAR) by supporting the lead doctor in identifying the correct professional attendance at the JAR meetings. The SUDIC nurse attends and is an active participant of the CDR operational group; they link with NLaG mortality lead and attend the paediatric end of life group.

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

local initiatives are adopted (Social media adverts / face book in relation to hot weather and suitable sleeping advice).

Key achievements

- All families have been offered bereavement support and signposting as required
- Monthly SUDIC training on the paediatric mandatory day
- 100% attendance at the CDR Operational Group
- Reviewed and updated the Northern Lincolnshire CDRM guidance to come into line with National Guidance
- The development of closer working relationship between SUDIC nurse and Police to improve support and information sharing for the families

Priorities 2021-22

- SUDIC nurse to lead on a task and finish group to improve the memory work provided to families
- SUDIC nurse and bereavement midwife to develop a study day for 2022
- Development of a SUDIC proforma to be completed at time child's presentation
- To continue to embed arrangements regarding the Key worker role to support families who are bereaved
- Sub group developed to look at the development of the key worker role
- Designated Doctor for Child Deaths and SUDIC nurse developing training for Trust staff to raise awareness of the process and support available.

CONTEXTUAL SAFEGUARDING

Contextual Safeguarding is an approach to understanding young people's experiences of significant harm beyond their families and recognises the impact of the public and social context on young people's lives, and consequentially their safety. It seeks to identify and respond to harm and abuse posed to young people outside their home, either from adults or young people. This can include CSE, peer or peer violence, abuse, modern day slavery, harmful sexual behaviour, abuse in gangs and groups, criminal exploitation and going missing from home or care; should not be seen in isolation as they often overlap, creating a harmful set of circumstances and experiences for children, young people, families and communities.

The safeguarding team works closely with our local partnership arrangements in developing local protocols and working in partnership to ensure how individual cases are managed locally.

Key Achievements

- Active partnership members of the NE Lincs Operational Vulnerabilities Meeting and the NE Lincs and N Lincs Multi Agency Child Exploitation meetings.
- High risk children and young people are flagged following this meeting on Systmone and symphony.
- CSE /CCE is included and discussed in the Level 3 safeguarding children training (face to face training.)
- Prior to Covid 19 pandemic awareness training was delivered to the Trust from the GRAFT team and updates from the lead police officer and Children Social Care lead.
- The safeguarding team continue to promote the CSE/CCE in supervision and encourage staff to use the KYSS tool and the "Warning and Vulnerability Check List" which has been made available to all staff in Gynaecology, midwifery, paediatrics and ECC.
- Prior to all training moving to eLearning the safeguarding team included awareness of modern day slavery in the level 2 and it is included in the supplementary reading that is sent to all staff who attend level 3 eLearning.
- Through attendance at OVM /MACE and the pre-birth pathway any concerns relating to CSE /CCE are raised, shared and appropriate referrals made.

- **Priorities 2021-22**
- To continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multi-agency meetings to share intelligence around this.

FEMALE GENITAL MUTILATION

Female Genital Mutilation (FGM) encompasses 'all procedures which involve partial or total removal of the female external genitalia, or any other injury to the female genital organs, for non-therapeutic reasons.' FGM can have far reaching consequences for the physical, psychological and sexual health of those women and girls affected. It is a violation of their human rights, a form of child abuse and is illegal in the UK.

Since the introduction of the Female Genital Mutilation Act (2003; replacing the Prohibition of Female Circumcision Act (1985), FGM has been a criminal offence). The first successful prosecution took place in February 2019. With increasing international migration, the UK has become host to many women affected by FGM. Research suggest 279,500 women and girls in the UK have undergone FGM and a further 22,000 girls are at risk of the procedure. Since 2008 women with FGM have made up about 1.5% of all women delivering in England and Wales.

To ensure that NLaG meets its statutory requirements:

- The Trust has an identified FGM Lead
- 2016/2020- FGM-IS Standard Operating Procedure
- All cases are reported to the Trust FGM lead
- Quarterly reporting to NHS Digital

Date	From Midwifery/ Obstetrics/ Gynaecology
2016-Jan 2021	75

Key Achievements

- Mandatory reporting of all cases of FGM is embedded within NLaG reported quarterly to NHSE and the safeguarding children's forum
- FGM is routinely asked within maternity services.
- Safeguarding training is included in mandatory midwifery training.
- FGM training is delivered in all levels of safeguarding training.
- Female infants identified at risk at birth are flagged via the FGM – IS system. Information is then shared with the HV service and GP via discharge information and liaison meetings with any concerns shared via a multi- disciplinary forum
- FGM policy including a flow chart to support staff in assessing the levels of risk in relation to FGM is accessible on the documents hub
- Statutory FGM reporting is carried out and reporting internally through the Safeguarding children Forum)

Priorities 2021-22

- Update guidance and policies for staff and provide information leaflets for families
- Ensure that clinical staff working in the Paediatrics arena have the ability to identify female children at risk of FGM by having the tools to do so – such as access to the NHS Spine via SMART cards
- Participate in multi – agency task and finish groups to promote best practice in safeguarding women and children re the responsibility all agencies to report to NHS digital and share information
- Embrace local and national networking opportunities to share knowledge and learning around FGM

DOMESTIC ABUSE

Domestic abuse is any incident or pattern of incidents of controlling behaviour, coercive behaviour or threatening behaviour, violence or abuse between those aged 16 or over who are family members or who are, or have been, intimate partners. This includes psychological, physical, sexual, financial and emotional abuse. It also includes 'honour'-based violence and forced marriage.

To ensure the Trust has robust arrangements there is

- A Named Lead for Domestic Abuse (DA).
- Domestic Abuse Guidance for all staff
- Policy for Trust staff affected by Domestic Abuse

Ongoing risks/challenges

It has been publicised and discussed nationally around the impact of COVID 19 lockdown may have in relation to increased and unseen domestic abuse.

The New Domestic Abuse Bill

The New Domestic Abuse Bill has identified that DA costs the country £66 billion and the cost implication of DA for health alone is £2.3 billion.

Whilst this is not yet in force, the legislation has identified some anticipated changes:

- the definition of DA to include economic abuse and controlling and manipulative non-physical abuse. It will identify a domestic abuse commissioner to drive the domestic abuse agenda forward. The other benefits of the legislation are prohibition of cross examination of victims by their abusers at family court and other protection orders that are currently being used now (DVPO/N's). The government is making 120 commitments which are non-legislative measures which includes:
- £8 million of Home Office funding to support children affected by domestic abuse a new crisis support system for those with no recourse to public funds.
- additional funding and capacity building for services for disabled, elderly and LGTB victims · updated support, training and guidance on economic abuse.
- new and additional training for job centre work coaches, police, social workers and probation staff to help them recognise and effectively tackle abuse
- improved support for victims in the family court
- additional £500,000 funding for provisions for male victims

Key Achievements

- Promoted Clare's Law via the safeguarding newsletter
- Proactive member of MARAC in both N Lincs and NE Lincs
- Safeguarding team have attended and are active participants at Domestic Abuse Strategy Groups for both N Lincs and NE Lincs
- Promoted MARAC training for Trust staff
- Continued to support to staff affected by domestic abuse
- Continued close working arrangements with Blue Door staff and have an Independent Domestic Abuse Advocate (IDVA) based within the team at both DPoW and SGH site
- Continued to flag domestic abuse victims on the ECC electronic system

- The safeguarding team have seen an increase in staff disclosing domestic abuse and have offered support and signposting.
- Domestic abuse is included in Level 3 safeguarding adults training and the updated safeguarding adults policy

Response to Covid-19:

Covid 19 has seen a rise in the incidents of domestic abuse in both N Lincs and NE Lincs which has impacted on the number of victims heard at MARAC meetings. This increase has led to the MARAC meetings being increased to weekly and then fortnightly from the usual monthly held meetings. This in turn has impacted on the safeguarding team who have continued to provide 100% attendance at the MARAC meetings.

Priorities 2021-22

- Review and update Domestic Abuse Policy and Guidance to come into line with the new DABill
- NLaG to be benchmarked against N Lincs and NE Lincs DA strategies
- To continue to develop and embed routine enquiry with the Trust

CHILDREN LOOKED AFTER NORTH AND NORTH EAST LINCOLNSHIRE

Our Children Looked After Health teams work in partnership with North and North east Lincolnshire Councils to ensure that the health needs of children who are looked after (CLA) and young people are met, reduce health inequalities, improve health and wellbeing outcomes for children who are looked after, care leavers and those placed for adoption. The health team provides advice and support to health and social care practitioners in order to improve these health outcomes. A Looked after Child is subject to a care order (placed into the care of local authorities by order of a court), and children accommodated under Section 20 (voluntary) of the Children Act 1989. Looked after children may live within foster homes, residential placements or with family members (connected carer's).

The Designated Doctors for Children Looked After are a part of this team and completes all the initial health assessments (IHA) for all children and babies placed in the areas. Our nurses on the teams complete all review health assessments (RHA) undertaken every 6 or 12 months depending on the age of the child.

The services are closely monitored by both the Vulnerabilities Oversight Board and the partners in the council and the CCG.

A Care Leaver is someone who has been in the care of the Local Authority for a period of 13 weeks or more spanning their 16th birthday (Leaving Care Act 2000). All local authorities (Department for Education, 2018) have a legal obligation to support young people making the transition from care to independence. Health and wellbeing are included in the care leaver's offer. Both our teams do not deliver a specific service offer to care leavers beyond aged 18 years to 25 years.

North East Lincolnshire Key performance indicators

N East Lincs	April 20	May 20	June 20	July 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	March 21
New in care	29	14	17	9	8	28	18	17	11	13	11	16
Late notifications	26	12	13	8	7	20	17	15	11	12	9	13
%	**89%**	**85%**	**76%**	**88%**	**87%**	**71%**	**94%**	**88%**	**100%**	**92%**	**81%**	**81%**

North Lincolnshire Key Performance Indicators

NL Lincs	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
IHA	100 %	100 %	100 %	100 %	100 %	100 %	71.42 %	100 %	100 %	87.5 %	75%	100 %
RHA	89%	94%	100 %	100 %	100 %	94%	88%	87%	100 %	100%	100 %	93%

In North Lincolnshire majority of the IHA and the RHA are completed on timescale. This is due to the lower numbers of children and young people coming into care compared with NEL. We work closely with the local authority in addressing the reasons around any late assessments completed and reason behind this.

Demographic data	North East Lincolnshire	North Lincolnshire
The number of children looked after as at 31 3 21:	595	208
The number who became looked after:	191	68
The number who ceased to be looked after:	142	86
The number of children who met the criteria of being looked after in the performance year:	448	202

**Note the performance data only reflects children who were looked after for more than one year and does not reflect the activity of those who were seen outside the published performance data SSDA903.*

There are significantly higher numbers of Children who are looked after in North East Lincolnshire than in North Lincolnshire. Over the past 5 years we have seen a static number of CLA in North Lincs and an increasing picture in NE Lincs.

Covid 19 Challenges

This year has been particularly hard for children and young people who are CLA with the Challenges that Covid 19 Pandemic has brought particularly in ensuring that this service has continued to meet the needs to this vulnerable group of children and young people.

- Both teams have continued to deliver both IHA and RHA throughout the pandemic.
- North Lincolnshire CLA during the pandemic initially completed all the IHA over the telephone, from March 2020-September 2020 a total of 36 children had their assessments this way, we then recommenced the IHA face to face within a Covidsafe environment. Since then we have arranged additional clinics so the remaining CLA were seen face to face for their physical examination to complete their assessment. A number of the CLA have subsequently left care and we are working with the CCG address this issue. This issue was put on the risk register
- A recovery plan with risk stratification to identify children and young people who met the criteria for face to face was agreed and implemented during the pandemic.

North East Lincolnshire key challenges

- Late notifications from children's social care of children and young people new into care has resulted in a not meeting the statutory timescales for IHA undertaken by the paediatrician (20 working days). The CLA should be notified within 48 hours of a child becoming Looked After. This could result in a delay in identifying any unmet health needs. This has been escalated to North East Lincolnshire Council, North East Lincolnshire Clinical Commissioning Group and within the Trust provider and remains on the both the CCG and NLaG risk registers. An action plan to improve the timeliness is in place. This is monitored through women's and children's governance arrangements and the Vulnerabilities Oversight Board and externally though the NE Lincolnshire Operational Multi-agency quarterly meeting.

Late notification of children becoming looked after

March 20- March 21	NEL	Late after 20 working days
New into Care	191	163 (85%)

Continued trend of children becoming looked after

- Sustained numbers of children becoming looked after continues into 2020-2021 which has impacted on service delivery. The Acute Trust has worked with NELCCG

to agree additional temporary funding of administrative and nursing hours to meet the demand. Although some children have returned home, there has been no significant downward trend in numbers of children looked after.

Key Achievements

- Continued additional funding and support from North East Lincolnshire Clinical Commissioning Group led to continue good performance for Statutory Review Health Assessments for children looked after by North East Lincolnshire placed in the local area.
- The use of telephone consultations and NHS Anywhere video consultations has allowed for efficient and effective use of resource but this is not a long term solution as children are missing vital consultation and assessment;
- Innovative opportunities to capture CLA health care plans from safeguarding medical records as a new born; chat tool in secure setting and seeing/using medical records for child on ward. This improves timeliness and reduces duplication for the child/young person.
- Recovery plan for COVID secure environment to see those children who have had risk stratification in place is working well.
- NEL review of the health passport work in collaboration with the child in care group.
- NEL performance of Statutory Initial Health Assessments (despite late notifications from children's social workers).
- NEL performance of Statutory Review Health Assessments.
- NL and NEL are progressing with Digital team to improve the electronic health assessment form and data improvements to inform service delivery, trends and performance.
- NEL Working in partnership with Safeguarding Children's Board to complete rapid reviews, serious case reviews.
- NEL Working with complex children in residential care.
- Monthly and quarterly performance reporting to senior management within the provider, commissioner and Local Authority
- Maintained regional and national links with specialist looked after children meetings.
- Continue to work in collaboration with our children and young people capturing their voices central to all service delivered.

Priorities 2021-22

- Post Covid -19 recovery plan is in place for North and North East Lincolnshire;
- For NEL to continue to work in partnership and support children's social care to improve late notification and the timeliness of health assessments
- To continue to develop a training passport for CLA and CL within the provider organisation
- To ensure that the services on both sites are appropriately commissioned in line with the support children and young people need.

TRAINING AND SUPERVISION

The provision and delivery of safeguarding training for both children and adults remains a key priority. It is a mandatory requirement for all staff to undergo this training to attain competencies appropriate to their role in line with the Intercollegiate Document for Safeguarding Children (2019) and Adults (2018).

Key Challenges

The Coronavirus Pandemic (2019) as such brought additional challenges ensuring all our staff received and maintained their mandatory safeguarding training compliance. In March 2020 we were asked to cease delivering face to face level 3 training and induction training.

Assignment Count	Required	Achieved	Compliance %
7133	40159	33684	83.88%

Competence Name	Assignment Count	Required	Achieved	Compliance %	Achieved	Compliance %
208|LOCAL|Deprivation of Liberty Safeguards (DOLS)|	2802	2802	2422	86.44%	2371	84.53%
208|LOCAL|Female Genital Mutilation|	538	538	421	78.25%	430	80.52%
208|LOCAL|Prevent - Level 1|	7133	7133	5996	84.06%	6175	86.09%
208|LOCAL|Prevent - Level 2|	868	868	793	91.36%	799	84.02%
208|LOCAL|Safeguarding Adults - Level 4 - 3 Yearly|	8	8	7	87.50%	4	57.14%
208|LOCAL|Safeguarding Children Level 5 - 3 Years|	4	4	2	50.00%	1	33.33%
208|LOCAL|Safeguarding Supervision - 12 Monthly|	141	141	79	56.03%	91	49.46%
208|LOCAL|Safeguarding Supervision - 3 Monthly|	54	54	43	79.63%	44	43.14%
208|LOCAL|Safeguarding Supervision - 6 Monthly|	729	729	325	44.58%	380	48.22%
NHS|MAND|Mental Capacity Act - 3 Years|	4089	4089	3345	81.80%	3257	79.42%
NHS|MAND|Safeguarding Adults Level 1 - 3 Years|	7133	7133	6137	86.04%	6205	86.50%
NHS|MAND|Safeguarding Adults Level 2 - 3 Years|	3988	3988	3290	82.50%	3586	82.74%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	426	426	232	54.46%	214	36.71%
NHS|MAND|Safeguarding Children Level 1 - 3 Years|	7133	7133	6117	85.76%	6074	84.68%
NHS|MAND|Safeguarding Children Level 2 - 3 Years|	4198	4198	3687	87.83%	3612	82.84%
NHS|MAND|Safeguarding Children Level 3 - 3 Years|	898	898	775	86.30%	752	76.04%
NHS|MAND|Safeguarding Children Level 4 - 3 Years|	17	17	13	76.47%	10	76.92%
Grand Total	**40159**	**40159**	**33684**	**84%**	**34005**	**82.39%**

- *March 2020-March 2021*

Analysis

Over the past year we have seen a reduction in compliance in some of our training levels. During the Q1-2 training figures remained stable; however Q3-4 saw a reduction in compliance.

Overall the reduction is 1%

There has been a reduction in DoLS, Prevent, Adults Level 4, Children Level 5, MCA, Adults Level 3, Children level 1, 2 and 3.

There has been an increase in FGM, Prevent Level 1, Adults Level 1, Adults level 2, and children Level 4 training.

Safeguarding Children Supervision has seen a reduction in compliance due to the continued challenged that Covid -19 has brought. We have seen an impact on staff being unable to access group supervision sessions in some areas.to be offered virtually throughout the pandemic. This is delivered

Risks Identified

Delivery of face to face safeguarding training stopped however this continued via NHSE eLearning atall Levels of safeguarding training.

During 2021 the safeguarding team introduced a two hour top up for the Level 3 safeguarding children training to ensure all our staff are complaint with the Intercollegiate Document 2019, are aware of local issues, thresholds, themes etc. and are given the chance to discuss their learning in avirtual team's environment.

Key Achievements

- Continued to deliver training though eLearning
- Continued to provide individual and ad-hoc safeguarding children supervision

Priorities 2021-22

- Deliver Adult safeguarding training in line with the Adult Intercollegiate document (2018)
- Re-stabilise the delivery of Safeguarding children level 3 training virtually/face to face
- Increase compliance of Level 4/5 training in adults and children
- Develop the Adults Supervision Policy and implement a supervision and implementation strategy for the Trust for Adults
- Review and Implement the Looked After Children: Roles and Competencies of healthcare staff (December 2020)
- Increase compliance in all levels of safeguarding training to meet Trust Targets

SAFEGUARDING REVIEWS

The safeguarding team are active participants in Safeguarding Children Partnership reviews, analysing cases through multiagency audits to learn lessons and identifying good practice.

The purposes of safeguarding reviews are to enable Local Safeguarding Boards/Safeguarding Partnerships and Community Partnerships to fulfil their obligations under the Children Act (2004), The Care Act (2014) and the Domestic Violence and Victims Act (2004).

There have been a total of 18 requests this year for information, and 34 records reviewed.This is an increase of 9 requests from last year.

Cases for 2020/21

- **Serious Practice Reviews**
  - There has been 1 new Serious Practice Review's commissioned by the Local Safeguarding Children Partnerships.
  - The Trust has been involved in 2 cases from previous years at varying stages of progress.

- **Thematic Reviews (Children Line of Sights / Rapid Reviews)**
  - There have been 18 thematic reviews led by the Children's Partnerships.

- **Serious Adult Reviews**
  - There has been 0 new Serious Adult Review commissioned by the Local Safeguarding Adult Boards, and a learning lessons review.
  - The Trust has been involved in 1 case from previous years where action plans have been re-visited by the Safeguarding Board.

- **Domestic Homicide Reviews**
  - There have been 4 new DHR's commissioned locally.
  - The Trust is currently involved in 1 DHRs from previous years

Key achievements

- Fulfilled partnership requests for information and contributed as authors and panel members to Line of Sight meetings, Children's Practice Reviews, Serious Adults reviews and Domestic Homicide Reviews.
- Met the Rapid Review timescale process of 5 days in sharing information.
- Continued to monitor reviews and action plans though the safeguarding operational group and safeguarding committee meeting

Priorities 2021-22

- To strengthen lessons learned arrangements for external reviews into revised internal processes.

SAFEGUARDING BOARDS AND PARTNERSHIPS

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

Following the Wood Report (2016), Safeguarding Children's Boards were replaced in 2019 by Partnership arrangements. There are now three organisations that are jointly responsible for the partnership arrangements to keep children safe. They are Local Authority, Police and the CCG working alongside other relevant agencies. The key messages are still around improving partnership working and joint responsibility. Whilst the statutory partners hold lead responsibility, NLaG will still be held to account for undertaking and delivering on its key safeguarding duties.

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

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

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

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

Safeguarding Children Priorities	Safeguarding Adult Priorities
Domestic Abuse Transition Child Exploitation	Neglect Self-neglect Domestic Abuse
Training Voice of the Child	Making Safeguarding Personal

Key achievements

- Attended Safeguarding Adults Boards and Children's Partnership meetings and associated subgroups
- Attended Local partnership Health Meetings to ensure the Governance and accountability for the Children's Partnership arrangements are robust, and the Executive lead in the CCG and safeguarding partnership meets their statutory responsibility.

CONCLUSION

The Safeguarding Annual report demonstrates that safeguarding children, young people, families and adults at risk remains a key Trust priority, demonstrating that NLaG is meeting its statutory responsibilities in relation to safeguarding children and adults in a highly complex and changing legislative framework and from a national perspective.

The Trust has responded to these changes and to ensure that everyone is aware of their own individual responsibilities as part of a wider multi-agency partnership arrangement.

Whilst significant progress and achievements have been made in all the key safeguarding agenda's detailed in this report, the team have prioritised and identified the key strategic developments required for 2020-21. These may change in line with other Trust priorities, emerging challenges nationally and the wider partnership priorities including national directives.

Our key underpinning message is that Safeguarding is everybody's responsibility regardless of their role within the Trust

Appendix 1

Priorities 2021-22

1. Prevent

- Review the Prevent Policy
- Review and Implementation of new Prevent Training and Competencies Framework 2021.

2. Adult Safeguarding

- Continue to embed 'Making Safeguarding Personal' and work with partners to put patients at the heart of what we do by embedding this culture.
- Work with adult social care to ensure that referrers receive feedback from concerns raised, and a consistent approach to referral thresholds is achieved.
- Embed staff knowledge and understanding relating to falls and referrals into safeguarding procedures.
- Attending falls huddles
- Review the Absconding Policy and flow charts
- Develop the Adults Supervision Policy and implement a supervision and implementation strategy for the Trust
- Review and update the Safeguarding Adults Hub Pages
- Allegations Policy (to include LADO and PiPoT
- Develop safeguarding champions
- Promote the 'Pressure Ulcers and the interface with a Safeguarding Enquiry: When to raise an Adults Safeguarding Concern' (DH 2018).

3. Safeguarding Week and other prominent days

- Continue to be involved in safeguarding weeks and promotion of training and study days
- Lead and contribute to Safeguarding Month in July and Domestic Abuse month in October

4. Vulnerabilities

- Develop and embed a Transition Pathway / Policy working in collaboration with Children's services
- Audit the use of RESPECT forms with Learning Disability patients
- Flag on our PAS systems patients with Learning Disability and Dementia to improve identification of vulnerable inpatients and attendance at outpatient appointments
- Progression of a 'Changing Places' facility at SGH
- Vulnerabilities round form – to then collate data
- Develop a Carers strategy
- Recruitment of Vulnerability Champions
- Secure the Learning Disability and Transition Nurse
- Update the Learning Disability and Dementia Strategy
- Combine the LD and Dementia training to Vulnerability training
- Priorities Develop and embed a Transition Pathway / Policy working in collaboration with Children's services
- Audit the use of RESPECT forms with Learning Disability patients
- Complete the National Audit for Dementia
- Community and Therapies engagement – improving links between primary and

secondary care.
- Relaunch and lead Dementia training as Vulnerabilities training half day session for front line staff responsible for the delivery of care to our patients.

5. MCA and DoLS

- To continue to support wards in completing their own DoLS applications
- To continue to support staff to embed MCA into practice
- To monitor closely the progression of the Bill and link with other Local NHS Trusts around implementation and plans for embedding LPS.
- Work with legal services department to ensure plans for new systems are embedded.
- Review the MCA DoLS Policy when the LPS are implemented.

6. MCA Amendment Bill

- Consider implications for NLaG Acute and Community Services once the public consultation commences regarding to MCA and DoLS Code of Practice.
- Provide detailed report to Board of Directors regarding Liberty Protection Safeguards, implications of the Bill and Codes of Practice.
- Review Team resources to implement the new LPS scheme including training, new processes, and expertise.
- Commission a Liberty Protection Safeguards Work stream for oversight and assurance that all aspects are covered prior to implementation next year.

7. Mental Health

- Mental health strategy for the Trust
- A Mental Health Pathway (Goole District Hospital)
- Continue suicide prevention work
- Embedding compliance with the Section of the MHA
- Establish links with higher education systems (student nurse training - Hull University)
- Working closely with the Adult Named Nurse focusing on patients with an underlying MH disorder and self-neglect.
- Capturing mental health patient experience
- Review the formal agreements with RDASH and NAVIGO
- Continue to progress compliance with the NCEPOD standards and recommendations where applicable suicide prevention; liaison mental health (treat as one); children and young people's mental health.
- Explore pathways for joint working to ensure children and young people do not have delays in waiting for appropriate services

8. Safeguarding and Midwifery

- Develop and implement a cascade safeguarding supervision model within midwifery
- Audit the effectiveness of the ICON rollout
- Develop a Learning Disability and Pregnancy guideline for Midwives.
- Health Visitor liaison form to be implemented electronically in North Lincs in order to align the process with North East Lincolnshire following the pilot within NE Lincs.

9. Children and Young People

- Develop an audit programme
- Embed the actions from the medical report audit and the identified actions from the safeguarding paediatric medical standards (RCPCH 2019)
- Review of the liaison professional's role to include increased support to paediatric safeguarding medicals by providing background health information to the examining paediatrician.
- Review the Failure to be Brought policy
- The roll out of CP-IS in paediatrics.
- Develop Web V safeguarding communication templates
- Multi-agency audit of Children/Young people attendances SGH

10. SUDIC

- SUDIC nurse to lead on a task and finish group to improve the memory work provided to families
- SUDIC nurse and bereavement midwife to develop a study day for 2022
- Development of a SUDIC proforma to be completed at time child's presentation
- To continue to embed arrangements regarding the Key worker role to support families who are bereaved
- Sub group developed to look at the development of the key worker role
- Designated Doctor for Child Deaths and SUDIC nurse developing training for Trust staff to raise awareness of the process and support available.

11. Contextual Safeguarding

- To continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multi-agency meetings to share intelligence around this

12. FGM

- Update guidance and policies for staff and provide information leaflets for families
- Ensure that clinical staff working in the Paediatrics arena have the ability to identify female children at risk of FGM by having the tools to do so – such as access to the NHS Spine via SMART cards
- Participate in multi – agency task and finish groups to promote best practice in safeguarding women and children re the responsibility all agencies to report to NHS digital and share information
- Embrace local and national networking opportunities to share knowledge and learning around FGM

12. Domestic Abuse

- review and update the DA Policy and guidance to come into line with the new DA Bill
- NLAG to be benchmarked against N Lincs and NE Lincs DA strategies
- To continue to develop and embed routine enquiry within the trust

13. CLA

- Post Covid -19 recovery plan is in place for North and North East Lincolnshire
- For NEL to continue to work in partnership and support children's social care to improve late notification and the timeliness of health assessments
- To continue to develop a training passport for CLA and CL within the provider organisation
- To ensure that the services on both sites are appropriately commissioned in line with the support children and young people need.

14. Training and Supervision

- Deliver Adult safeguarding training in line with the Adult Intercollegiate document (2018)
- Re-stabilise the delivery of Safeguarding children level 3 training virtually/face to face
- Increase compliance of Level 4/5 training in adults and children
- Develop the Adults Supervision Policy and implement a supervision and implementation strategy for the Trust for Adults
- Review and Implement the Looked After Children: Roles and Competencies of healthcare staff (December 2020)
- Increase compliance in all levels of safeguarding training to meet Trust Targets

15. Safeguarding Reviews

- To strengthen lessons learned arrangements for eternal reviews into revised internal lessons learned processes

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)206

DATE OF MEETING	5th October 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Christine Brereton – Director of People
CONTACT OFFICER	Christine Brereton – Director of People
SUBJECT	Workforce
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The people report outlines highlights, low lights and risks in month. The risks are aligned to the People Risk Register and are consistently triangulated. Consultation has been formally closed with the People Directorate however the HR element is currently on-going.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Links to Strategic Objective 2 – To be a Good Employer and Strategic Objective 5 – To Provide Good Leadership.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	

People Directorate September 2021

Highlights	Lowlights	Risks
Workforce Committee Updates on Employee Relation cases and a Deep Dive on Culture have been produced and tabled at the Committee which outlines an overview of the current HR casework, risks and mitigation. The Culture Deep Dive presentation outlined the future direction and objectives linked to the NLAG People Strategy and broader NHS People Plan. **People Directorate Restructure** The People Directorate consultation concluded on the 18th August and now is in a period of implementation. The HR element of the consultation was extended but will conclude on the 5th October before again moving into a phase of implementation. **NHS People Plan** Work continues on the People Performance Framework development so the Trust can demonstrate how it is delivering against the specific targets through the ICS framework. We are on track with the key deliverables. **WORKFORCE:** Following changes to recent government guidelines, the Trust are in the process of reviewing practice in relation to avoidance of covid high risk areas for those that are deemed to be extremely clinical vulnerable. The guidance now states that because of available evidence in relation to the effectiveness of the vaccination and PPE, risks can now be mitigated and those that had been previously been excluded from high risk areas may now be able to return to practice. Guidance will be produced and those impacted will be engaged to be reassessed. A review of staff required to work in the community linked to Carehome staff vaccination is on-going and being scoped currently.	Travel, accommodation and Sourcing of international recruits. Covid continues to make international recruitment difficult due to the closure of borders. Travel guidance has now started to relax meaning greater flexibilities in international recruitment. 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. Turnover has gradually deteriorated over time since the start of the pandemic in April 2020 to present**.** The latest turnover data point is 9.8% 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%.	**As per the People Risk Register** **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. **AFC –** High levels of outstanding job matching workload although now reducing with the new processes in place. **Sickness –** Levels of sickness have reduced however the risk of increased levels of sickness remains high particularly during winter months.

AFC Panel Process
The new AFC evaluation process is now in practice with agreement from our Trade Union partners. The Trust is now training a wider cohort of panel members that will enable greater availability. There is still a backlog of jobs requiring matching and consistency checking but these are now reducing that the new process is in place. There is a low risk to the timing of the training given the national back log and waiting list (for training).

Trust wide Vacancies
Trust wide vacancies have increased in month by 37.61 WTE and now are at 9.8%. This is largely due gaps in the trainee rotation fill rate and a small increase in unregistered nurse vacancies. Recruitment activity, across various work streams including recruitment for international nursing and HCAs, is ongoing at an increased rate alongside targeted medical campaigns. In the last 12 months recruitment activity has increased by 19.88%. Travel difficulties are delaying starts for new employees for overseas, with regular engagement taking place to facilitate starts as quickly as possible. 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.

Sickness Absence - Over the last 3 months the sickness rates have slowly increased to 5.74% as of July 2021.

The main reason for absence in terms of **overall days lost** is anxiety/ stress/ depression/ other psychiatric illnesses. The Trust has now employed a new Health and Wellbeing business partner to specifically drive the Health and Wellbeing agenda forward.

Short term sickness is being driven by gastrointestinal problems and influenza (covid inclusive).

Daily monitoring has recommenced with ICC and Infection Control lead to monitor specifically covid absences.

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 an ambitious workforce plan that is been driven by the people strategy, much of this activity will require TU engagement. A proposal has been tabled with our Union colleague that is currently being considered.

COVID Booster/FLU Campaign – The project is now operational and has commenced the delivery of the flu vaccination via the peer vaccinator network. The covid booster program is set to commence on the 4th of October (dependant on the national supply chain for delivery of the vaccination). New guidance has now been released that allows for the delivery of both the flu and covid vaccination at the same appointment. Hubs have been re-established at DPOW and SGH and it is hoped that staff will accept both the booster and flu vaccine at the same time following updated guidance. Flu incentive proposals are currently with the Health Tree Foundation Committee for consideration. **CULTURE** **Equality Diversity and Inclusion** Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Data – These two reports were submitted to Workforce Committee and Trust Management Board in August and are being separately tabled on the agenda at Board for information.. The data as contractually required has been uploaded to the NHS England's WRES and WDES sites. An EDI work plan is in draft which will take account of the findings of the WRES, WDES and GPG actions for improvement, and provide direction to ensure we meet our Public Sector Equality Duties. The Equality and Diversity Networks have been relaunched (BAME, LGBTQ+ and Disability). The Terms of Reference are in draft, the Chair Person's and Deputies in the process of being appointed and an EDI calendar is being designed for the HUB to promote future meetings and key EDI events. **Long Service Awards** Letters to all staff entitled to an LSA will go out to confirm whether they would like their Letters and lapel pins in advance of the deferred celebrations now tentatively scheduled for Spring 2022.	**Staffing** Recruitment to address resource constraints in Leadership, Culture & OD is in progress.	**Culture** – Until we can see improvement in NSS staff responses on what it feels like to work at the Trust, here is a risk that organisational culture adversely affects the Trust's ability to continuously focus on quality improvement influencing the quality of employee experience and thus the quality of patient care and the Trust's reputation and relationship with regulatory bodies.

Risk Assessments – Work continues with risk assessments and is part of the on-boarding process for new starters and are managed by recruitment. Work continues to finalise those outstanding **7693** out of which we have a total of **7224** completed RA's and **418** outstanding. Of the 418 outstanding 50% of these are for bank staff. **Culture Task and Finish Group** – replaced by the **Culture & Engagement Transformation Programme** tabled with Executives, further socialisation and scoping of the Transformation Board and Working Group models in development. The People Pulse Survey is next scheduled for Dec 2021. The National Staff Survey starts 4ht Oct – 26th Nov with a comprehensive communications campaign starting with a message from the Chief Executive 4th October. **Health & Wellbeing** – , Health & Wellbeing Business Partner in post, undertaking a First Look audit of all HWB initiatives and developing initial skeleton plan to identify immediate priorities to address staff HWB during winter pressures; on site counselling soon to be available one day a week at Grimsby and one day a week at Scunthorpe, with additional counselling provision across 3 sites to be secured through repurposing NHSEI monies, CISM training in progress to train 4 staff members as qualified CISM de-briefers, MHFA and suicide prevention training offer to staff planned, HWB Steering Group to be refreshed and additional membership included to lead on HWB strategy.	Health and Wellbeing – £31,000 of £40,000 secured from ICS for staff HWB provision has not been spent and must be spent by the end of the financial year, necessary actions are being completed to repurpose the funding	**Health and Wellbeing –** ICS monies would potentially need to be returned if they cannot be spent by the end of the financial year**.**
LEADERSHIP **Mandatory training and appraisal –**Core mandatory training is currently 92% for the Trust, role specific 82% and PADR 81%, there has a been a steady increase in compliance. 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. **Leadership development** - A Leadership Development Programme for all leaders, refreshing the Trust Values and supporting the Culture and Engagement Transformation Programme will be scoped by Dec 2021 for delivery to commence 2022 if approved. **Executive Development** - A series of executive development sessions to be mapped to support the Culture & Engagement Transformation Programme.	**Annual Appraisal** – not compliant with Trust target- currently 81% against a target of 85%. **Mandatory Training** –. Currently achieving 92% against a target of 90% for core mandatory training and 82% against a target of 85%for role specific mandatory training- remains on People risk register until consistently achieving.	**Mandatory Training and Appraisal** – Due to the current capacity issues staff are not released for training, and some training has been stood down and therefore training compliance will not progress.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)207

DATE OF MEETING	5th October 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Christine Brereton – Director of People
CONTACT OFFICER	Christine Brereton – Director of People
SUBJECT	Workforce Race Equality Standard (WRES)
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	Being presented at October Board due to August Board being utilised as a Board Development Day The report updates the Trust Board on: • progress against the Workforce Race Equality Standard (WRES) Indicators • our submission, the revised data, and information as per our contractual requirements. And • highlights key priorities and actions required during 2021/22, to make improvements against the WRES.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Links to Strategic Objective 2 – To be a Good Employer and Strategic Objective 5 – To Provide Good Leadership.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	

Northern Lincolnshire and Goole NHS Foundation Trust

Workforce Race Equality Standard Report for Trust Board October 2021

1.0	**PURPOSE OF THE REPORT**
1.1	As part of the annual business cycle the full Workforce Race Equality Standard (WRES) report has been approved at Trust Management Board and Workforce Committee. This report is for information.
1.2	To update the Trust Board on our submission and the data, as per our contractual requirements.
1.3	To highlight key priorities and actions required to make improvements against the Workforce Race Equality Standard
2.0	**BACKGROUND/CONTEXT**
2.1	The Workforce Race Equality Standard (WRES) was introduced from 1st April 2015 by the NHS Equality and Diversity Council (EDC).
2.2	The link provided signposts to a short four minute video clip describing the Workforce Race Equality Standard. https://www.youtube.com/watch?v=G44C9yn-oo0
2.3	Research and evidence suggest less favourable treatment of Black and Minority Ethnic (BME) staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients.
2.4	The WRES seeks to prompt enquiry to better understand why BME staff receive poorer treatment than White staff in the workplace and to facilitate the closing of those gaps.
2.5	In its simplest form, the WRES offers local NHS organisations the tools to understand their workforce race equality performance, including the degree of BME representation at senior management and board level. The WRES highlights differences between the experience and treatment of White and BME staff in the NHS. The principal outcome of measuring performance against the standard is that it helps organisations to measure where they are against key best practice indicators, where they need to be, and how to plan for improvements to achieve and maintain optimum performance for each indicator.
2.6	The WRES requires NHS organisations to demonstrate progress against specific workforce metrics including a metric on Board BME representation.
3.0	**IMPLICATIONS FOR THE ORGANISATION**
3.1	As of the 1st April 2015, the WRES forms part of the standard NHS contract. From April 2016 it has also formed part of the CQC inspections framework under the 'Well Led' domain.
3.2	A fundamental component to enable making progress against this standard is staff

	engagement and involvement.
4.0	**DATA ANALYSIS – METRICS FOR THE 9 WRES INDICATORS** **METRICS** **Metric/WRES 1** – Percentage of staff in each Agenda for Change (AFC) bands 1-9 and VSM (including executive Board Members) compared with the percentage of staff in the overall workforce. **Metric/WRES 2** – Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants. **Metric/WRES 3** – Relative likelihood of BME staff entering the formal disciplinary process compared to white staff. **Metric/WRES 4** – Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff. **Metric/WRES 5** – Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or public in the last 12 months. **Metric/WRES 6** – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months. **Metric/WRES 7** – Percentage of staff believing that their trust provides equal opportunities for career progression or promotion. **Metric/WRES 8** - In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleagues. **Metric 9/WRES** - Percentage difference between the organisations board voting membership and its overall workforce.
4.1	WRES 1 In 2021 BME staff represents 11.28% of all staff in AfC bands 1-9 and VSM's. This is an increase on last year of 0.91%. The percentage of BME staff in a Band 8 position or above (including VSM) is very similar, from 6.47% in 2020 to 6.4% this year. It also shows that there is a lower percentage of BME staff in Bands 8-9 and VSM compared to their representation in the overall workforce. As recommended by NHS England, Medical and Dental Grades (which includes Trainee Grades) are excluded in the Bands 8-9 and VSM figures as these groups generally have a much higher proportion of BME staff. This group in 2020 consisted of 430 BME staff and 124 white staff, and in 2021 consists of 424 BME staff and 135 white staff, which statically shows very little change.
4.2	WRES 2 The relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts. The data periods used are between 1st April 2019 and 31st March 2020 and, 1st of April 2020 and 31st March 2021. The 2019/20 data shows white staff have a likelihood which is 3.56 times greater than BME staff to be appointed from shortlisting.

In 2020/21 this likelihood increased significantly, almost doubling, to a ratio of white staff having a 6.02 times greater chance of being appointed from shortlisting compared to BME applicants.

As a comparator from the 2018 WRES data the National Picture shows that white staff are 1.45 times more likely to be appointed from short listing than BME staff.

4.3 WRES 3

In 2020 the relative likelihood of BME staff entering a formal disciplinary process compared to white staff was 0.46. A number below 1 show that BME staff are less likely to enter a formal disciplinary than white staff. However, in 2021** the relative likelihood of BME staff entering a formal disciplinary process compared to white staff significantly increased to 1.91 showing that BME staff are nearly twice as likely to enter the disciplinary process compared to white staff.

**The significant increase in the number of disciplinary sanctions for BAME staff, this is due to concerns that were raised to the Head of Nursing in April 2020, in relation to unauthorised access to patient's information which led to a full HR investigation. As a result of that investigation a number of staff where issued with a sanction, in total 102 White staff / 32 BAME / 10 Ethnicity not stated or declared.

4.4 WRES 4

The relative likelihood of BME staff accessing non-mandatory training compared to white staff in 2020 was an equal result. However, in 2021 figures show a positive result of 1.04 times greater. Therefore, BME staffs in 2021 are slightly more likely to access non-mandatory training and CPD than white staff.

4.5 **NHS Staff Survey 2020**

The WRES indicators 5, 6, 7 and 8 below represent key findings in the NHS staff survey for the Northern Lincolnshire and Goole NHS FT staff.

- WRES 5 - BME staff at NLaG feel that harassment, bullying or abuse from patients, relatives or the public in the last 12 months has improved from last year and is less than reported in the National average scores.

  However, it should be noted that BME staff report a 2.8% higher experience than their white colleagues.

- WRES 6 – There has been an increase in experiencing of harassment, bullying or abuse from colleagues for staff but this is significantly worse for our BME staff with an increase of 0.8% from last year's data and a gap of 8% between white and BME staff.

- WRES 7 - In 2019 BME staff felt 11% less likely to receive equal career development/promotional opportunities compared to white staff. However, this gap has improved to a 5.8% gap in 2020.

- WRES 8 – In 2019 BME staff felt 6.4% more likely to have personally experienced discrimination at work from their manager/team leader or other colleagues compared to white staff. However, this percentage gap has worsened during 2020 showing the gap is now 12.1%.

4.6 WRES 9

There has been little change in Trust Board BME representation in the last year with 6.7% in 2020 and 7.1% in 2021. It must be noted that due to the small numbers in this group this indicator is very fragile and could easily change.

5.0 PROGRESS , KEY PRIORITIES, AND ACTIONS

5.1 Progress 2020/2021

- Equality and Diversity Strategy, and Equality Objectives – NLaG has a Trust Board approved Equality and Diversity Strategy, shortly to commence a refresh (due by end of 2022). It is intended that we will complete an assessment of our EDI planned actions for 2021-22 against the EDS2 framework, enabling us to craft an implementation plan reflecting relevant development actions, benchmarked against best practice across the four EDS2 framework themes:

- Better health outcomes (Patient focused)
- Improved access and experience (Patient focused)
- A representative and supported workforce (Organisation focused)
- Inclusive leadership (Workforce focused)

This approach will provide assurance that we are addressing our actions committed to in our ICS EDI submission June 2021, integrated into the EDS2 framework.

- The People Directorate will report progress against our strategic aims via the Workforce Committee. As part of the strategy there are a number of Equality Objectives of which one is to deliver against the Workforce Race Equality Standard. Another is to develop and form a number of staff equality support networks e.g. BAME ethnic minority staff network.
- An NLaG BAME staff equality network has been formed. The network is in its early stages and staff interest in the group is growing. The intention is to encourage BAME staff to lead and chair this network with People Directorate support, and to develop a forum for energetic, positive change. We have started to hold a number of BAME focus groups to engage in a deeper dialogue centred on understanding our BAME colleagues' lived experience of working at NLaG. The intention is to use the findings from these focus groups to inform our 2021/22 action plan.

- An Equality Impact Assessment (EIA) policy and procedure has been put in place to ensure policies, procedures and functions do not discriminate against any particular groups. A repository to support EIA governance has been developed to monitor and review completed EIA's, and to monitor any remedial actions required.
- Preliminary conversations have taken place to strengthen the links between the Trust's Pride and Respect Campaign and our staff from minority groups such as BME.
- All staff, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious bias
- All new staff receives equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious bias.

5.2 Key Priorities 2020/21

In general the WRES data can be very fragile and it would be inappropriate to lose focus on any areas such as recruitment and Trust Board representation. However, by far the most significant area which we must focus on relates to the WRES 2 recruitment and the NHS Staff Survey findings.

	The experiences of our BME staff in terms of: BME staff experiencing bullying, harassment or abuse from staff, • Equal Opportunities for BME staff, • And Discrimination at work experienced by BME staff.
6.0	**FURTHER ACTIONS REQUIRED**
6.1	Ensure that all WRES actions are monitored through the Equality and Diversity action plan and in 2022, included in the wider engagement and culture work and plans. Conduct further analysis of workforce data to gain a greater understanding of the data at local levels and to build a true organisational picture across different work areas. These findings will be integrated into Workforce Committee reporting and wider action plans. To report progress against these internally through agreed governance structures and report these bi-annually to our commissioners through the equality and diversity reporting mechanism.
6.2	More specific actions are to: • The People Directorate plans a deep dive into this data to support implementation plans currently in flow to address BAME recruitment disparity, and to provide assurance that recruitment panels are representative, fair and free from unconscious bias. • Continue the development of a BME staff equality network within a wider staff networks engagement and culture programme for 2021-2022. • Collect staff stories in relation to fairness, equal opportunities and discrimination. • Use staff experience/stories to inform training, recruitment services and operational HR. • Strengthen the links with the NLaG Pride and Respect Campaign and ensure that WRES is mainstreamed into the whole programme. • Strengthen links to the Freedom to Speak Up campaign. • To refresh the Equality Impact Assessment process.

7.0	**The report to be received.**
7.1	To note the contents of this report against the NHS Workforce Race Equality Standard.
7.2	Assured with the content which we are required to share with NHS England and our commissioners.
7.3	To agree the priorities, key areas of focus and WRES actions, and offer any support as identified.

NLG(21)208

DATE OF MEETING	5th October 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Christine Brereton – Director of People
CONTACT OFFICER	Christine Brereton – Director of People
SUBJECT	Workforce Disability Equality Standard (WDES)
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	Being presented at October Board due to August Board being utilised as a Board Development Day To update the Trust Board on: • progress against the Workforce Disability Equality Standard Indicators • our submission and the data, as per our contractual requirements. And: • To highlight key priorities and actions required to make improvements against the Workforce Disability Equality Standard.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Links to Strategic Objective 2 – To be a Good Employer and Strategic Objective 5 – To Provide Good Leadership.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	

Northern Lincolnshire and Goole NHS Foundation Trust

Workforce Disability Equality Standard Report for Trust Board October 2021

1.0	**PURPOSE OF THE REPORT**
1.1	As part of the annual business cycle the full Workforce Disability Equality Standard (WDES) report has been approved at Trust Management Board and Workforce Committee. This report is for information. The WDES metrics can be seen here https://www.england.nhs.uk/about/equality/equality-hub/wdes/
1.2	To update the Trust Board on our submission and the data, as per our contractual requirements.
1.3	To highlight key priorities and actions required to make improvements against the Workforce Disability Equality Standard.
2.0	**BACKGROUND/CONTEXT**
2.1	As set out in the NHS Long Term Plan, respect, equality and diversity are central to changing culture and will be at the heart of our workforce implementation plan. The NHS draws on a remarkably rich diversity of people to provide care to our patients. But we fall short in valuing their contributions and ensuring fair treatment and respect. NHS England, with its partners, is committed to tackling discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients and the delivery of high quality healthcare.
2.2	The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the NHS. The WDES follows the NHS Workforce Race Equality Standard (WRES) as a tool and an enabler of change.
2.3	The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant NHS organisation to develop a local action plan, and enable them to demonstrate progress against the indicators of disability equality.
2.4	The WDES is mandated through the NHS Standard Contract and as of the 1st April 2019, it will form part of the standard NHS contract and it is highly likely to form part of future CQC inspections under the 'Well Led' domain.
2.5	It was restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.
2.6	The implementation of the WDES will enable us to better understand the experiences of disabled staff. It will support positive change for existing employees and enable a more

	inclusive environment for our disabled staff.
2.7	The report must be published by 31 August 2021 and based on the data from the 2020-21 financial year.
2.8	A key component to making progress against this standard is staff engagement and involvement.
3.0	**DATA ANALYSIS – METRICS**
3.1	**Metric/WDES 1** - Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff. **Metric/WDES 2** - Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts. **Metric/WDES 3** - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. **Metric/WDES 4** - Staff Survey Q13a-d – a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/Service users, their relatives or other members of the public ii. Managers iii. Other colleagues. b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. **Metric/WDES 5** - Staff Survey Q14 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. **Metric/WDES 6** - Staff Survey Q11e - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. **Metric/WDES 7** - Staff Survey Q5f - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. **Metric/WDES 8** Staff Survey Q26b - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. **Metric/WDES 9** - a) The staff engagement score for Disabled staff, compared to non-disabled staff, b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No). **Metric/WDES 10** - Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.

Metric 1

Metric 1 shows the percentage of NLaG staff who have classified themselves as having a disability compared to those staff who do not have a disability using Agenda for Change (AfC) pay bands or medical and dental subgroups and very senior managers (including Executive Board members). The percentages are clustered into 4 groups for non-clinical staff and 7 groups for clinical staff. This is due the small numbers of staff in each pay band.

This data was collected from ESR as at 31 March 2020 to 31 March 2021.

		Metric 1a Non-Medical Workforce						**Mar-20**	
Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.		Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
		Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
	Cluster 1: AfC Bands 1 – 4	52	3.0%	1483	85.1%	208	11.9%	1743	82.2 %
	Cluster 2 : AfC Band 5 – 7	4	1.5%	241	89.3%	25	9.3%	270	12.7%
	Cluster 3 : AfC Band 8a – 8b	3	5.3%	50	87.7%	4	7.0%	57	2.7%
	Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	1	2.0%	44	86.3%	6	11.8%	51	2.4%
		Metric 1b Medical Workforce						**Mar-20**	
		Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
		Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
	Cluster 1: AfC Bands 1 – 4	35	2.4%	1230	83.7%	205	13.9%	1470	31.5%
	Cluster 2 : AfC Band 5 – 7	67	2.8%	2034	84.2%	314	13.0%	2415	51.8%
	Cluster 3 : AfC Band 8a – 8b	2	1.7%	101	87.1%	13	11.2%	116	2.5%
	Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	0	0.0%	25	92.6%	2	7.4%	27	0.6%
	Cluster 5: Medical and Dental staff, Consultants	1	0.5%	169	82.4%	35	17.1%	205	4.4%
	Cluster 6: Medical and Dental staff, Non-consultant career grade	0	0.0%	135	84.9%	24	15.1%	159	3.4%
	Cluster 7: Medical and Dental staff, Medical and Dental trainee grades	3	1.1%	242	90.3%	23	8.6%	268	5.8%

3.2

		Metric 1a Non-Medical Workforce						Mar-21	
		Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
		Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.	Cluster 1: AfC Bands 1 – 4	52	3.0%	1519	86.7%	181	10.3%	1752	81.2%
	Cluster 2 : AfC Band 5 – 7	8	2.7%	264	89.2%	24	8.1%	296	13.7%
	Cluster 3 : AfC Band 8a – 8b	4	6.5%	56	90.3%	2	3.2%	62	2.9%
	Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	1	2.1%	45	95.7%	1	2.1%	47	2.2%

3.3

3.4

		Metric 1b Medical Workforce						Mar-21	
		Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
		Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
	Cluster 1: AfC Bands 1 – 4	39	2.5%	1351	86.5%	172	11.0%	1562	32.4%
	Cluster 2 : AfC Band 5 – 7	75	3.0%	2108	85.6%	281	11.4%	2464	51.1%
	Cluster 3 : AfC Band 8a – 8b	1	0.9%	101	90.2%	10	8.9%	112	2.3%
	Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	0	0.0%	31	96.9%	1	3.1%	32	0.7%
	Cluster 5: Medical and Dental staff, Consultants	2	0.9%	180	83.3%	34	15.7%	216	4.5%
	Cluster 6: Medical and Dental staff, Non-consultant career grade	1	0.6%	126	81.8%	27	17.5%	154	3.2%
	Cluster 7: Medical and Dental staff, Medical and Dental trainee grades	3	1.1%	225	78.9%	57	20.0%	285	5.91%

The above tables, metric 1a and metric 1b clearly show that the percentage of disabled staff in both the non-medical and medical workforce is very low. It also highlights in both tables that there are very high percentages of the workforce which record as either unknown or a null response. It can be seen that the numbers in each group were very similar in 2021 when compared to 2020.

Metric 2

Demonstrates the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. The data periods used are between 1st April 2019 and 31st March 2020 and, 1st of April 2020 and 31st March 2021. The likelihood of disabled staff and non-disabled staff being appointed from short listing in 2019-20 was equal but in 2020-21this increased to non-disabled staff being 1.6 more likely to be appointed from short listing compared to disabled staff.

3.5 *It should also be noted that NLaG as part of the Department of Work and Pensions scheme are a Disability Confident Employer, and therefore operate a guaranteed interview

	scheme for disabled applicants who meet the minimum person specification.
3.6	**Metric 3** Demonstrates the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. Data is based on the average numbers of staff entering the formal capability procedure. Due to small number of disabled staff in the Trust (196) compared to non-disabled staff (6006), with 790 unknown. Disabled staff are 2.48 time more likely to enter a capability process than non-disabled staff.
	2020 NHS Staff Survey Results Analysis Metric's 4, 5, 6, 7, 8 and 9a The % between 2019 and 2020 are very similar with very little change. One area which shows additional concern is metric 5, disabled staff who believe that NLaG provide equal opportunities for career progression or promotion. • Metric 4 – Staff feel harassment, bullying or abuse in the last 12 months from: Patient's, relatives or the public is 9.7% higher for disabled staff than non-disabled staff. - Manager's is 13.4% higher for disabled staff than non-disabled staff. - Other colleague's is 14.6% higher for disabled staff than non-disabled staff. - Disabled staff are 7% more likely to report harassment, bullying or abuse at work than non-disabled staff. • Metric 5 – Disabled staff feel 13.3% less likely to receive equal opportunities in terms of career progression or promotion at work compared to non-disabled staff. This has also decreased 4.1% compared to the previous year. • Metric 6 – Disabled staff felt 13.5% more pressured to attend work, despite not feeling well enough to perform their duties compared to non-disabled staff. • Metric 7 – 14.3% less disabled staff felt satisfied that their organisation valued their work compared to non-disabled staff. • Metric 8 – Only 72% of disabled staff feel we have made adequate adjustments to enable them to carry out their work. • Metric 9a – The engagement score for disabled staff is 0.6 less than that of non-disabled staff. Metric 9 part b Has the Trust taken action to facilitate the voices of Disabled staff? Yes as part of the Trust's Equality Objectives Trust is developing a Disability Network to give disabled staff a voice. **Metric 10** The NLaG Board and Executive Team who classify themselves as having a disability is very similar in 2020 (6.66%) and 7.14% in 2121.

4.0	**PROGRESS, KEY PRIORITIES AND ACTIONS REQUIRED**
4.1	**Progress 2020/2021**
	Equality and Diversity Strategy, and Equality Objectives – NLaG now has a Trust Board approved Equality and Diversity Strategy which is driving forward this agenda The People Directorate will report progress against our strategic aims via the Workforce Committee. As part of the strategy there are a number of Equality Objectives of which one is to deliver against the Workforce Equality Standards. Another is to develop and form a number of staff equality support networks e.g. disabled staff network. An NLaG disabled staff equality network has been formed. The network is in its early stages and staff interest in the group is growing. The intention is to encourage staff with a disability or long term condition to lead and chair this network with People Directorate support, and to develop a forum for energetic, positive change. Although in its early stages we recognise the importance of engaging in a deeper dialogue with this group of staff to their lived experience working at NLaG. The intention is to use the findings from these focus groups to inform our 2021/22 action plan. An Equality Impact Assessment (EIA) policy and procedure has been put in place to ensure policies, procedures and functions do not discriminate against any particular groups. A repository to support EIA governance has been developed to monitor and review completed EIA's, and to monitor any remedial actions required. Preliminary conversations have taken place to strengthen the links between the Trust's Pride and Respect Campaign and our staff from all minority groups. All staff, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious bias All new staffs receive equality, diversity and inclusion training which have a focus on inclusive behaviours and exploring unconscious bias.
4.2	**Key Priorities 2021/22** To use our newly formed disabled staff equality network to increase disability awareness at NLaG and give this group of staff a voice to share their concerns. An initial disability equality staff network aim will be to consider how to improve the validity of data in Metric 1 by reducing the large percentage of staff in the unknown or null column across all pay bands in both the medical and non-medical workforce. The disabled staff equality network will also assist NLaG to understand the National NHS staff survey results against all the WDES metrics which show that in NLaG disabled staffs have a much worse experience than that of non-disabled staff.
4.3	**Actions Required** Ensure that all WDES actions are monitored through the Equality, Diversity and Inclusion (EDI) action plan and report against these internally through agreed governance structures, and report bi- annually to our commissioners. It is our intention in 2021 to assess our current EDI action plan against the EDS2 Framework. This will enable us to construct a refreshed implementation plan covering the four themes set out in the EDS2 framework:

	• Better health outcomes (Patient focused) • Improved access and experience (Patient focused) • A representative and supported workforce (Organisation focused) • Inclusive leadership (Workforce focused) This approach will provide assurance that we are addressing our actions committed to in our ICS EDI submission June 2021, integrated into the EDS2 framework. This will be done alongside a refresh of our EDI Strategy, due for renewal 2022. More specific actions are to: Develop and grow our disability staff network, and ensure that this network is able to feed into the organisation's decision making processes and give this staff group a clearer voice. Conduct further analysis of workforce data to gain a greater understanding of the data at local levels and to build a true organisational picture across different work areas with a focus on reducing the large percentage of staff who record unknown or null in their disability/ability status. These findings will be integrated into Workforce Committee reporting and wider action plans. To refresh the Equality Impact Assessment process, to align with the Trust governance process.
5.0	**The report to be received.**
5.1	To note the contents of this report against the NHS Workforce Disability Equality Standard.
5.2	Assurance for the data content which we are required to share with NHS England and our commissioners.
5.3	To agree the key priorities of focus and WDES actions, and offer any support as identified.

NLG(21)209

DATE OF MEETING	05 October 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Michael Whitworth, NED & Chair of Workforce Committee
CONTACT OFFICER	Michael Whitworth, NED & Chair of Workforce Committee
SUBJECT	Workforce Committee Highlight Report and Board Challenge
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The Committee recommended highlighting two matters of concern to the Board, namely: • Risks to adequate staffing levels during the winter due to anticipated levels of sickness • The rating given to the Trust by our medical trainees when compared to our peers. The Committee was very assured by a "deep dive" review of culture and engagement that also covered health and wellbeing, and equality, diversity, and inclusion. The Committee endorsed the planned development of "A Just & Learning Culture" for employee relations.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not	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.

applicable (N/A)	The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
			✓	✓	

Northern Lincolnshire and Goole NHS Foundation Trust

BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	05 October 2021
Report From:	Michael Whitworth, NED & Chair of Workforce Committee
Highlight Report: Workforce Committee – 28 September 2021	

1 Introduction

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

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

2.1 As part of the review of the integrated workforce performance report the Committee noted management's keen awareness of the current and projected impact of sickness on Trust service delivery and commended the range of mitigating actions already in train and further on-going work.

2.1.1 It was noted that this has been managed in previous years and should be considered in the context of the overall winter plan, however, the Committee wanted the Board to be aware of the considerable challenges this year.

2.2 The Committee received and reviewed 2 post graduate medical education reports. The Trusts low rating from our trainees when compared with regional and national peers, and the weakening of our year-on-year position was discussed in depth. The Committee was assured that the Medical Education team and the Medical Directorate have a clear understanding of the issues, a range of mitigations and a passionate commitment to improve the situation.

2.2.1 It should be noted that although the ratings from our trainees were generally very low there have and continue to be examples of very high-rated medical education training being provided by the Trust.

2.2.2 However, the Committee has asked for an update from the Medical Directorate at its next meeting and will maintain oversight of improvements.

3 **Items for Committee Ratification and Assurance**

3.1 The Committee undertook a deep dive of Organisation Culture, including health and wellbeing and was very assured by the progress being made.

3.1.1 The additional staff capacity and expertise in this aspect of the People Directorate team was recognised and welcomed by the Committee.

3.2 The Committee discussed a review of HR casework over the last 24 months and plans to transformationally improve the Trust's disciplinary processes.

The improvements already shown in the performance metrics and the plans to develop “A Just & Learning Culture” approach to employee relations was very much welcomed by the Committee.
Confirm or Challenge of the Board Assurance Framework:
No changes to the Board Assurance Framework were recommended.
Action Required by the Trust Board:
The Board is asked to receive and note the content of this highlight report.

NLG(21)210

DATE OF MEETING	05 October 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Michael Whitworth, NED & Chair of Workforce Committee
CONTACT OFFICER	Michael Whitworth, NED & Chair of Workforce Committee
SUBJECT	Workforce Committee Self-Assessment
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The Committee has undertaken an annual self-assessment which is attached. Since the re-establishment of the Committee a annual work plan has been approved and the format and operation of the Committee amended to focus on assurance, oversight and support. The outstanding actions will be addressed through the new Terms of Reference which will be considered by the Board at its October 2021 meeting.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients. The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of

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

ASSESSMENT TOOL FOR EVALUATION OF WORKFORCE COMMITTEE - September 2021

Introduction

In accordance with the requirements of good corporate governance and in order to ensure their ongoing effectiveness, it is recommended that Trusts should undertake a formal and rigorous annual evaluation of the performance of its Board sub-committees. The following assessment tool has been developed to evaluate the performance of the Workforce Committee.

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
Terms of Reference					
The Committee has clearly defined Terms of Reference which have been approved by the Trust Board.	X X X X		TOR	Need to be updated	New TOR
The Terms of Reference are regularly reviewed and updated.	X X X X		Committee workplan and annual Board review	Recently approved earlier this year	
The Committee has been true to its Terms of Reference.	X X X X		Minutes of meetings	There have been amendments approved by the Board to all committee operations due to Covid.	
The Committee has worked purposefully and methodically to achieve the objectives it set for itself in order to fulfil the Terms of Reference.	X X X X		Minutes of meetings and Board highlight reports and GAG assurance	Since revision of TOR and workplan. New workplan agreed.	
Reporting & Accountability					
The Committee has reported regularly and in a way that has furthered the work of the Trust Board and / or provided the necessary assurance to the Trust Board on workforce matters.	X X	X	Board minutes. Board highlight reports. Board deep dive workforce session. GAG highlight reports and workforce briefing.	Didn't have clear information to be able to provide sufficient assurance, but this appears to be resolved now	

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
The Committee has escalated matters to the Trust Board as necessary.	X X X X		Board minutes.	Key matters have been FTSU, BAF, training and recruitment and retention.	
The Committee has received regular reports and / or minutes from the sub-committees which report to it.	X X X	X		Not clear what sub-committees feed into this meeting.	To be resolved at September meeting and in new TOR.
Issues are escalated from these sub-committees as necessary.	X X N/A				
The 'highlight' reports from the committee confine themselves to matters which cannot be dealt with at sub-committee level and require escalation.	X X X N/A		Highlight reports and Board minutes		
The Committee has provided timely support to Clinical & Non-Clinical Directorates (either directly or via the relevant sub-committees) on workforce matters in order to reduce risk to the Trust.	X X X X		All matters referred to the Committee have been dealt with. A system of cross committee referral has been established, and any matters raised by TMB, directors or divisions are considered by the Committee.		

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
Leadership					
The Committee is well led.	X X X			Subject to C19 amendments.	
Frequency of Meetings					
The Committee has met at the frequency defined in its Terms of Reference.	X X X	X	Minutes. New meeting schedule and work plan has been approved and established	Covid hindered this	
Where necessary, additional meetings of the Committee have been held.	X X N/A			N/A The format of the Committee has changed to facilitate and focus discussion on assurance.	
Duration of Meetings					
There is sufficient time during meetings to consider and debate agenda items and ensure sufficient challenge.	X X X X		Feedback from Committee members	This has improved over the year when the Committee has been operation.	
Attendance					
Meetings have been well attended.	X X	X X	Minutes and attendance log	They have been quorate when held. Executive attendance, outside the HR Director, is sometimes limited.	New TOR
Membership					
The Committee consists of the right number of appropriately knowledgeable, experienced, developed and supported members who have been able to contribute	X X X		Feedback from members.	The committee regularly has specialists attending and reporting on specific matters such as FTSU, medical matters etc.	

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required
	Yes	No			
effectively and who have the authority to make decisions.					
The membership of the committee is kept under review.	X X X X		Annual review	In attendance “membership” is also reviewed.	
Content					
The business of the committee is appropriate and relevant.	X X X X		Annual work plan linked to Trust priorities, BAF and regulatory requirements.		
Receipt of Information					
The Committee has received timely, accurate and relevant information to achieve the objectives it set for itself in order to fulfil the Terms of Reference and in order to enable assurance to be provided to the Trust Board.	X X X X		Committee papers	Recent reports have contained appropriate accurate information to be able to assure colleagues. Considerable work has been undertaken to improve data quality as well as the for at and content of committee reports.	
Effectiveness of the Committee					
The Committee can demonstrate its effectiveness over the last 12 months.	X X X		All key statutory requirements have been met.	Difficult due to Covid, but can see that substantial positive changes have been made. Within the agreed limits imposed by the Board to manage C19.	

NLG(21)210

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Director - Public
REPORT FROM	Michael Whitworth, Committee Chair
CONTACT OFFICER	Helen Harris, Director of Corporate Governance
SUBJECT	Terms of Reference for Workforce Committee
BACKGROUND DOCUMENT (if any)	Workforce Committee Terms of Reference
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Workforce Committee – 28 September 2021 recommend the Trust Board approve the revised Terms of Reference.
EXECUTIVE SUMMARY	The Workforce Committee Terms of Reference document has been updated, as highlighted throughout in yellow (see attached), and a new Committee workplan template has also been appended: - Trust Secretary to Director of Corporate Governance throughout. - Section 1: Constitution, added for consistency compared to other TOR. - Section 2: Purpose and Objectives (this section has been merged). - Section 4.1.6 – 4.1.8: to be deleted as a duplication. - Section 5.1.7: Board Assurance Framework reviewed on a quarterly basis. - Section 6: Voting Membership (was Core Membership); Addition of Associate Non-Executive Directors (NEDs) for core membership; Non-Voting Member – new subsection title; other NEDs and Executive Directors to attend as desired, and a Governor to attend. - Section 6.4 and 6.5 to be removed as not required and is a duplication. - Section 7: Formal deputies can attend up to 25% of all meetings and where there are joint Trust roles attendance is 50%; formal deputies will be counted towards quoracy; there must be two Non-Executive

	Directors and one Executive Director for the committee to be quorate; late papers may be submitted at the discretion of the Chair. - Appendix A: new Committee Workplan has been produced to ensure consistency across all committees. The Workforce Committee recommend the Trust Board approve the proposed amendments to the Committee Terms of Reference.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Risk to Strategic Objective 2: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients. Risk to Strategic Objective 5: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
	✓				

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Corporate Governance

WORKFORCE COMMITTEE

Membership and Terms of Reference

Reference:	DCT093
Version:	1.2
This version issued:	Date?
Result of last review:	Addition of work plan and various changes (as highlighted)
Date approved by owner (if applicable):	*enter* date of approval
Date approved:	*enter* date of approval
Approving body:	Trust Board
Date for review:	September 2022
Owner:	~~Christine Brereton, Director of People~~ Director of Corporate Governance
Document type:	Terms of Reference
Number of pages:	13 (including front sheet)
Author / Contact:	~~Christine Brereton, Director of People~~ Director of Corporate Governance

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

1.0 Constitution

1.1 The Trust has established the Workforce Committee, as a formal sub-committee of the Trust Board. This Committee is responsible for oversight, challenge and assurance, on behalf of the Trust Board, in respect of Trust strategies, plans and performance against key operational targets.

2.0 Purpose

2.1 The Committee's oversight remit will extend to:

- Implementation of the People Strategy along with its priorities and sub-strategies;
- Resource and budget requirements for the implementation of the People Strategy;
- Risk Management of risks associated with the People Strategy;
- Performance of the People Directorate and related metrics of the Trust; and
- Monitoring, assuring and reporting to the Trust Board regulatory requirements concerning Workforce e.g. FTSU, and Equality and Diversity reporting

2.2 The Committee will report the outcome of each meeting to the Trust Board, raise any concerns and make recommendations for action to the Trust Board across this remit.

~~Assessing and identifying risk within the People portfolio and escalating this as appropriate.~~

2.3 The specific objectives of the Workforce Committee are to ensure risks pertaining to the strategy and transactions of workforce and organisational development are identified and managed and conform with the following:

- To provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability;
- To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities;
- To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential;
- To provide support and opportunities for staff to maintain their health, wellbeing and safety;
- To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through

local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families;

- To have a process for staff to raise an internal grievance;
- To encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure; and
- To promote the delivery of quality education by and for all staff.

3.0 Authority

3.1 The Workforce Committee is authorised by the Trust Board:

3.1.1 to investigate any activity within its terms of reference and produce an annual work program;

3.1.2 to approve or ratify (as appropriate) those policies and procedures for which it has responsibility as listed in the 'Policy Schedule';

3.1.3 to promote a learning organisation and culture, which is open and transparent; and

3.1.4 to establish and approve the terms of reference of such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference.

3.2 The Committee is only able to recommend the commitment of financial resources in respect of matters identified in these terms of reference and as set out in the Scheme of Delegation and Standing Financial Instructions.

3.3 The Chief Financial Officer must be informed of any recommendation requiring use of resources. Any other matters requiring a decision on the use of resources are to be referred to the Trust Board and/or the Chief Financial Officer.

4.0 Accountability & Reporting Arrangements

4.1 Key Arrangements

4.1.1 The Committee, appointed under and subject to the Standing Orders of the Trust, is a sub-committee of the Trust Board, and will submit copies of its minutes for inclusion on the Trust Board agenda. The Trust Board will also receive details of the outcome of the annual evaluation of performance of the Committee.

4.1.2 The Committee will ensure that significant issues are escalated to the Trust Board via monthly 'highlight' reports with recommendations for action where appropriate.

4.1.3 Executive and Non-Executive / Associate Non-Executive Committee members will be expected to ensure appropriate cross over with the work of other Trust Board sub-committees, to avoid adoption of incompatible strategies or plans, and eliminate duplication of workload.

4.1.4 Where relevant, the Committee will seek assurance on relevant matters directly from operational staff, requiring attendance at meetings as required.

4.1.5 The Committee will agree an Annual Work Programme/Cycle of Business (Appendix A), which will be reviewed at each Annual Evaluation of the Committee.

~~4.1.6 The Committee will have the following reporting responsibilities:~~

~~To ensure that the minutes of its meetings are formally recorded and submitted to the Trust Board. These minutes shall be accompanied by a summary prepared by the chair of the meeting outlining the key issues discussed at the meeting and those issues that need to be brought to the attention of the Trust Board~~

~~4.1.7 To produce those assurance and performance management reports listed in the Committee's annual work programme which has been agreed with, and are required by, the Trust Board~~

~~4.1.8 Any items of specific concern, or which require the Trust Board approval, will be subject to a separate report~~

~~To provide exception reports to the Trust Board highlighting key developments / achievements or potential issues~~

4.1.9 To produce an annual report for the Board of Directors setting out:

- the role and the main responsibilities of the committee
- membership of the committee
- number of meetings and attendance
- a description of the main activities during the year
- ~~a completed annual self-assessment (the format to be approved by the Audit Risk & Governance Committee) and the identification of any development needs for the Committee.~~

4.2 Reporting Groups

4.2.1 The groups identified below will be required to submit the following information to the Committee:

- Their terms or reference for formal approval and review;

- The minutes of their meetings, together with a summary prepared by the Chair of that group outlining the key issues discussed at the meeting and those issues that need to be brought to the attention of this Committee;

- To produce those assurance and performance management reports listed in the individual group's annual work programmes which have been agreed with, and are required by, this Committee;

- An annual report setting out the progress they have made and future development; and

- Any report or briefing requested by this Committee.

4.2.2. The groups are:

- A number of operational groups ~~committees~~ will support the work of the Workforce Committee ~~as identified below various feeder groups will support the Workforce Committee in~~ by providing ~~Board a~~assurance around a range of activities related to the remit of the group by the provision of periodic reports and action plans.

5 Responsibilities of the Committee

5.1 On behalf of the Trust Board, the Committee will:

5.1.1 Influence and monitor the development of the People Strategy and Culture work within the Trust incorporating the Trust Vision and Values, Engagement, Pride and Respect programme and the National, Regional and Local Transformation agenda.

5.1.2 Act to provide assurance to the Trust Board that agreed strategies and programmes of work, including performance management of operational teams, are clearly scoped, appropriately resourced and delivered in line with best practice and against the NHS Constitution's Staff Pledge[1].

5.1.3 Provide assurance, raise concerns (if appropriate) and make recommendations to the Board of Directors in respect of:

5.1.4 The development and ongoing review of an effective People Strategy that is aligned with the Trust's strategic vision and values, making appropriate recommendations to the Board for approval. Review progress against agreed action plans and trajectories to achieve locally determined or nationally set/mandated standards and targets including:

- Monitor Trust performance and data quality on national and local initiatives against Workforce Key Performance Indicators (KPIs) and other indicators/standards

[1] The NHS Constitution for England - GOV.UK (www.gov.uk)

- Staff survey results (local and national)
- Attendance levels
- Demographic makeup of the organisation
- Turnover
- Occupational health data
- Recruitment
- Annual Workforce plan with the involvement of multidisciplinary teams
- Equality & Diversity.

5.1.5 Monitor educational, training, learning activities and recruitment to ensure that it complies with required legal and mandated standards, the expectations of the Trust and supports Service development/transformation and evidence based practice;

5.1.6 Consider the control and mitigation of workforce-related risks and provide assurance to the Board that such risks are being effectively controlled and managed via active use of the Board Assurance Framework (BAF);

5.1.7 To review the relevant sections of the Board Assurance Framework on a quarterly basis, giving consideration to the assurance provided, whether the key elements are appropriate in light of any concerns about which the Committee may be aware, and whether the underpinning risks provide sufficient assurance that the strategic risks is being appropriately managed;

5.1.8 Ensure that statutory workforce requirements and reports are submitted in a timely manner to support effective and safe management of services;

5.1.9 Receive the minutes of the appropriate forums which monitor the delivery of the trusts Equality & Diversity Action Plan;

5.1.10 Support the development of emerging innovative roles;

5.1.11 Understand the workforce implications of service transformation within the Trust;

5.1.12 Ensure high level risks and mitigation plans are appropriately highlighted to the Trust Board with clear articulation of the actions required at board level.

6 Membership

6.1 Voting ~~Core~~ Membership

6.1.1 The Committee will comprise:

- Three Non-Executive Directors ~~(Chair)~~ or Associate Non-Executive Directors
- ~~Two additional Non-Executive Directors (one of whom will be the Deputy Chair)~~

6.1.2 Associate Non-Executive Directors to be included as core/voting members of Committee and to be counted towards quoracy and can be counted towards voting rights (where applicable).

6.2 ~~Invited~~ Non-Voting Member ~~Attendance~~

6.2.1 The Director of People will be in regular attendance.

6.2.2 There is a standing invitation to all Executive Directors and Non-Executive Directors / Associate Non-Executives to attend the committee.

6.2.3 Executive Directors are requested to note the annual programme of meetings within their diaries and the content of the annual work plan to facilitate their attendance when they are either leading or have an interest in an agenda item.

6.3 Other Persons Attending Meetings

6.3.1 The following will attend as agenda items dictate or where a pre-existing or externally driven reporting requirement exists:

- ~~Chief Nurse or ??~~
- BAME Staff Representative
- Chairman of Staff Side

6.3.2 Other Non-Executive Directors / Associate Non-Executive Directors and Executive Directors can attend as desired but will not form part of the permanent membership of this committee.

6.3.3 The Chief Executive has a right of attendance of all meetings of the Committee and may be included in the quoracy subject to agreement by the Chair.

6.3.4 An invitation to join the committee as an attendee will be extended to a Governor to be identified by the Lead Governor.

~~An invitation to join the committee as an attendee will be extended for a BAME staff representative from within the Trust.~~

~~An invitation to join the committee as an attendee will be extended to the Chairman of the Staff Side.~~

~~The committee may, from time to time and as the agenda dictates, require attendance from other Directors/Senior Officers of the Trust not mentioned above.~~

6.3.5 Executive Directors may on occasion invite other senior officers to attend the Committee, with the approval of the Committee Chair, to present specific items, or for developmental purposes.

6.3.6 The Chair of the Committee may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to deal with the business

on the agenda. Such personnel will be in attendance and will have no voting rights.

6.3.7 On a rotational basis Divisional Management Teams will be invited to the Committee to be held accountable for, and provide assurance against, delivery of the workforce agenda.

6.3.8 The Director of Corporate Governance ~~Trust Secretary~~ may be in attendance at meetings as the agenda dictates.

~~6.4 Deputising~~

~~In the event that an officer is unable to attend to address an agenda item they may identify an appropriate officer to deputise on their behalf.~~

~~6.5 Responsibility of Members and Attendees~~

~~Members of the Committee have a responsibility to:~~

- ~~Act as 'champions', disseminating information and good practice as appropriate;~~
- ~~Identify agenda items, for consideration by the Chair, to the Lead Director/Secretary at least 12 days before the meeting;~~
- ~~Prepare and submit papers for a meeting, using the Trust template at least 8 days before the meeting;~~
- ~~If unable to attend, send their apologies to the Chair and Secretary prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf;~~
- ~~When matters are discussed in confidence at the meeting, to maintain such confidences;~~
- ~~Declare any conflicts of interest/potential conflicts of interest in accordance with the Northern Lincolnshire & Goole NHS Foundation Trust's policies and procedures; and~~
- ~~At the start of the meeting, declare any conflicts of interest/potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the Northern Lincolnshire & Goole NHS Foundation Trust's policies and procedures).~~

7. Procedural Issues

~~The Lead Director is the Director of People and has corporate responsibility for:~~

- ~~Liaising with the Chair on all aspects of the work of the Committee, including providing advice;~~
- ~~Ensuring the Committee acts in accordance with standing orders and the scheme of reservation and delegation;~~
- ~~Identifying an officer to undertake the role of Secretary; and~~
- ~~Overseeing the delivery of the Secretary's duties.~~

7.1 Frequency of Meetings

7.1.1 Meetings will normally take place ~~twice~~ every other month covering items arising from the three pillars of the People Strategy, notably: Workforce, Leadership & Education and Culture and Engagement. Meetings will take place at least one week before public Trust Board meetings (so as to allow this Committee to report to the Trust Board).

7.1.2 The business of each meeting will be transacted within a maximum of two and a half hours.

7.2 Chairperson

The Chair of the Committee is the Non-Executive Director appointed by the Chair of the Northern Lincolnshire & Goole NHS Foundation Trust. The Deputy Chair of the Committee is one of the additional Non-Executive Directors / Associate Non-Executive Directors. If the Chair is not present, then the Deputy Chair shall chair the meeting.

7.3 Secretary

The Director of People's Executive Personal Assistant will act as Secretary to the Committee, preparing agenda papers in conjunction with the Chairperson, and Director of People.

7.4 Attendance

7.4.1 Attendance is a minimum of 75% of all committee meetings.

7.4.2 Executive Directors who are unable to attend will arrange for the attendance of an appointed deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend. Formal deputies appointed can attend up to 25% of all meetings.

7.4.3 Joint Trust roles, or any such role, the attendance required is 50% of Committee meetings with appointed deputies covering the remainder of meetings.

7.5 Quorum

7.5.1 The committee will be deemed to be quorate when there are ~~four~~ three members, two of whom will be Non-Executive Directors / Associate Non-Executive Directors and ~~two~~ one will be ~~Executive Directors, one must be~~ the Director of People.

~~quorum will be a minimum of three members, of whom at least two should be a two Non-Executive Directors and two Executive Directors, one should be the Director Of People. when considering if the meeting is quorate, only those individuals who are voting members can be counted, non – voting deputies and attendees cannot be considered as contributing to the quorum.~~

7.5.2 Formally appointed deputies will be counted towards quoracy and have voting rights (where applicable).

7.5.3 A quorum must be maintained at all meetings.

7.6 Administration & Minutes of Meetings

7.6.1 Minutes of meetings will be circulated with the agenda papers to all members well in advance of each meeting but no less than ~~five 5~~ seven calendar ~~working~~ days before each meeting. In addition to the circulation of minutes, the 'action log' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within timescale.

7.6.2 Agenda items for consideration to be submitted 12 calendar days before the meeting.

7.6.3 Submission of papers to members should take place seven calendar days before the meeting. Late papers may be submitted at the discretion of the Chair.

7.6.4 The Secretary of the Committee will be responsible for:

- ~~Attending the meeting;~~
- Ensuring correct and formal minutes (as per Section 7.6.1) are taken in the format prescribed in the Governance Strategy and, once agreed by the Chair, distributing minutes to the members and submitting a copy to the Trust Board Secretary;
- Keeping a record of matters arising and issues to be carried forward;
- Producing an action list following each meeting and ensuring any outstanding action is carried forward on the action list until complete;
- Producing a schedule of meetings to be agreed for each calendar year and making the necessary arrangements for confirming these dates and booking appropriate rooms and facilities;
- Providing appropriate support to the Chair, Lead Director and the Committee members;
- Providing notice of each meeting and requesting agenda items as per Section 7.6.2. ~~no later than 10 calendar 14 days before a meeting;~~
- Agreeing the agenda with the Chair and the Joint Lead Directors prior to sending the agenda and papers to members as per section 7.6.3. ~~no later than five calendar 7 days before the meeting;~~

- Ensuring the Annual Work Programme is up to date and distributed at each meeting; and

- Ensuring the papers of the Committee are filed in accordance with the Northern Lincolnshire & Goole NHS Foundation Trust's policies and procedures.

~~**7.6.5** Agenda items for consideration must be submitted 10 calendar days before the meeting.~~

~~**7.6.6** Submission of papers to members must be submitted three five calendar days before the meeting.~~

7.7 Decision Making

7.7.1 Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.

7.7.2 Where this is not possible then the chair of the meeting will ask for members to vote using a show of hands, all such votes will be compliant with the current Standing Financial Instructions (SFIs) and Scheme of Delegation of the Northern Lincolnshire & Goole NHS Foundation Trust.

7.7.3 In the event of a formal vote the chair will clarify what members are being asked to vote on – the 'motion'. Subject to meeting being quorate a simple majority of members present will prevail. In the event of a tied vote, the chair of the meeting may have a second and deciding vote.

7.7.4 Only the members of the Committee present at the meeting will be eligible to vote. Members not present and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

7.7.5 The Trust's Standing Orders and SFIs apply to the operation of this Committee.

7.7.6 Decisions which are outside of the Scheme of Delegation will be escalated to the Trust Board with the findings and recommendations of the Sub Committee for action at board level.

7.8 Monitoring Compliance & Effectiveness

7.8.1 In accordance with the requirements of good governance and in order to ensure its ongoing effectiveness, the Workforce Committee will undertake an annual evaluation of its performance and attendance levels.

7.8.2 Where gaps in compliance are identified arising from this evaluation, an action plan will be developed and implementation will be monitored by the Workforce Committee. The results from the annual evaluation exercise, including any agreed actions, will be reported to the Trust Board.

7.9 Review

The terms of Reference will be reviewed every year, with recommendations on changes submitted to the Trust Board for approval.

8 Equality Act (2010)

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

8.2 The Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

8.3 The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

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

The electronic master copy of this document is held by Document Control, Office of the Director of Corporate Governance ~~Trust Secretary~~, NL&G NHS Foundation Trust.

Northern Lincolnshire and Goole NHS Foundation Trust

Appendix A

Workforce Committee

Committee Workplan Template

Item of Business	Committee Oversight	BAF Requirement	Trust Priority	Delivery Method	Frequency	Lead	20xx									20xx		
							Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
STRATEGY																		
SECTION HEADING																		

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)211

DATE OF MEETING	5 October 2021
REPORT FOR	**Trust Board of Directors**
REPORT FROM	Lee Bond, Chief Financial Officer
CONTACT OFFICERS	Brian Shipley, Deputy Director of Finance Matt Clements, Assistant Director of Finance – Management Accounts
SUBJECT	**Executive Report – Finance – M05**
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee
EXECUTIVE SUMMARY	This report highlights the reported financial position of Month 05 of the 2021/22 reporting period

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

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

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Finance Report Month 5

August – 2021/22

Executive Summary Month 5 2021/22

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

The Trust reported a £0.04m surplus for the month of August, which was £0.03m adverse to plan. The year-to-date position is now a £0.06m surplus, which is marginally favourable (£0.05m) to plan.

Income was £10.31m below plan in month.

• This includes an £8.62m adverse donated income variance which is excluded from NHSE&I financial targets, and is due to the re-profiling of EPC capital funding grants. ERF income was £1.84m below plan, which was primarily as a result of low elective, day case and outpatient follow-up activity, and the recent re-profiling of the thresholds to 95%. ERF income actuals were £0.12m negative in month due to the impact of the ICS income values announced following the national May freeze position.

• Elective Recovery Funding (ERF) – the trust has achieved an estimated £3.65m ERF income year-to-date. Further validation of the activity will need to be undertaken, and the Trust achievement of ERF income is dependant on the overall ICS position. The overall ICS did not achieve the ERF thresholds in July or August, though it did for April to June. Quarter 2's non-achievement has been due to Trusts not achieving the increased productivity target of 95% of 19-20 activity, which NHSE&I recently increased from 85%.

Pay was £0.02m overspent in month.

• Medical staff was £0.09m overspent in month. This was partly due to Anaesthetic Middle Grade rota delays, and due to agency premiums for covering vacancies predominantly in Urology, ENT and T&O. The overspend was also as a result of additional waiting list expenditure, including Ophthalmology risk stratification activity. This also includes an estimate for Middle Grade pay reforms which has no attached funding.

• Nursing was £0.11m overspent in month due to supernumerary overspends following international recruitment, use of escalation and surge beds and increased staff absence, partially offset through continued underspends in Midwifery.

• Other Pay variances include £0.03m Flowers costs, for which the Trust has not been reimbursed (£0.15m year-to-date).

Non Pay was £1.53m underspent in month due to low activity, mainly because of slippage in planned Independent Sector additional capacity and the consumables costs associated with it, offsetting the loss of ERF income discussed above.

Post EBITDA items were £0.11m underspent in month due to reduced depreciation and PDC as a result of capital programme delays.

Income & Expenditure to 31st August 2021

		Current Month			Year to Date		
Income & Expenditure	**Annual Plan to 31st March 2022 £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**
Clinical Income	344,241	28,687	28,699	12	143,434	143,691	257
ERF Income	9,761	1,712	(123)	(1,835)	8,672	3,651	(5,021)
Block Top Up	59,816	4,985	4,984	(0)	24,923	24,922	(1)
Covid Inside Envelope Block	13,524	1,127	1,127	0	5,635	5,635	0
Covid Outside the Envelope	690	115	79	(36)	575	680	105
Other Income	37,182	3,098	3,271	173	15,492	15,473	(18)
Donated Income	41,638	10,351	1,731	(8,620)	37,375	4,371	(33,004)
Clinical Pay	(247,987)	(20,714)	(20,806)	(92)	(104,479)	(104,786)	(307)
Other Pay	(67,795)	(5,688)	(5,616)	73	(28,223)	(28,072)	150
Total Pay	**(315,783)**	**(26,402)**	**(26,421)**	**(19)**	**(132,702)**	**(132,858)**	**(157)**
Clinical Non Pay	(68,025)	(6,046)	(5,064)	982	(29,664)	(27,839)	1,824
Other Non Pay	(68,375)	(5,855)	(5,309)	547	(29,758)	(27,292)	2,466
ERF Expenditure			0	0		0	0
Total Non Pay	**(136,400)**	**(11,901)**	**(10,372)**	**1,529**	**(59,421)**	**(55,131)**	**4,290**
Operating Expenditure	**(452,183)**	**(38,303)**	**(36,794)**	**1,510**	**(192,123)**	**(187,989)**	**4,134**
EBITDA	**54,669**	**11,771**	**2,974**	**(8,798)**	**43,983**	**10,434**	**(33,549)**
Depreciation	(12,539)	(967)	(923)	44	(4,708)	(4,552)	156
Interest Expenses & Other Costs	(186)	(16)	(16)	(0)	(78)	(83)	(6)
Dividend	(4,939)	(399)	(333)	66	(1,919)	(1,664)	255
Total Post EBITDA Items	**(17,664)**	**(1,381)**	**(1,271)**	**110**	**(6,704)**	**(6,299)**	**405**
Remove Capital Donated I&E Impact	(41,374)	(10,329)	(1,667)	8,662	(37,268)	(4,078)	33,190
I&E Surplus / (Deficit)	**(4,368)**	**61**	**36**	**(25)**	**12**	**57**	**46**

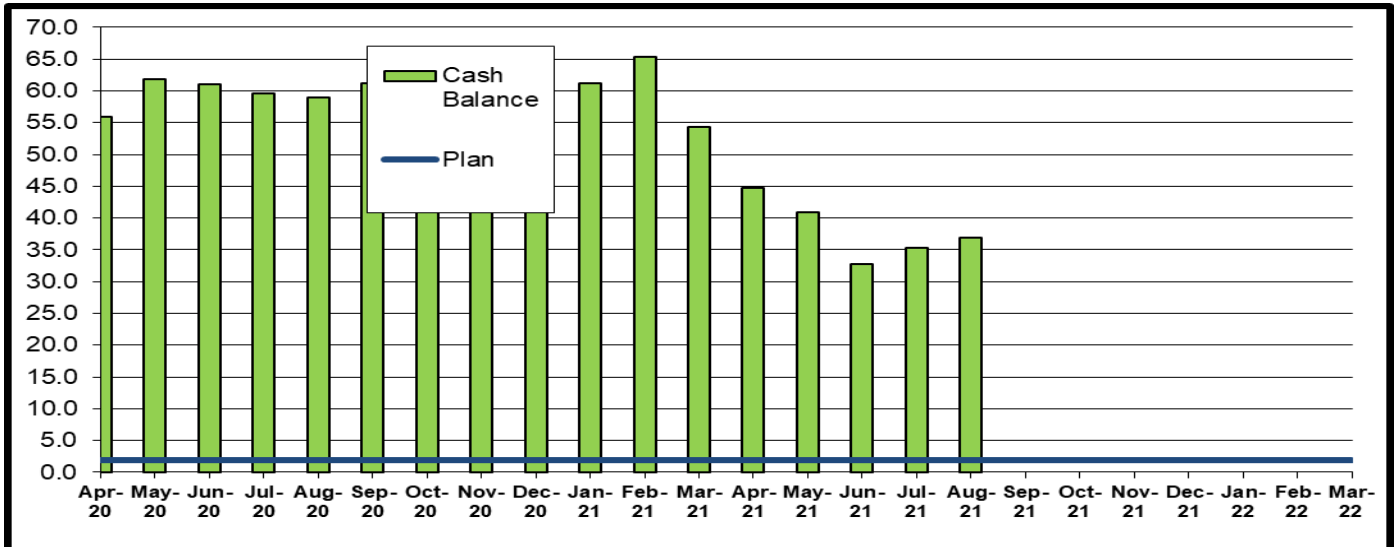
COVID-19 Expenditure

Expenditure Category	Year-to-date 21-22		
	Pay (£k)	Non-pay (£k)	Total (£k)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	1,147	0	1,147
Existing workforce additional shifts to meet increased demand	2,617	0	2,617
Backfill for higher sickness absence	1,106	0	1,106
PPE associated costs	0	3	3
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0	5	5
Remote management of patients	6	0	6
Segregation of patient pathways	0	20	20
Decontamination	0	95	95
After care and support costs (community, mental health, primary care)	0	22	22
Outside Envelope Remote working for non-patient activities	0	0	0
Outside Envelope COVID-19 - Vaccination Programme - Provider/ Hospital hubs	69	2	70
Outside Envelope COVID-19 - Deployment of final year student nurses	137	0	137
Outside Envelope COVID-19 - International quarantine costs	0	6	6
Outside Envelope Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	216	36	252
Outside Envelope COVID-19 virus testing - rt-PCR virus testing	0	17	17
Outside Envelope COVID-19 virus testing - Rapid / point of care testing - all other locally procured devices	0	435	435
Outside Envelope NIHR SIREN testing - research staff costs	14	0	14
Total COVID-19 Expenditure	5,312	642	5,954
Total Trust Operating Expenditure (including COVID-19 expenditure and all other operating expenditure)	132,858	55,131	187,989
COVID-19 % of Total Trust Operating Expenditure	4.0%	1.2%	3.2%

Cash

The cash balance at 31st August was £36.86m, an in-month increase of £1.6m.

	£m	£m
Cash Balance as at 31st August		**36.86**
Commitments:		
Income received in advance	4.33	
Capital creditors	3.72	
Capital loan repayments	0.39	
August PAYE/NI/Pension	10.13	
Public Dividend Capital	1.66	
Annual leave income	4.49	
Invoices due for payment not yet authorised	4.06	
To support other creditors due	6.18	
		(34.96)
NHSi minimum balance		**1.90**



Balance Sheet as at 31st August 2021

	Last Month	This Month
	£mil	£mil
Total Fixed Assets	196.69	199.50
Stocks & WIP	3.29	3.63
Debtors	13.57	13.85
Prepayments	6.11	5.87
Cash	35.26	36.86
Total Current Assets	58.23	60.20
Creditors : Revenue	36.73	39.64
Creditors : Capital	3.19	3.72
Accruals	15.93	14.80
Deferred Income	3.85	4.33
Finance Lease Obligations	0.01	0.01
Loans < 1 year	0.71	0.73
Provisions	2.18	2.45
Total Current Liabilities	62.60	65.68
Net Current Assets/(Liabilities)	(4.38)	(5.48)
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)	178.21	179.91
TOTAL CAPITAL & RESERVES	178.21	179.91

- Stock has increased this month in the following areas: Pathology and theatres at all 3 sites.
- Debtors increased in month, this relates to additional income for elective recovery. The debtors for 2020/21 relating to annual leave and 'flowers' are still outstanding.
- Prepayments have increased this month, relating to vehicle insurance and maintenance contracts.
- Revenue creditors and accruals have also increased. The increase is in relation to outstanding pay costs and costs incurred in relation to the elective recovery plan. The BPPC figures for the Trust are continuing to be above 90% for non-NHS invoices, the in month value paid within 30 days was 94.14% and the number of invoices paid 92.37%. NHS invoices saw an improvement in month to 88.21% relating to the value paid within 30 days and a reduction in the number paid to 68.59%. All invoices need to be authorised promptly in

NLG(21)212

DATE OF MEETING	Tuesday 5th October 2021
REPORT FOR	Trust Board (Public Board)
REPORT FROM	Jug Johal Director of Estates and Facilities
CONTACT OFFICER	Jug Johal Director of Estates and Facilities
SUBJECT	Estates and Facilities Executive Report
BACKGROUND DOCUMENT (if any)	Not applicable
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Estates and Facilities SMT
EXECUTIVE SUMMARY	The report provides a brief overview of the highlights, lowlights and risks within the services in the Estates and Facilities Directorate. Updating the board of key successes and outcomes and current/future projects.

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

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

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

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

Facilities Services

Highlights	Lowlights	Risks
• National Standards of Healthcare Cleaning released on 26th April 2021. Project structure, meetings and Governance in place, GAP analysis completed, reviewing FR ratings for all areas. On Target •	• Requirement for increased cleaning audit / monitoring presents significant staff shortfall and resulting cost pressure	• Additional Resource • Revised auditing programme with all stakeholders • Impact on quality outcome / Star Ratings
• Independent NHS Food Service report released November 2020. High level action Plan completed based on review, awaiting NHS standards to be released, anticipated during in October 2021 •	• NHSI/E forming specialised group to assess impact, offer guidance, post report • Some recommendations could increase cost, but not quality	• Step away from local suppliers • Increased waste • Increased costs to support delivery model, capital equipment and infrastructure
• NLaG collaboration with York & Harrogate (NoECPC) for retendering of Linen & Laundry Services, evaluation complete, awaiting outcome of successful tender	• Previous process collapsed, operating on contract extension however, service and quality remain high	• Collaboration to share any legal costs
• Intense operational support to Emergency Departments and Red Zones	• Resource pressures linked so absence and recruitment	• CCTV project clashes with high volume of existing schemes. Plan in place to minimise risk
• Security Car Parking Contract mobilised, initiated CCTV Delivery group to oversee Capital Investment linked to contract	• Pandemic has increased consumption of consumables resulting in enormous waste outputs	• Resource investment to build upon legislative need
• Revised Waste resource OBC focusing on processing waste prior to collection / disposal from site, increasing compliance. Progressing to Business Planning for 2022 – 23	• Without financial plan to support, staff retention for bank is difficult	• Capacity of established roles to support additional pressures becomes significant risk.
• Recruiting to support Operational / Winter Pressure plans for Bank staff		

Commercial Services

Highlights	Lowlights	Risks
• Accommodation configuration adjusted at SGH to support the increase in HYMS Students in the August 21 intake due to relocating tenants in 2-bedded rooms to single bedded. • Significant increase in Private Patient demand. Opportunity to target waiting lists if theatre slots are available. • Fatigue Rooms introduced at SGH and DPOWH. These are incorporated in the Accommodation Policy which has been approved at Trust Management Board. • Seamless relocation of Endoscopy team, with temporary decant to boardroom as part of Endoscopy project to keep in line with JAG accreditation. • Receipt of £14k credits in quarter from decontamination Services provider; • Improved oversight of Instrument repairs at DPoWH site as they are being managed through Decontamination Contract; • Improved utilisation of DSA to facilitate instrument procurement via Provider (VAT recovery); • Confirmation has been received from North Lincolnshire Council (NLC) that the Trust can re-occupy children's centre's for Maternity Services, specifically Barton. • Memorandums of Terms of Occupancy (MOTOs) engrossments have been issued to formalise the Trusts' occupation in NHS PS properties. • The Trust has agreed an extension to the Letter of Intent with Breathe Energy for the design (to RIBA stage 4) of the PSDS funded (£40.3m) energy decarbonisation works as we progress towards entering into a works contract (NEC4).	• Still unable to secure a regular weekly/ monthly theatre session which would allow for better planning and performance of Private Patients function. • Demand for accommodation at both sites exceeds supply. SGH is particularly impacted. • Unable to implement ideal Hybrid working paper which would benefit the continuation of current job roles that could continue working Agile. • Overall Trust activity value improved slightly by 1% during quarter but remains 8% below the Minimum Services Level; • Late instrument deliveries exceeded Tolerance Threshold at 0.76% monthly average however recent improvements are noted; Progress on lease arrangements with NLC for the Community Equipment Store remains challenging with NLC seeking to apply additional cost pressures to the Trust.	• Ability to provide surgery slots to meet demand for Private Patients. • If the Trust is unable to provide accommodation this can impact workforce and patient care. • Both Accommodation sites currently unable to meet the increased HYMS numbers over the next two years. • Severe potential that we will not be able to offer admin space to teams (especially at DPOW) or adhere to Space utilisation policy and social distancing Loaning of Instruments to Trent Cliffs may lead to shortages at Trust;

Safety & Statutory Compliance

Highlights	Lowlights	Risks
• Phase one of the fire alarm replacement at DPOW completed and funding secured for phase two which will complete the full alarm replacement, • Validation of queries raised by NHSE/I on ERIC submission completed and returned. • Completion of fire work to D&F floors in Coronation Block at SGH • Ongoing Covid queries all responded to. • Completion of PAM on-line return for 20/21 and continue to participate in national working group for future development.. • Recruitment commenced for E&F trainer to deliver face to face fire training commencing in January 2022. • Ongoing involvement in EPC work and Capital Projects to ensure compliance with HTM and statutory requirements (avoids delays in handover). • Discussions with community lone worker system providers on audits and increasing usage. • Currently all 2021/22 AP training included in revised budget but no development training available	• Number of staff seconded to ICCand Energy Project resulting in work pressures (one staff member resigned) • No face to face fire training in accordance with HTM requirements. Agreement from FireAuthority to allow on-line training tobe undertaken where practical training should have been undertaken. Plan to recommence in January 2022 • Covid workload has required somework to be delayed due to resources required • Training compliance hit by Covidwhich means additional training required when restrictions lifted.	• Seconded staff may not return to substantive posts sowill create vacancies • No dedicated training venue for E&F (currently used for Practice Development Nurses) so may affect ability to “catchup” delayed training • Training budget will need to be increased for 21/22 due to increase in AP numbers

ESTATES & ENGINEERING

Highlights	Lowlights	Risks
• The estates team successfully completed a management restructure at the end of FY 19/20, which has provided more ownership at the granular level directly improving trust wide control of assurance in the Trust, furthermore, enabling greater team interaction and development. • Continued improvements to the trust infrastructure is on-going, BLM and capital funding has resulted in improved, modernised heating and medical vacuum pump systems at DPoW, which ensures resilience as we move into the winter period. • Projects/Operations/Clinical The pandemic, whilst it has put pressures on all teams, it has developed closer collaboration with clinical counterparts as we strive to make the environment better for staff and patients alike. • This year has seen recruitment improve which has resulted in a near full establishment. This blend of external and internal personnel wanting to improve and excel has changed the dynamic and drive of the team. • Continued drive to digitise and develop estates management through a Computer Aided Facilities Management (CAFM) system as reactive maintenance requests move to an online portal late 2021/early 2022. • External training has now returned to pre-pandemic levels, which now sees estates attendance and resulting compliance levels increase. • Approval of £1.7M to fund DPoW oxygen infrastructure this FY.	• Due to the increased level of fundingreceived by the Trust, and the subsequent volume of work, has impacted the capacity of our key contractors to complete work in a timely manner, and supply chain support. • BLM funding continues to be a significant issue, impacting what the estates department can deliver. We are currently taking money from next year's budget to conduct critical roofing repairs this year. This is unsustainable • The volume of capital works has impacted the ability to perform ongoing estate compliance work due to strain on technical resources. • Work with BOC to develop the oxygen systems at DPoW and SGH has taken its time, as has the clinical plan.	• Critica infrastructure still poses a risk to the estate. EPC and the new ED/AAU have helped in some regard with tackling the on-going issue, but the level of funding required to mitigate the risk still runs into £Ms. • Ongoing support to capital works impactingon estate compliance. • Estate management still feel there is an imbalance between the workforce and compliance/project support requirements. Risk of over-working staff and burnout.

CAPITAL PROJECTS

Highlights	Lowlights	Risks

• Successful completion of a number of projects including: The MRI scanner facility at DPoW; Theatre E refurbishment at Scunthorpe; Fire alarm installation (Phase 1) at DPoW; Water infrastructure works at DPoW; Pharmacy Robot at SGH.
• Successful commencement of a number of projects, including preconstruction works, for: Ward 25 refurbishment at SGH; Endoscopy at DPoW; Modular (CCU) removal at DPoW; X-ray room 4 at DPoW; Old MRI removal at DPoW; Fire alarm install DPoW – Ph.2 (On site); BLM works for 2021/22.
• Successful recruitment of a Fire Officer and Capital Projects Officer
• MRI scheme at Scunthorpe progressing (completion January 2022)
• ED/AAU – DPoW, works include:
  • New car parks; rerouting of bus service & Blue Light routes; relocation of Patient and Visitor Parking; Construction of new steel-framed car park (due to complete Nov'21); New ED building & HV Substation progressing.
• ED/AAU – SGH, works include:
  • Refurbishment of the Coronation Block levels D&F and relocation of staff, Private Patients, doctors mess facility, library and multi-faith room; Relocation of Occ.Health to Global House; Refurbishment of old Occ.Health into Doctors on Call rooms; new car park with 91-spaces for patients & visitors / 58 spaces for staff; Successful demolition of the former Admin (War Memorial) Building with full historic 3D video captured.
• EPC – GDH, works include:
  • Removal of the coal fired boilers; installation of new loft and cavity wall insulation; completion of LED lighting upgrade; Gas supply upgrade; BMS upgrade ongoing, due to complete October 21
	• Impact of Covid-19 on project works on site
	• Difficulties and delays in recruiting / maintaining sufficient staff to deliver projects effectively and sustainably
	• Project delays due to supply chain and material shortages, in particular MRI SGH & ED/AAU
		• Supply chain and material resource availability impacting on ability to deliver projects
		• Potential for short-term supply / demand issues leading to inflation within the supply chain impacting on ability to deliver projects
		• Difficulty in recruitingstaff to both permanent and fixed-term roles
		• ED/AAU budget constraints
		• EPC Funding extension

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)213

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Gill Ponder, Chair of Finance & Performance Committee
CONTACT OFFICERS	N/A
SUBJECT	F&P Committee Highlight Report - 25 August and 29 September 2021 - FINANCE
BACKGROUND DOCUMENT (if any)	Minutes of meeting
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	Finance and Digital matters to highlight to Trust Board from the meetings held on 25 August and 29 September 2021 were: • Both the Trust and the System failed to hit the new 95% threshold to obtain ERF payments. • H1 financial plan was on track, but there were risks to delivery of the H2 financial plan. • Capital was underspent due to re-profiling of EPC grant and unforeseen delays to capital projects. • Expression of interest in new hospital submitted under HIP. • IAAU Full Business Case noted and supported.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable	SO1 1.2 SO1 1.3 SO1 1.4 SO1 1.5 SO1 1.6 SO3 3.1 SO3 3.2 SO4				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	✓

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5 October 2021
Report From:	Finance & Performance Committees held on 25 August & 29 September 2021

Highlight Report:

- The threshold for receipt of the ERF payments had increased from 85% to 95% and the Trust and system partners had not achieved the new threshold.
- Savings were on track against the Cost Improvement programme, but there were concerns about future cost pressures arising from the non-recurrent nature of many of the savings.
- Completion of the actions required to exit from Financial Special Measures was on track for completion by the end of October.
- The Trust were on track to deliver the H1 plan, but there were risks to H2 arising from lack of permanent staff, added efficiency risk, the ERF challenge, reduced Covid funding and the cost of the new Urgent Care front door model.
- The Trust were aiming to recover slippage on Capital programmes, but discussions were taking place with BEIS about the availability of funding into 2022/3, the impact on energy efficiency schemes and the ability to place high value contracts that would run into the next financial year. A discussion with Auditors might be required on that before it was signed off.
- The expression of interest for the Health Infrastructure Plan future new hospitals programme was noted and supported by the Committee.
- The progression of the IAAU business case from OBC to FBC was noted and supported. Key next steps were finalisation of Guaranteed Maximum Prices and a letter of Commissioner Support.

Confirm or Challenge of the Board Assurance Framework:

There was a need to reduce spend on temporary staffing to prevent cost pressures arising from planned recruitment. The Committee challenged the usage of agency staff in non-patient facing roles and the level of support being given to Divisions who were not achieving planned cost savings. Benchmarking results were due to be reviewed by the Committee when the data was available, to enable the Committee to discuss any opportunities to reduce costs and improve the underlying financial deficit.

Action Required by the Trust Board:

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)214

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board - Public
REPORT FROM	Gill Ponder, Chair of F&P Committee
CONTACT OFFICER	Gill Ponder
SUBJECT	Finance & Performance Committee Self-Assessment
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee
EXECUTIVE SUMMARY	A Committee self-assessment review was undertaken in July 2021 and the attached report includes comments received and the subsequent action plan agreed at its meeting in August 2021. Also attached is the current Committee Workplan, noting this is still to be transferred into the new format.

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

ASSESSMENT TOOL FOR EVALUATION OF BOARD COMMITTEES

ACTION PLAN – August 2021

Introduction

In accordance with the requirements of good corporate governance and in order to ensure their ongoing effectiveness, it is recommended that Trusts should undertake a formal and rigorous annual evaluation of the performance of its Board committees[1]. The following assessment tool has been developed to evaluate the performance of the Finance & Performance Committee.

Objective	Achieved Yes	Achieved No	Evidence of Achievement	Additional Comments	Action Required	Action Taken / To be Taken
Terms of Reference						
1. The Committee has clearly defined Terms of Reference which have been approved by the Trust Board.	X X X X X		○ Terms of Reference ○ Committee Minutes ○ Trust Board Minutes ○ Document Control Database	• TOR exist, but need to be reviewed	• Review attendees, e.g. Associate Director of Business Planning & Performance Management and Digital Director and review status of non-voting members and deputies in counting towards quoracy.	**Complete**. **Action** - All Committee TOR's being reviewed by Director of Corporate Governance, but in the meantime, interim TOR's covering attendance and quoracy issues agreed at July meeting and would be formally ratified at Board meeting on 7 Sept 2021.
2. The Terms of Reference are regularly reviewed and updated.	X X X X		○ Terms of Reference ○ Committee Minutes ○ Trust Board Minutes ○ Document Control Database	• Can't comment on how frequently this has occurred in the past	• None	**Action** - Add a quarterly review of TOR and Committee compliance to Workplan.
3. The Committee has been true to its Terms of Reference.	X X X X X		○ Committee Minutes ○ Action Log ○ Annual Review of Effectiveness ○	• This is true for the meetings I have attended	• Review comments from longer serving Committee members.	Done. **Action** - When new TOR's produced by Director of Corporate Governance, check Committee Workplan

[1] Integrated Governance Handbook, February 2006

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required	Action Taken / To be Taken
	Yes	No				
						to ensure all items covered and to ensure that there are no items that fall within the scope of other Committees
4. The Committee has worked purposefully and methodically to achieve the objectives it set for itself in order to fulfil the Terms of Reference.	X X X X	X	○ Committee Minutes ○ Work Programme ○ Action Log	• I have not seen any Committee objectives • Review and record of current and completed actions in place • The committee has a very detailed work plan with adequate time allocated	• Review existing objectives or need to set objectives if there are none.	**Action** - Confirm whether or not there are any existing objectives. - Set objectives for 21/22 in line with Trust priorities and TOR.
Reporting & Accountability						
5. The Committee has reported regularly and in a way that has furthered the work of the Trust Board and / or provided the necessary assurance to the Trust Board.	X X X X X		○ Trust Board Minutes ○ Statement of Internal Control (SIC) ○ External Standards & Compliance Reports	• Evidence is also Board highlight reports?	• Board to comment?	**Action** - Add Highlight Reports to list of evidence available. - Seek feedback from Board members to confirm this is being achieved.
6. The Committee has escalated matters to the Trust Board as necessary.	X X X X X		○ Trust Board Agenda & Minutes ○ 'Highlight' Reports including review of the Board Assurance Framework (BAF)	• The summaries are always succinct and provide evidence of the Trust position around these matters • True for the 3 meetings I have attended		**Action** - Include this in request for feedback from Board.
7. The Committee has received regular reports and / or minutes from the sub-groups which report to it.	X X X X		○ Committee Agenda & Minutes ○ Work Programme	• Not applicable, as there are no sub-groups that report to the Committee		**Action** - Confirm that there are no sub-groups that should be reporting to the Committee.
8. Issues are escalated from these groups as	X X		○ Committee Agenda & Minutes	• Not applicable, as there are no sub-		N/A

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required	Action Taken / To be Taken
	Yes	No				
necessary.	X X		○ 'Highlight' Reports from sub-groups	groups that report to the Committee		
9. The 'highlight' reports from these groups avoid unnecessary detail and confine themselves to matters which cannot be dealt with at group level and require escalation.	X X X X		○ 'Highlight' Reports from sub-groups ○ Committee Minutes	• Not applicable, as there are no sub-groups that report to the Committee • Ensure reports remain succinct		N/A
10. The Committee has provided timely and effective direction, advice and support to Clinical & Non-Clinical Directorates (either directly or via the relevant groups) on relevant matters and in order to reduce risk to the Trust.	X X X X		○ Action Log ○ Committee Minutes	• Not sure. Does the alignment of NEDs to certain divisions satisfy this requirement?	• To be determined	**Action** - 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
11. The roles of and relationship between this Committee and the other Board Assurance committees are clear and avoid duplication of effort.	X X X X X		○ Terms of Reference ○ Committee Agenda & Minutes	• From what I have seen so far, there is clarity of Committee responsibilities, although some overlap between issues going to F&P and Audit Committee • Ensure that there is sufficient cross-committee representation with NEDs attending min of 2 committees	• Clarify demarcation between F&P and Audit Committee items -	**Action** - Suggest a review of the roles of all Committees to ensure there are no gaps or overlaps and make any necessary amendments to TOR. - Execs and NED's attending more than one Committee to challenge areas where they spot gaps or duplication

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required	Action Taken / To be Taken
	Yes	No				
12. Issues are referred to other Board Assurance Committees or management decision making groups, as appropriate.	X X X X X		○ Referral Communication ○ Committee Minutes	• I have seen evidence of this happening	• **None**	**Action** - Add minutes of meetings to list of evidence available
Leadership						
13. The Committee is well led.	X X X X X		○ Evaluation Results & Feedback ○ Committee minutes	• The previous Chair did a very good job of leading the Committee and the new Chair is conscious of the need to fulfil that role • Meetings are always well Chaired and minuted	• New Chair to try to live up to the standards set by the previous Chair.	**Action** - Add a Review of Meeting to the end of the agenda for each meeting to allow a brief discussion of what went well and what could be improved in future
Frequency of Meetings						
14. The Committee has met at the frequency defined in its Terms of Reference.	X X X X	X	○ Meeting Schedule ○ Committee Agenda & Minutes	• Monthly meetings held	• None	**Action** - Ensure that monthly meeting dates are scheduled well in advance
15. Where necessary, additional meetings of the Committee have been held.	N/A X X N/A		○ Committee Agenda & Minutes ○ Action Log ○ Attendance Matrix	• Not since I joined the Trust, as there has not been a need. Unsure of what happened previously	• None	**Action** – Where there are significant issues that cannot be covered in sufficient detail during a normal meeting, schedule an extra meeting to allow time for scrutiny, challenge and discussion
Duration of Meetings						
16. There is sufficient time during meetings to consider and debate agenda items and	X X X X		○ Committee Agenda & Minutes	• The meetings I have attended seemed to have sufficient time,	• Keep time under review to ensure that items are properly considered	**Action** – set realistic agendas that allow time for discussion and challenge

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required	Action Taken / To be Taken
	Yes	No				
ensure sufficient challenge.	X			but it is a very busy agenda • There have been occasions where late submissions of apologies have been submitted and difficulties with quoracy have arisen • Sometimes specific agenda items do require more time to allow a detailed discussion and analysis of reports	-	- Rotate the order of the core agenda topics, so the same areas do not feel rushed if time is running short at meetings - Confirm order of agenda items at agenda set meetings - Where there is insufficient time to cover essential topics properly, arrange a short, specific extra meeting rather than rushing through items
Attendance						
17. Meetings have been well attended.	X X X	X X	○ Committee Minutes ○ Attendance Matrix	• Recent non-attendance of Execs • The June meeting was not quorate, but I believe previous attendance levels have been good	• Ensure quorate • Review TOR and monitor apologies to ensure quoracy issues are flagged early, so they can be resolved	**Action** – Monitor apologies and raise quoracy issues early to enable early action to resolve - Committee members to attend a minimum of 75% of meetings - Execs to send a Deputy where they are unavailable for a maximum of 25% of meetings
Membership						
18. The Committee consists of the right number of appropriately knowledgeable, experienced,	X X X X X		○ Terms of Reference ○ Committee Minutes ○ Attendance Matrix	• Subject to above • I think the Director of Digital should be a	• Review Committee attendees.	Done in interim TOR's

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required	Action Taken / To be Taken
	Yes	No				
developed and supported members who have been able to contribute effectively and who have the authority to make decisions where required.				member of the Committee, as that is such a key enabler to delivery of strategy and strategic objectives, as well as improving performance		
19. The membership of the committee is kept under review.	X X X X X		○ Terms of Reference ○ Committee Minutes ○ Trust Board Minutes	• Reviewing it now, but not sure how often that has been done previously	• Review membership of Committee as part of review of TOR's.	Done in interim TOR's. **Action** – review quarterly as part of review of TOR's.
Content						
20. The business of the committee is appropriate and relevant.	X X X X X		○ Committee Agenda & Minutes ○ Action Log ○ Work Programme	• Workplan is clear and items on agenda are all relevant to the Committee's TORs	• None	**Action** – include a review of this as part of the quarterly TOR reviews.
Receipt of Information						
21. The Committee has received timely, accurate and relevant information to achieve the objectives it set for itself in order to fulfil the Terms of Reference and in order to enable assurance to be provided to the Trust Board.	X X X X	X	○ Committee Agenda & Minutes	• I think that papers could be submitted earlier. In my view, papers should be available 1 week before meetings. I realise that the current meeting schedule means that data is not available then, but we should aspire to this to give time for preparation and triangulation of information to enable Committee members	• Review meeting schedule for next year to ensure there is sufficient time for data to be received, papers submitted 1 week before meetings and time to get highlight reports to Board so those papers are available 1 week before meetings -	**Action** – Review schedule of meetings to ensure alignment with availability of data and Board Meetings - Submit papers no later than 1 week before meeting - Produce highlight reports in time for inclusion in Board papers 1 week before Board meeting

Objective	Achieved		Evidence of Achievement	Additional Comments	Action Required	Action Taken / To be Taken
	Yes	No				
				to challenge appropriately • See comments above (receipt of information)		

As part of the evaluation exercise, the following supporting information will be provided to the Committee:

- F&P Terms of Reference
- Current Annual Workplan

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

Draft Work Plan for the Finance and Performance Committee – 2021/2022

Items of Business	Aug 2021	Sept 21	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	April 2021	May 2021	June 2021	July 2021
PERFORMANCE												
Strategic objective 1.2 is the risk that the Trust fails to deliver against constitutional and other regulatory Performance targets												
a) Performance will be reviewed each month as part of the review of the IPR which covers constitutional, regulatory and local performance targets	X	X	X	X	X	X	X	X	X	X	X	X
b) Monthly Deep Dives into areas where improvement in performance is required	Cancer	Long Waiting Patients – 52 weeks and 104 days	Outpatient Follow-ups	Risk Stratification	Diagnostics	Urgent & Emergency Care and Community Response	Cancer	Long Waiting Patients – 52 weeks and 104 days	Outpatient Follow-ups	Risk Stratification	Diagnostics	Urgent & Emergency Care and Community Response
TRANSFORMATION PROJECTS (Based on operational priorities 21/22)												
Integrated Urgent and Emergency Care, AAU Scheme and Patient Flow, including updates on: **- Performance** **- Quality Improvement** **- Finance** **- Workforce** **- progress with capital schemes against plans and** **- progress with transformation projects required to redesign services to transform clinical pathways and fit within financial envelope**		X			X			X			X	
Recovery of Patient Waiting Lists per Speciality, including updates on: - **High risk specialities**			X			X			X			X

Items of Business	Aug 2021	Sept 21	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	April 2021	May 2021	June 2021	July 2021
- **Fragile services** - **Non-admitted and follow-ups**												
OPD Transformation Project, including: - **Connected Health** - **PIFU** - **Patient Letters** - **Administrative Pathway**		**X**			**X**			**X**			**X**	
BUSINESS PLANNING												
Annual Business Planning Cycle			Business planning timetable			Business planning/ Operational	Draft Ops plan 22/23	Draft Ops plan 22/23	Final ops plan 2021 /22			
BUSINESS CONTINUITY												
Strategic Objective 1.6 is the risk that the Trust's business continuity arrangements are not adequate to cope												
Updates will be provided to the committee to gain assurance, including EPRR				**x**						**x**		
STRATEGIC DEVELOPMENT												
Strategic Objective 3.2 is the risk that the Trust fails to secure and deploy adequate major capital												
Capital Planning (including investment in IT, Medical Equipment, core capital, Emergency Capital and STP Capital)		(b)								**(a)**		
a) NLAG strategic capital plan										**(a)**		
b) Wave 4 capital bid update – AAU and ED (OBC due Oct 21)		(b)										
Strategic Objective 1.3 is the risk that the Trust will fail to develop, agree, achieve approval and implement an effective clinical strategy												
Humber Acute Services c) Programme 1 – Interim Clinical Plan					(c)				(c)			(c)

Items of Business	Aug 2021	Sept 21	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	April 2021	May 2021	June 2021	July 2021
d) Programme 2 – Core Service Change (U&EC, Maternity/Paediatrics, Planned Care)				(d)			(d)			(d)		
e) Programme 3 – Humber-wide Transformation and Strategic Capital (major redevelopment)		(e)		(e)			(e)				(e)	
NLAG a. 5 Year Strategic Framework			(f)				(f)					
FINANCE												
Strategic Objective 3.1 is the risk that either the Trust or HCV HCP will fail to achieve their financial objectives and responsibilities												
Financial Performance will be reviewed each month as part of the review of the Monthly finance report ensuring the achievement of the points below	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
a. Achieving the control total agreed with NHSI for the Trust for 2021/22, including cost efficiency	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
b. Addressing the underlying deficit position of the Trust of circa (60m)	**x**			**x**			**x**			**x**		
c. Achieving the HCV HCP system target			**X**			**X**			**X**			**X**
Cost Efficiency, to include: - **Reference Cost process, submission and outputs** - **Patient Level Costing** - **Model Hospital** - **Benchmarking**		**x**			**x**			**x**			**x**	
Use of Resources Progress against Use of Resources Assessment			**x**					**x**				
ESTATES AND FACILITIES												
Strategic Objective 1.4 is the risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate												

Items of Business	Aug 2021	Sept 21	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	April 2021	May 2021	June 2021	July 2021
A cycle of reviews is in place to give assurance that the Trust's key risks in this area are being managed, mitigated and escalated where appropriate	None	Asbestos	LV/HV	Civils Infrastructure	Sustainability Report	Estates Strategy Update	Water	Lifts	Ventilation	BLM and Premises Assurance	Medical Gases	Fire Report
DIGITAL SERVICES												
Strategic Objective 1.5 is the risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care												
Updates will be provided to the committee to gain assurance, including:			x			x			x			x
a) Digital Strategy Progress on Priorities b) Funding for Digital Programmes c) Business Intelligence & Insights (Data Improvements)			Business Intelligence			Progress Report on Priorities			Approval Annual Priorities			Financial Update
d) Clinical Data Improvement Programme			**X**			**X**			**X**			**X**
GOVERNANCE OF THE COMMITTEE												
BAF The BAF risks have been embedded into the different areas of the committee work plan and will be reviewed as indicated – which takes into account the level of risk in each area Review of the current BAF risk ratings against the target risk ratings on a quarterly/4 monthly basis to gain assurance on the direction of travel	**X SO1 1.2**	**X SO1 1.3**	**X SO1 1.4**	**X SO1 1.5**	**X SO1 1.6**	**X SO3 3.1**	**X SO3 3.2**	**X SO1 1.2**	**X SO1 1.3**	**X SO1 1.4**	**X SO1 1.5**	**X SO1 1.6**
Review of the Work Plan, Action Plan and Terms of Reference			**X**			**X**			**X**			**X**
Annual effectiveness review of the Committee										**X**		
Total Items per month	**8**	**12**	**15**	**9**	**10**	**13**	**10**	**12**	**12**	**12**	**10**	**12**

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)214

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board
REPORT FROM	Gillian Ponder, Committee Chair
CONTACT OFFICER	Helen Harris, Director of Corporate Governance
SUBJECT	Terms of Reference for Finance and Performance Committee
BACKGROUND DOCUMENT (if any)	Finance and Performance Terms of Reference
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance and Performance Committee – 29 September 2021 recommend the Trust Board approve the revised Terms of Reference.
EXECUTIVE SUMMARY	The Finance and Performance Committee (F&PC) Membership and Terms of Reference document has been updated, as highlighted throughout in yellow (see attached), and a new Committee workplan template has also been appended: - Trust Secretary to Director of Corporate Governance throughout - Section 3.1.1: to approve Trust strategies and policies as per the Committee's remit - Section 5: addition of Responsibilities section broken down by key topic and the Board Assurance Framework reviewed on a quarterly basis and deep dives to be undertaken as per the Committee's workplan - Section 7: Addition of Associate Non-Executive Directors (NEDs) for core membership; Other NEDs and Executive Directors to attend as desired, and a Governor to attend; Formal deputies can attend up to 25% of all meetings and where there are joint Trust roles attendance is 50%; new section on Decision Making. - Section 8: meetings to normally be held monthly; formal deputies will be counted towards quoracy; papers to the members not less than seven or consideration 12 days prior to the meeting - Appendix A: new Committee Workplan has been produced to ensure consistency across all committees.

	The Finance and Performance Committee recommend the Trust Board approve the proposed amendments to the Committee Terms of Reference.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Strategic Objective 1 – 1.2, 1.4, 1.5, 1.6, 3 – 3.1, 3.2.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
	✓				

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Corporate Governance ~~Finance~~

FINANCE & PERFORMANCE COMMITTEE

Membership and Terms of Reference

Reference:	DCT124
Version:	1.5
This version issued:	Date?
Result of last review:	Addition of work plan and various changes (as highlighted)
Date approved by owner (if applicable):	Date?
Date approved:	Date?
Approving body:	Trust Board
Date for review:	September 2022
Owner:	~~Chair of Finance & Performance Committee~~ Director of Corporate Governance
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	~~Chief Financial Officer~~ Director of Corporate Governance

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

1.0 Constitution

1.1 The Trust has established the Finance and Performance Committee, as a formal sub-committee of the Trust Board. This Committee is responsible for oversight, challenge and assurance, on behalf of the Trust Board, in respect of Trust strategies, plans and performance against key operational targets. This will include the management of financial resources within parameters set by regulators**.**

2.0 Purpose

2.1 The Committee's oversight remit will extend to all critical drivers of financial and operational performance including operational and financial planning, contracting, financial savings programmes and recovery plans, service strategy, Digital Services, and estates and facilities.

2.2 The Committee will report the outcome of each meeting to the Trust Board, raise any concerns and make recommendations for action to the Trust Board across this remit.

2.3 To make any recommendation on changes to the Forecast Outturn to the Trust Board.

3.0 Authority

3.1 The Committee may take the following actions on behalf of the Trust Board (subject to the "Reservation of Powers to the Board and Delegation of Powers"):

3.1.1 ~~Review~~ Approve Trust strategies and policies~~, procedures and guidelines~~ that fall within the remit of the Committee.

3.1.2 Scrutinise operational and financial plans, and the effectiveness of delivery against those plans

3.1.3 Scrutinise management arrangements and structures put in place to support financial and operational performance management

3.1.4 Recommend appropriate corrective and other actions to mitigate identified risks and to ensure compliance with financial and other operational performance targets

3.2 The Committee is responsible for oversight as to whether the Trust has in place appropriate arrangements to effectively manage financial and operational performance within any required parameters. The Committee is required to provide appropriate assurance to the Trust Board in this regard.

4.0 Accountability & Reporting Arrangements

4.1 The Finance and Performance Committee, appointed under and subject to the Standing Orders of the Trust, is a sub-committee of the Trust Board, and will

submit copies of its minutes for inclusion on the Trust Board agenda. The Trust Board will also receive details of the outcome of the annual evaluation of performance of the Committee.

4.2 The Committee will ensure that significant issues are escalated to the Trust Board via monthly 'highlight' reports with recommendations for action where appropriate.

4.3 Executive and Non-Executive / Associate Non Executive Committee members will be expected to ensure appropriate cross over with the work of other Trust Board sub-committees, to avoid adoption of incompatible strategies or plans, and eliminate duplication of workload.

4.4 The Committee will receive updates on a regular basis, in any appropriate format, regarding key drivers of financial and operational performance, including, but not exclusively:

- Contracting and income recovery
- Service strategy
- Operational and financial planning
- Savings and improvement programmes
- Digital Services strategies and plans
- Estates and Facilities strategies and plans

4.5 Where relevant, the Committee will seek assurance on relevant matters directly from operational staff, requiring attendance at meetings as required.

4.6 The Committee will agree an Annual Work Programme/Cycle of Business, which will be reviewed at each Annual Evaluation of the Committee.

5.0 Responsibilities

On behalf of the Trust Board, the Committee will:

5.1 Financial and Operational Performance

- Review and challenge construction of operational and financial plans for the planning period as defined by the regulators.
- Review, interpret and challenge in-year financial and operational performance.
- Oversee the development and delivery of any corrective action plans and advise the Trust Board accordingly.
- Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the Trust Board.
- Refer issues of quality or specific aspects of the Quality and Safety Committee's remit, and maintain communication between the two committees to provide joint assurance to the Trust Board.

5.2 Estates Strategy and maintenance programmes

- Review the delivery of the Trust's estates strategy and planned maintenance programmes as agreed by the Trust Board.
- Consider initiatives and review proposals for land and property development and transactions prior to submission to the Trust Board for approval.

5.3 Digital Strategy, Performance and Development

- Review the delivery of the Trust's Digital Strategy and planned development programmes as agreed by the Trust Board.

5.4 Capital and Other Investment Programmes and Decisions

- Oversee the development, management and delivery of the Trust's annual capital programme and other agreed investment programmes.
- Evaluate, scrutinise and approve the financial validity of individual significant investment decisions (that require Board approval), including the review of outline and full business cases.

Business cases that require Board approval will be referred to the Committee following initial review by the Trust Management Board or Capital Investment Board.

5.5 Cost improvement plans

- To oversee the delivery of the Trust's cost improvement plans and the development of associated efficiency and productivity programmes.

5.6 Business Development Opportunities and Business Cases

- Evaluate emerging opportunities on behalf of the Trust Board.
- Consider the merit of developed business cases for new service developments and service disinvestments prior to submission to the Trust Board for approval.

5.7 Review the Board Assurance Framework on a quarterly basis, giving consideration to the assurance provided, whether the key elements are appropriate in light of any concerns about which the Committee may be aware, and whether the underpinning risks provide sufficient assurance that the strategic risk is being appropriately managed, and undertake deep dives as per the committee's workplan.

5.8 Recommend appropriate responses and mitigation for risks linked to financial and operational performance, utilising the Trust Risk Register and associated assurance processes such as the Board Assurance Framework.

5.9 To review and approve strategies and policies~~, procedures and guidelines~~ relevant to the work of the Committee.

5.10 The Committee will agree an appropriate annual workplan (Appendix A), and monitor progress in delivering this plan through the year.

~~Review on behalf of the Trust Board annual and longer term financial plans, for revenue, capital and cash management, in line with the Trust's business planning cycle.~~

~~Review the agreement of service contracts to secure Trust income.~~

~~Provide assurance to the Trust Board that appropriate budgetary control arrangements are in place to monitor and deliver annual financial plans.~~

~~Review the Trust's performance against its annual financial plan and budgets, and monitor any necessary corrective action plans.~~

~~Review on behalf of the Trust Board the appropriateness of activity and operational performance targets and trajectories.~~

~~Review the Trust's operational performance against required thresholds, and recommend and monitor any necessary corrective action plans.~~

~~Provide overview and scrutiny in any areas of financial and operational performance.~~

~~Monitor the effectiveness of the Trust's financial and operational performance reporting systems, ensuring that the Board is assured of continued compliance through its reporting.~~

~~Provide assurance to the Trust Board that appropriate savings and efficiency improvement programmes are in place.~~

~~Review the Trust's delivery of agreed savings and efficiency improvements.~~

~~Ensure that financial and operational plans are consistent with Trust and service strategies.~~

~~Review critical linkages between financial and operational plans and workforce, IM&T and Estates and Facilities factors, to provide assurance to the Trust Board that plans are coherent and understood.~~

6.0 Membership

6.1 ~~Core~~ Voting Membership

6.1.1 The Committee will comprise:

- three Non-Executive Directors or Associate Non-Executive Directors
- Chief Operating Officer
- Chief Financial Officer
- Director of Estates and Facilities
- Chief Information Officer

6.1.2 Associate Non-Executive Directors to be included as core members of the Committee and to be counted towards quoracy and can be counted towards voting rights (where applicable).

6.2 Invited Non-Voting Member Attendance

Attendance required from:

- Deputy Finance Director
- ~~Chief Operating Officer~~
- ~~Director of Finance~~
- ~~Director of Estates & Facilities~~
- ~~Associate Director of Business Planning and Performance Management~~

6.3 Other Persons Attending Meetings

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

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

6.3.3 The Chief Executive has a right of attendance of all meetings of the Committee and may be included in the quoracy subject to agreement by the Chair.

6.3.4 An invitation to join the committee as an attendee will be extended to a Governor to be identified by the Lead Governor.

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

6.3.6 Executive Directors may on occasion invite other senior officers to attend the Committee, with the approval of the Committee Chair, to present specific items, or for developmental purposes.

6.3.7 The Director of Corporate Governance ~~Trust Secretary~~ may be in attendance at meetings as the agenda dictates.

7.0 Procedural Issues

7.1 Frequency of Meetings

Meetings will be normally be held monthly, in the week preceding the monthly meeting of the Trust Board.

7.2 Chairperson

One of the Non-Executive Director or Associated Non-Executive Director members of the Committee will be appointed as Chairperson, ~~the~~ others shall deputise in the~~ir~~ absence of the Chair.

7.3 Secretary

The Executive Director members ~~Chief Financial Officer~~ will agree in advance the agenda for each Committee meeting in conjunction with the Chairperson~~man, with input as required from other members of the Committee.~~ Secretarial support to the Committee will be provided from the Directorate of Finance.

7.4 Attendance

7.4.1 Each core member of the Committee should attend at least 75% of meetings in any given annual cycle. Each core Executive Director must ensure that in his/her absence, a nominated deputy is briefed to present required information and to respond to scrutiny on his/her behalf.

7.4.2 Executive Directors who are unable to attend will arrange for the attendance of an appointed deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend. Formal deputies appointed can attend up to 25% of all meetings.

7.4.3 For Joint Trust roles, such as the Chief Financial Officer or any such role, the attendance required is 50% of Committee meetings with appointed deputies covering the remainder of meetings.

7.5 Quorum

7.5.1 The Committee will be deemed to be quorate when there is attendance by at least two Non-Executive Directors / Associate Non-Executive Directors and two Executive Directors, one of whom must be either the Chief Financial Officer or the Chief Operating Officer.

7.5.2 Formally appointed deputies will be counted towards quoracy and have voting rights (where applicable).

7.5.3 A quorum must be maintained at all meetings.

7.6 Administration and Minutes of Meetings

7.6.1 Minutes of meetings will be circulated with the agenda papers to all members well in advance of each meeting but no less than ~~3~~ seven ~~working~~ calendar days before each meeting. In addition to the circulation of minutes, the 'action log' of actions agreed at each meeting will be circulated following each meeting

7.6.2 Agenda items for consideration to be submitted 12 calendar days before the meeting.

7.6.3 Submission of papers to members should take place seven calendar days before the meeting. Late papers may be submitted at the discretion of the Chair.

7.7 Decision Making

7.7.1 Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.

7.7.2 Where this is not possible then the chair of the meeting will ask for members to vote using a show of hands, all such votes will be compliant with the current Standing Financial Instructions and Scheme of Delegation of the Northern Lincolnshire & Goole NHS Foundation Trust.

7.7.3 In the event of a formal vote the chair will clarify what members are being asked to vote on – the 'motion'. Subject to meeting being quorate a simple majority of members present will prevail. In the event of a tied vote, the chair of the meeting may have a second and deciding vote.

7.7.4 Only the members of the Committee present at the meeting will be eligible to vote. Members not present and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

7.7.5 The Trust's Standing Orders and Standing Financial Instructions apply to the operation of this Committee.

7.7.6 Decisions which are outside of the Scheme of Delegation will be escalated to the Trust Board with the findings and recommendations of the Sub Committee for action at board level.

7.8 Monitoring, Compliance & Effectiveness

7.8.1 In accordance with the requirements of good governance and in order to ensure its ongoing effectiveness, the Finance and Performance Committee will undertake an annual evaluation of its performance and attendance levels.

7.8.2 A performance evaluation tool, which reflects the requirements outlined within this Terms of Reference, has been developed for this purpose. As part of this evaluation, the committee will formally review the:

- Performance against core duties
- Completion of the actions outlined in the action log
- Effectiveness of the Annual Work Programme

7.8.3 Where gaps in compliance are identified arising from this evaluation, an action plan will be developed, and implementation will be monitored by the Committee.

7.8.4 The results from the annual evaluation exercise, including any agreed actions, will be reported to the Trust Board.

7.9 Review

These Terms of Reference will be reviewed every year at the time of the annual performance review of the committee or sooner should the need arise.

8.0 Equality Act (2010)

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

8.2 The Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

8.3 The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

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

Office of the Director of Corporate Governance ~~Trust Secretary~~, NL&G NHS Foundation Trust.

Appendix A

Committee Name

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committee Workplan Template

Item of Business	Committee Oversight	BAF Requirement	Reference to TOR	Trust Priority	Delivery Method	Frequency	Lead	20xx									20xx		
								Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
SECTION HEADING																			
SECTION HEADING																			

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)215

DATE OF MEETING	5 October 2021
REPORT FOR	**Trust Board of Directors**
REPORT FROM	Lee Bond, Chief Financial Officer
CONTACT OFFICERS	Brian Shipley, Deputy Director of Finance Zoe Plant, Head of Contracting & Costing
SUBJECT	**H2 Planning Process**
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee – 25 August 2021
EXECUTIVE SUMMARY	This paper highlights the approach to the business planning process for H2 and then preparation for 2022/21 acknowledging that guidance on plans has not yet been received.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	SO1 – 1.2 SO3 – 3.1 & 3.2 SO4				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
			✓		✓

Business Planning Process

Introduction

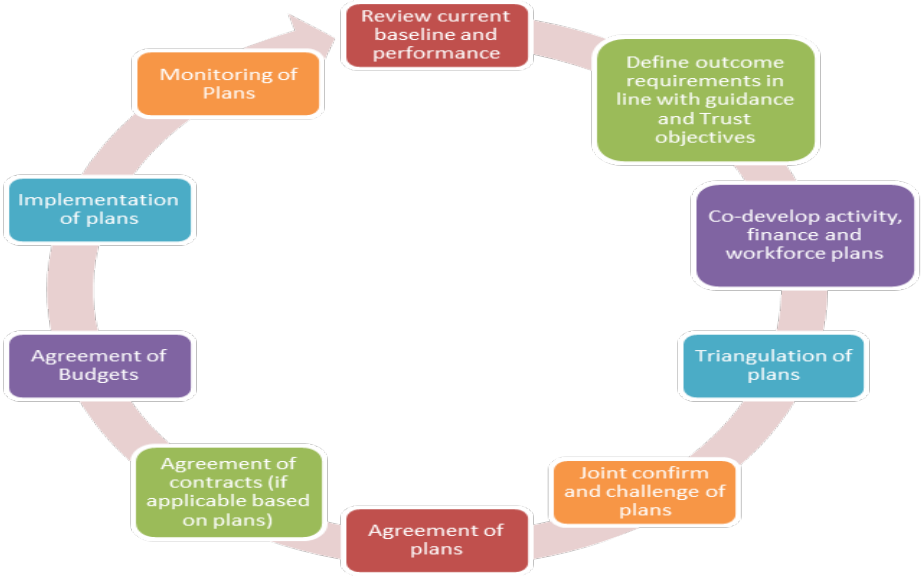
As the Trust enters the final weeks of the H1 (April 2021 to September 2021) planning period attention needs to turn to planning for H2 (October 2021 to March 2022). In the absence of detailed NHS Planning Guidance for H2 the Trust is looking to develop its own planning process which will dovetail with the guidance once it emerges.

Aim

The aim of this process is to produce a congruent plan, co-produced by the operational & corporate teams, which is in line with agreed assumptions and delivers against our corporate objectives.

Methodology

The business planning process



Business planning preparation and work in progress

- Activity
  - Monitoring against the H1 plan will continue to ensure that we have a clear picture of current performance and a clear understanding of the waiting list position. This includes the following
    - weekly planning meetings
    - weekly reports available on Power Bi to monitor activity v plan
    - formal month end monitoring with detailed narrative from all specialties on delivery and plans for month ahead
  - The divisions are developing detailed plans which will look to reduce our waiting lists such that we will have no patients waiting longer than 40 weeks and less than 9000 overdue outpatient follow ups by the end of the financial year (currently 2047 patients waiting over 40 weeks and 27,894 overdue follow up appointments)
  - Plans are being constructed in the following categories
    - Activity that can be done within current resources
    - Activity that can be done internally with additional resources
    - Activity that we have commissioned from the Independent sector from insourcing and outsourcing.
    - Additional activity that we need to commission from the Independent sector
    - Changes in activity due to transformation and or HASR – Interim Clinical Plan impact.

- A submission of activity that we can contract from the Independent Sector (IS) in H2 is currently being finalised.
- These plans are currently undergoing an initial confirm and challenge sessions with Divisional Groups to ensure we are not duplicating any recovery contracts already in place and that we can articulate the rationale for the various assumptions that have been used to formulate the plan.

- **Finance**
  - An analysis of income and expenditure starting with the 19/20 outturn position has been prepared so that the underlying run rate deficit of the Trust can be widely understood.
  - Pivotal to this work will be an assessment of the income that can be earned via the Elective Recovery Fund (ERF). In order to qualify for this income the Trust must deliver a minimum of 95% of its 19/20 activity baseline. Work is currently underway to ensure that our internally resourced capacity delivers a minimum 98% of the 19/20 baseline.
  - Work is also underway to ascertain changes in pathways and services that will affect the financial position in each division due to the HASR Interim Clinical Plan.
  - Cost improvement plans for the entire year were developed as part of the H1 period. There is still a small, unidentified element within the plans and some concern over the recurrent nature of the plans. However, the bigger issue concerns the widely trailed expectation of a significantly larger efficiency ask in H2. Guidance in this area is expected at the end of August. Once this is known we can assess the size of the gap that might exist.
  - Divisional business plans were produced before the start of the financial the year and included business cases for service developments and cost pressures. These business cases will need to be reviewed as part of business planning process to see if they remain appropriate. It is unlikely that there will be new funding for these so they will need to be self-funding or part of a 'place' scheme that will be cost neutral across partners. A more robust and comprehensive planning process for both revenue and capital developments will be introduced in the 3rd quarter of this year as part of planning for 2022/23.
- **Workforce**
  - The workforce team is currently pulling together a collective reporting methodology which includes the required responses for business planning and responses to the ICS on the people strategy to avoid duplication and ensure that they are consistent.
  - The methodology used in H1 will be replicated with a close working approach with Divisions to understand any large-scale change programmes, establishment shifts etc and then overlapped with the known recruitment pipeline and turnover to give us a forecast.
  - A major plank of this planning work will be the conclusion of a Trust wide establishment review of our nursing workforce which has been underway for a number of weeks now. The output of that process, and any funding considerations will be a key feature of the H2 planning process
  - Workforce narrative will be in-line with our People Strategy reporting.

Next Steps

Once the initial confirm and challenge process has been undertaken and the activity numbers finalised, the financial value of the plan can be worked through to assess the potential for earning the additional Elective Recovery Fund (if this is still available) to see how this will impact on the overall financial plan. Until the new guidance and financial regime is known, any work on this will be based on assumptions, but early indications whether the activity plan will generate additional funding will be assessed as per the rules being applied to H1 Elective Recovery Fund.

Although the overall plan is not due for submission until early November, the Trust is planning to use this time to ensure the activity plans are robust and that the organisation is in a position to deliver the plans from the very start of the period. This process is being co-ordinated at the Thursday morning Business Planning meetings which has representatives from Operations, Finance, Information, and Workforce. Key stakeholders from these meetings will also be involved with joint meetings with other partners.

Triangulation

Once the activity, finance and workforce plans have been prepared a triangulation exercise will be undertaken to ensure that the individual submissions are all congruent and that they are in line with the agreed assumptions and deliver the desired outcome.

- A presentation/paper will then be prepared to detail the final outcomes and summaries of each element to assist in getting final sign off internally and externally with a narrative to support the plan. Depending on the guidance this will likely include the following -
    - Introduction
    - Agreed assumptions
    - Methodology and governance
    - High level activity table with narrative
    - High level impact on waiting lists
    - High level finance table with narrative
    - High level CIP table with narrative
    - High level workforce table with narrative
    - Risks and mitigations narrative
- This presentation paper will then be presented to Finance and Performance Committee and the NL & NEL Joint Planning meeting.

Joint Working

Business Planning meetings have been put in the diary with the local CCG fortnightly on a Friday morning to provide a forum to discuss the plans and ensure that all the transformation work is appropriately reflected in the relevant providers. This forum has worked effectively in previous years and was seen by the region as an excellent way of ensuring that plans are 'owned' by key stakeholders at 'place' and that transformation projects and assumptions are co-produced and agreed.

Contracts

If applicable, NHS standard contracts will be put in place that agree with the plans produced. Updated Provider to Provider contracts will also need to be negotiated and agreed to ensure they reflect any changes in service delivery. It will be necessary to ensure that Independent Sector contracts are in place to deliver the additional activity in the agreed plans.

Trust Budgets

Budgets will be agreed with divisions and directorates based on submitted plans that will include income, expenditure and cost improvement plans. A formal H2 Budget proposition will be presented to TMB and Board for approval in line with best practice.

Monitoring

All the plans will be monitored monthly against actual delivery for internal and external reporting. Associated performance in particular progress against reducing waiting lists will also be monitored regularly to check that we are achieving our outcome targets.

Recommendation

The Trust Board is asked to note the proposed business planning cycle, current work in progress and future tasks to ensure the timely delivery of the plans. Updates will be provided at subsequent meetings once guidance has been received and first draft plans have been constructed.

Annex A

NLaG internal planning timetable for H2 (October 2021 - March 2022)		
Key milestone	**Detail**	**Date**
Independent Sector submission		**19/08/2021**
Development of activity / workforce plans	Weekly planning meeting	19/08/2021
Planning update paper	**F&P committee**	**25/08/2021**
Executive confirm & challenge of activity plan to date	Executive led planning & performance meeting	26/08/2021
Development of activity / workforce plans	Weekly planning meeting	02/09/2021
Planning update paper	**TMB**	**06/09/2021**
Development of activity / workforce plans / revision of waiting list trajectories	Weekly planning meeting	09/09/2021
Transformational projects, planning assumptions	Joint NL planning meeting	10/09/2021
2021/22 Operation Planning Guidance & 2021/22 Financial and contracting guidance (H2) publication		**16/09/2021**
Executive confirm & challenge of activity plans / trajectories	Executive led planning & performance meeting	16/09/2021
Planning update paper	**TMB**	**20/09/2021**
Review of plans against H2 guidance	Weekly planning meeting	23/09/2021
Transformational projects, planning assumptions	Joint NL planning meeting	24/09/2021
Planning update paper	**F&P committee**	**29/09/2021**
	Weekly planning meeting	30/09/2021
Planning update paper	**TMB**	**04/10/2021**
Planning update paper	**Trust Board**	**05/10/2021**
	Weekly planning meeting	07/10/2021
	Joint NL planning meeting	08/10/2021
Workforce, Activity & Performance (SDCS) submission window & functional templates issued		**14/10/2021**
	Weekly planning meeting	14/10/2021
Planning update paper - ? Sign off plan	**TMB**	**18/10/2021**
	Weekly planning meeting	21/10/2021
	Joint NL planning meeting	22/10/2021
Planning update paper - ? Sign off plan	**F&P committee**	**27/10/2021**
	Executive led planning & performance meeting	28/10/2021
	Weekly planning meeting	04/11/2021
Finance - System submission window		**08/11/2021**
Planning update paper	**TMB**	**08/11/2021**
Workforce, Activity & Performance (SDCS) submission window closes		**11/11/2021**
Finance - System submission window closes		**11/11/2021**
	Weekly planning meeting	11/11/2021
	Joint NL planning meeting	12/11/2021
	Weekly planning meeting	18/11/2021
Finance - Provider submission window		**22/11/2021**
Planning update paper	**TMB**	**22/11/2021**
Planning update paper	**F&P committee**	**24/11/2021**
Finance - Provider submission window closes		**25/11/2021**
	Executive led planning & performance meeting	25/11/2021
	Joint NL planning meeting	26/11/2021
Planning update paper	**Trust Board**	**07/12/2021**

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)216

DATE OF MEETING	5th October 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Ivan McConnell, Director of Strategic Development
CONTACT OFFICER	Kerry Carroll, Deputy Director of Strategic Development Claire Hansen, HAS Programme Director
SUBJECT	**Executive Report - Strategic & Transformation**
BACKGROUND DOCUMENT (if any)	Submission of Humber Hospitals £720 million Expression of Interest in the DHSC Health Infrastructure (Future Hospitals) Plan *(refer to agenda item NLG(21) 217)*
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The attached report provides the Board with an update and overview of our progress against the delivery of: **Strategic Objective 4 – To work more collaboratively** The attached template provides the highlights, lowlights and risks against the Trust Priorities 4 and 9. The Board is asked to note: • The progress that is being made on the delivery of the Humber Acute Services critical milestones of both Programme 1 Interim Clinical Plan and Programme 2 Core Service Change • The progress that is being made on the development of a Capital SOC to support major capital investment within NLAG and HUTH and the recent submission of the Expression of Interest *(refer to agenda item NLG(21) 217* • Our continued participation in and leadership of collaborative ventures through partnership working

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	**Strategic Risk 8:** Inability to pursue a clear organisational strategy that staff and stakeholders are aware of and support **Strategic Risk 9:** Lack of an integrated ICS, Humber system, service and organisational sustainability including the ability to attract inward investment and Trust clinical strategy which delivers long term				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			✓

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

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

- With Hull University Teaching Hospitals, we will complete the Interim Clinical Plan ***(programme 1)***
- With partners in the Humber Acute Services Review, we will engage fully in leading and supporting the development by the end of 2021 of a Pre-Consultation Business Case (PCBC) for the delivery of new models of care for ***(programme 2) linked to submission of a Capital EOI and Pre SOC (Programme 3) for:***

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

Trust Priority 9: Partnership and System Working

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

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

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

Highlights	Lowlights	Risks
Overall • Implementation of Joint Development Board to report to Committees in Common between both NLAG and HUTH to oversee Programme 1 – Interim Clinical Plan • Submission of the Humber Hospitals £720 million Expression of Interest (EOI) to the DHSC Health Infrastructure (Future Hospitals) Plan on 9/9/21 • Gateway reviews successfully progressing including formal Independent Clinical Reviews for Programme 2 • Circa 8000 responses received through the What Matters to You engagement • Agreement of Primary/Secondary Care Interface Groups as link for Primary Care • Informatics scope agreed (GIS Process and model agreed across programme) • Finance team workshop held • ICS Digital workshop held • Comms framework prepared **Programme 1:** • 4/10 Humber clinical leads appointed and in post • Strategy workshops for all phase 1 specialties held and drafts being prepared for approval • MoU and SLA finalised – subject to legal sign off • Activity, contracting and finance processes all mapped through for Neurology and plan for change completed for approval as test specialty • **Programme 2:** • Continued programme of workshops and focus groups for all 3 programmes as we progress into evaluation phase • Data cycles and evaluation including Out of Hospital integration and impact continues • Engagement with, Ambulance (EMAS/YAS), Voluntary Sector to support options development and evaluation • System wide Transport workshop held in September to develop future opportunities aligned to HASR longer term options • Mental Health workshop scheduled for October to work through issues and opportunities	• Complicated acute review spanning all programmes and aligning to out of hospital and community diagnostic changes • Challenges of continuous engagement and involvement / time commitments for busy operational staff (including key clinical leads during recovery phase) • Capital funding sources not yet agreed	• Alignment of PCBC and Capital SOC – Strategic and Economic Case to ensure successful completion of NHSE/I Gateway 2 Process • Pathways in P2 look beyond hospital boundaries and require OOH transformation • Potential options may be subject to OSC, Public challenge resulting in IRP Review, JR or SoS review • Potential options may displace activity to neighbouring health economies • Aligning all out of hospitals programmes to avoid duplication

- Second review/confirm and challenge of UEC undertaken by Reg Clin Director UEC and Reg Clin Director Primary Care
- Engagement with ICS, HEE and NHSE/I National workforce planning leads on areas to consider for future healthcare skills planning and workshops scheduled for November across all key stakeholders to develop
- Continues engagement with Doncaster and Lincoln health systems re potential displacement activity and EMAS/YAS in terms of potential pathway changes
- Engagement with Primary Care Networks aligning to Out of Hospital programmes in place
- NHSE/I monthly assurance review continue with positive challenge and support
- Pre Consultation Business Case framework progressing at draft level populating the following areas in readiness for co-production through to December:
    - Case for Change
    - PH Data
    - Options – Case for change, benefits, pathways, patient and staff impact, evaluation
- Evaluation Criteria Framework in place to progress to evaluation of the options throughout October/November
- Clinical Senate reviews being scheduled for November including evaluation
- Clinical Interdependencies workshops held to define the UEC and Maternity, Paediatrics requirements (system wide)
- Geographical Intelligence System (GIS) spacial mapping in development for the options alongside additional BI data modelling for Planned Care and Diagnostics

Programme 3

- Following submission of EOI, workshops scheduled to progress the development of the Capital SOC aligned to the PCBC
- 5-10 year modelling progressing with agreed assumptions linking to PCBC

- The delivery of changed pathways will require capital investment in digital as well as wider infrastructure
- Planned care pathways must align to wider ICS CDH programme implementation
- Potential further COVID wave and ability to continue with engagement and evaluation of key stakeholders
- Capacity to roll out activity, contracting and finance processes to other specialties in P1

Trust Priority 9: Partnership and System working

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

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

NLG(21)217

DATE OF MEETING	5th October 2021
REPORT FOR	Trust Board
REPORT FROM	Ivan McConnell, Director of Strategic Development
CONTACT OFFICER	Ivan McConnell, Director of Strategic Development
SUBJECT	Capital Investment Expression of Interest
BACKGROUND DOCUMENT (if any)	Expressions of Interest (attached)
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	✓ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: ICS, CCGs, HASR EOG and CDG
EXECUTIVE SUMMARY	The Trust Board is asked to note that the Trust in partnership with Hull University Teaching Hospitals NHS Trust has submitted an Expression of Interest (EOI) for capital investment through the national hospitals programme. The EOI was submitted as part of the Humber Acute Services (HAS) Programme and has support from CCGs and the Humber Coast and Vale ICS. NHSE/I Regional team have been engaged during the development process and have supported the application as funding will be required if we are to deliver the objectives of the Core Service Change element of HAS Services. The submission also has local authority support. The EOI is a portfolio submission totalling £720m, including: • £350m Scunthorpe General Hospital • £250m Hull University Teaching Hospitals • £120m Diana princess of Wales The Expression of Interest will now be subject to national review by DHSC and NHSE/I. We have been advised that the process may now take two stages – as yet to be confirmed – • Reduce to a long list of applications, c30 • c30 asked to submit SOC document • SOCs to be evaluated and a final shortlist of 8 selected It is anticipated the process will be complete by end of March 22.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4	✓ 1 - 1.5 ✓ 1 - 1.6 ✓ 2 ✓ 3 - 3.1	✓ 3 - 3.2 ✓ 4 ✓ 5 ☐ Not applicable		
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Department of Health & Social Care

Health infrastructure plan: future new hospitals – expression of interest template for NHS organisations

Published 15 July 2021

Guidelines to trusts

Completing the form

Trusts should submit their completed expression of interest form to futurenewhospitals@dhsc.gov.uk by midday on 9 September 2021.

Please note the above mailbox is only for template submissions and/or questions from trusts relating to this stage of the process. Any other queries should be routed to the Department of Health and Social Care (DHSC) correspondence centre and media queries to our press office.

Trusts should submit information in the template proforma and conform to the word limit. Submissions above the word count will not be considered.

No additional information will be accepted or considered as part of this stage of the selection process, outside of this proforma.

No external funding or resource should be used to prepare the case and no additional pre-prepared documentation will be accepted.

Trusts are permitted to submit more than one form (for example for different sites) but must indicate how each proposal affects the trust as a whole and any dependencies between proposals as well as the site-based approach.

Important notes

Cost and savings estimates are only requested to give an early indication of the likely scale of investment required. We appreciate that many schemes will be put forward at the very early stages of development and so precise cost or savings estimates may not be available. We will only use estimates at this stage to understand the broad order of magnitude of costs of potential schemes in the pipeline and any key assumptions being made.

These costs estimates do not equate to a bid for this amount of funding. The ultimate size, scope and cost of shortlisted proposals will be determined in conjunction with the new hospital programme.

Savings estimates could reflect initial assumptions at this stage about efficiency as a result of any investment, for example reductions in backlog maintenance, land disposals, high level floor space and bed data if available.

Please note by submitting this information to the Department of Health and Social Care, you are agreeing that they are permitted to share the form or extracts of it with relevant officials in NHS England and NHS Improvement and their regional teams, and HM Treasury, on an OFFICIAL-SENSITIVE-COMMERCIAL basis.

Next steps

This summary information will form one part of the first stage of the process. It will be combined with evidence from existing national datasets (official data, signed off by provider chief executives) as well as discussions with regional and local NHS leaders. The later stage of the selection process in autumn or winter 2021 will allow for more detailed discussions and further evidence to be provided, if appropriate.

We hope to inform trusts of the outcome of this first stage, including more detail on the later selection process, during autumn 2021. The outcome of the first phase will be a longlist of proposals to continue to stage 2.

We aim to make the final decision on the next 8 hospitals to form part of the national programme by spring 2022.

Expressions of interest – form for completion

New hospital criteria

A whole new hospital site on a new site or current NHS land (either a single service or consolidation of services on a new site).

A major new clinical building on an existing site or a new wing of an existing hospital (provided it contains a whole clinical service, such as maternity or children's services).

Trust type

Acute
Community

Region

North East and Yorkshire

Trust name

Hull University Teaching Hospitals NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust

Site covered

Scunthorpe General Hospital
Hull Royal Infirmary
Castle Hill Hospital
Diana Princess of Wales Hospital, Grimsby

Indicative cost of scheme [241 words]

Our proposed capital scheme is based upon a portfolio application across two providers/four sites, where we need to rebuild or redevelop our failing infrastructure to implement new models of care and ensure that, as "Anchor" organisations, we fulfil our commitment to local regeneration and economic growth in some of the most deprived areas in the country.

Our portfolio, in priority order, is:

- Rebuild of Scunthorpe General Hospital – on a brown field site with improved access and use of green wire to reduce carbon emissions - £350m
- Redevelopment of medicine and surgery facilities at Hull Royal Infirmary with an aligned Elective/Day Case Hub at Castle Hill Hospital developing it as a specialist elective centre - £250m
- Redevelopment of Diana Princess of Wales Hospital, Grimsby (existing site) – improving access and care quality - £120m

Projected capital costs are based on April 2021 figures. The projected cost (£6,000/m^2) has been benchmarked against outturn costs for a number of our recently completed schemes and includes provisions for Net Zero compliance, enhancement of digital capability and potential changes to the scope of the scheme in the planning period.

Our capital requirements are based upon the detailed work we have undertaken on our Humber Acute Services Transformation Programme, which includes:

- "Left Shift" of activity from hospital to community settings
- Reducing inpatient bed numbers through the use of SDEC and AAU pathways
- Making increased use of community-based diagnostics
- Creating split facilities – Unscheduled Care and Green Elective/Day Case Hubs

Indicative savings of scheme [245 words]

Our proposed service transformation and capital investment programme will achieve an annual revenue cost saving of £36.4m (net of capital charges). Under the 'do minimum' option, the additional revenue cost associated with managing increased acute hospital workloads will be £437.4m/year (at Year 15). Under the proposed approach, the corresponding revenue cost increase would be reduced to £401.0m/year. In determining the overall revenue cost implications, provision has been made for appropriate investment in primary and community care to support service transformation/'left shift'.

	Additional Annual Revenue Costs		
Category	**Do Minimum**	**Proposed**	**Variance**
Service delivery - direct costs	£416.4m	£377.7m	-£38.7m
Equipment maintenance costs	£1.0m	£4.0m	£3.0m
FM costs	£19.9m	£19.2m	-£0.7m
Sub Total	***£437.4m***	***£401.0m***	***-£36.4m***
Cost of capital @3.5% pa	£5.4m	£22.4m	£17.0m
Depreciation costs	£4.7m	£23.1m	£18.4m
Sub Total	***£10.1m***	***£45.5m***	***£35.4m***
Grand Total	**£447.5m**	**£446.5m**	**-£1.0m**

Our proposed service transformation programme requires capital investment of £720m. Under the 'do minimum' scenario significant capital expenditure (£100m) would be required to increase capacity in the acute sector. Further investment would be required to keep our buildings serviceable, including an unavoidable investment of £59m to address known Critical Infrastructure Risks. Addressing all known Backlog Maintenance issues (including CIR), would require an overall investment of £105m.

Hospital Site/Building	**BLM Value**	**CIR Element**
SGH	£60m	£28m
HRI (tower block)	£17m	£12m
DPoW	£28m	£19m
Grand Total	**£105m**	**£59m**

Supported by our Local Authorities and LEPs we have undertaken initial analysis to quantify the wider economic and social impact of our proposed investment. This has shown that the proposed investment will facilitate economic growth and create social value in our local communities, resulting in a net financial benefit of £1.58bn across the Humber.

Status of plans and engagement to date with partners [248 words]

Without capital investment our Humber-wide acute service collaboration and plans for sustainable clinical services will not be deliverable.

Our capital options are based upon the emerging models of care within the Humber Acute Services programme, which will deliver a Pre-Consultation Business Case in December 2021. Formal consultation will be undertaken from May 2022, subject to NHSE/I and Clinical Senate approval. A "pre-SOC document" for capital investment is being developed in parallel ensuring full alignment. This vanguard work on PCBC/SOC alignment, supported by NHSE/I, will inform the development of new national planning guidance.

We have undertaken extensive public, patient and staff engagement:

- What Matters to You (4000 people) – identifies timely access as a priority
- Birthing Choices (1150 people) – identifies co-located maternity units as a priority
- Clinical redesign workshops (700+ primary, community and secondary care staff)
- OSC and representative engagement
- Clinical Senate, GIRFT, College and NHSE/I workshops

We have established a Capital Advisory Board with representatives of Hull and Lincoln Universities, Hull & East Riding and Lincolnshire LEPs, and our Local Authority partners, who all strongly support our proposals. We have also strengthened our provider governance – HUTH and NLaG have established Committees in Common to oversee our collaboration.

Our plans are well advanced, our options for future service delivery are sustainable and reflect what we have heard from our stakeholders. Our proposed programme of capital development has been designed to facilitate a flexible, agile and lean approach to design, procurement and delivery. We are ready to move forward at pace.

Summary of scheme [247 words]

Our proposed capital scheme is a portfolio application across two trusts/four sites. The scheme is critical to delivering clinical transformation across the region and is closely aligned to out-of-hospital developments (specifically, the ICS strategy for the development of community diagnostic services, including new Community Diagnostic Hubs in Scunthorpe, Hull, Grimsby and York) and local regeneration strategies (specifically, the Scunthorpe Towns Deal plan and Hull City Council's master-planning exercise for the Anlaby Road area).

Our portfolio, in priority order, is:

1. Scunthorpe Hospital:
    - Hospital rebuild on a campus site (town centre location identified with North Lincolnshire Council)
    - Development of split emergency and elective/day case hubs

- Optimised digital infrastructure
- "Green wire" providing energy from waste site
- Aligned research/training facilities

2. Hull University Teaching Hospitals:
    - Partial-rebuild and refurbishment of Tower Block
        - Three new-build ward blocks to deliver improved facilities for medicine/surgery
        - Refurbishment of Tower Block as office accommodation (aligned to One Public Estate)
    - New-build day case theatres at Castle Hill Hospital, developing it as a specialist elective centre

3. Diana Princess of Wales Hospital, Grimsby
    - Partial-rebuild of existing site
    - Aligned to Grimsby Town Centre regeneration plans
    - Development of split emergency and elective/day case hubs

Our portfolio application will enable both trusts to increase their levels of clinical collaboration, delivering improved patient experience and a more integrated service offering. By delivering significant clinical service reconfiguration across urgent and emergency care, maternity, paediatric and neonatal services, planned care and diagnostics we will deliver national guidance, whilst also improving patient access and experience.

Expression of interest – statement [750 words]

Improved Outcomes

Our population needs us to change fundamentally the way we provide acute care – our current service configuration is not meeting their needs and our current infrastructure does not support modern models of care. By working collaboratively to make best use of staff, skills, buildings and equipment, our proposed clinical changes will deliver upper decile performance and make it easier for patients to get the care they need.

We will move services that do not need to be in hospital closer to patients' homes, building on successes in Frailty and Cardiology pathways where this "left shift" of activity is already improving access and outcomes for patients and actively addressing health inequalities through provision of proactive or anticipatory care. We will invest in digital technology, implementing interoperable systems, Command Centres, robotics and AI, in line with the ICS Digital Strategy.

These changes will deliver wide-ranging benefits:

	Benefit	**Mechanism**
Urgent and Emergency Care	length of stay ↓ hospital bed numbers ↓	implementation of SDEC and AAU models
	hospital attendances ↓	enhanced use of community assets "hear and see and treat"
	efficiency/productivity ↑	use of Advanced Care Practitioners enhanced use of digital

Maternity, Paediatrics and Neonatal	neonatal capacity in HUTH ↑	repatriating some Northern Lincolnshire cases from Sheffield
	Royal College standards ✓	responding to workforce challenges
	Choice ✓	potential to implement co-located maternity units
Planned Care and Diagnostics	support elective recovery ✓	stand-alone Elective/Day Case Hubs protecting elective theatre time
	efficiency/productivity ↑	improved patient flow
	improved access ✓	pathways aligned with implementation of Community Diagnostic Hubs

Stronger, Greener Buildings

Our proposed investment programme will enable us to provide a hospital estate that is smart, flexible, able to cope with serious outbreaks of infection and the effects of climate change, energy efficient and environmentally sustainable.

Our current infrastructure has not coped well during the Covid-19 pandemic. Infection prevention and control measures have resulted in reduced bed numbers, treating patients in pop-up facilities and other sub-optimal solutions. Backlog maintenance across our sites totals £105m and in some instances over 82% of our infrastructure is at risk of imminent failure or requires major repair or replacement.

Our proposals do not implement a like-for-like hospital build. Instead, they will deliver smarter, more flexible buildings, split unscheduled care from elective/day case work, deliver single rooms, isolation rooms and small bays to optimise patient flow.

Our investment will deliver on our emerging ICS Green Plan delivering carbon reduction, energy efficiency, clean air, and biodiverse local environments. We will capitalise on our unique opportunity to use the academic and commercial expertise in renewable energy that is concentrated in the Humber region. The site identified for the rebuild of Scunthorpe Hospital will utilise “Green Wires” to deliver energy directly from renewables in partnership with the Local Authority. We will use modern methods of construction across the portfolio, resulting in reduced cost and improved environmental sustainability. We will maximise the use of technology in building design and operation, enabling us to reduce bed numbers, reduce staff and patient travel and implement alternatives to admission.

Levelling Up Humber

Our economic and social impact assessment has shown that our investment of £720m in healthcare infrastructure will deliver £1.58 billion in social profit to our local communities. Serving some of the most deprived areas of the country, with lower-than-average life expectancies and some of the worst public health outcomes nationally. This significant social benefit is critical to delivery of our ICS’s ambitious levelling-up commitment.

Our proposed investment is backed by a strong “Anchor Network” across the region and is integral to the delivery of regional regeneration strategies, Local Authority Master Plans and Town Deals. Planning has been undertaken collaboratively with Local Authorities and wider partners (Universities, LEPs), adopting a “One Public Estate” approach, to ensure maximum return on

investment, leveraging wider economic benefits through increased private sector investment in allied industries.

We are working with partners to exploit the benefits of the Humber's forthcoming Freeport status, leveraging investment into MedTech and health research, and developing an innovation collaborative in partnership with the Universities of Hull and Lincoln.

Working with education and skills providers, we are committed to building a skilled local workforce, harnessing apprenticeships, career passports, rotational posts, and shared career pathways. We have strengthened our university relationships and are working on improved strategic workforce planning in partnership with HEE. We will improve health, social and economic wellbeing by supporting the creation of high-quality jobs and improved cross-sectoral career prospects encompassing health and care, construction, engineering, research and innovation.

Working collaboratively, we are seeking to build better places and better prospects for our population.

Declaration

I confirm that the information in this form is accurate at the time of completion and that I have appropriate executive approval from my trusts to submit this expression of interest.

Yes

Name: Ivan McConnell

Role: Director, Humber Acute Services

Email address: ivan.mcconnell@nhs.net

Phone number: 07544 378201

Date approved by trust boards: 26 August 2021

Glossary of terms

AAU	Acute Assessment Unit
AI	Artificial Intelligence
BLM	Back-log Maintenance
CIR	Critical Infrastructure Risk
DPoW	Diana Princess of Wales Hospital, Grimsby
GIRFT	Getting It Right First Time
HEE	Health Education England
HRI	Hull Royal Infirmary
HUTH	Hull University Teaching Hospitals NHS Trust
ICS	Integrated Care System
LEP	Local Enterprise Partnership
NLaG	Northern Lincolnshire and Goole NHS Foundation Trust
OSC	(Local Authority) Overview and Scrutiny Committee
PCBC	Pre-Consultation Business Case
SDEC	Same Day Emergency Care
SGH	Scunthorpe General Hospital
SOC	Strategic Outline Case

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)218

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee
CONTACT OFFICERS	Ellie Monkhouse – Chief Nurse Dr. Kate Wood – Medical Director
SUBJECT	HTF Trustees' Committee Highlight Report – 16 September 2021
BACKGROUND DOCUMENT (if any)	HTF Trustees' Committee ToRs
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None
EXECUTIVE SUMMARY	The attached highlight report summarises key issues presented to, and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 16 September 2021 and worthy of highlighting to the Public Trust Board.

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

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

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

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5 October 2021
Report From:	Health Tree Foundation Trustees' Committee held on 16 September 2021

Highlight Report:

Fusion Biopsy Machine

- The Committee finally approved the purchase of a Fusion Biopsy machine and an accompanying Ultrasound machine for the Trust's Urology Service. The sum of £79,785 was granted, following extensive trials of three sets of equipment, prior to making the final decision. All required departmental approvals have been obtained and the new acquisitions will be sited at Goole. This will not only enhance GDH services but also allow benefit patients across the ICS in concert with partner trusts.

Confirm or Challenge of the Board Assurance Framework:

Not Applicable

Action Required by the Trust Board:

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

Neil Gammon
Independent Chair of Health Tree Foundation Trustees' Committee

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NLG(21)219

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Linda Jackson, Acting Chair
CONTACT OFFICER	As above
SUBJECT	Committees in Common Highlight Report and Board Challenge – Humber Acute Services Review Development Committee – August 2021
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	The same report has been presented to the Hull University Teaching Hospital NHS Trust
EXECUTIVE SUMMARY	The report provides an update from the Committees in Common meeting held in August 2021

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Strategic Objective 4 – To Work More Collaboratively				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Report to the Board in Public
Humber Acute Services Development Committee held on 26 August 2021

Item: Director Overview Report	Level of assurance gained: Good
Ivan McConnell presented the overview and advised that programmes 1 2 and 3 were progressing well with ongoing reviews from the Clinical Senate. NHS E/I were also carrying out formal reviews and providing friendly and critical challenge. From a governance point of view the Committee in Common had agreed its Terms of Reference and received any issues of escalation from the Programme Board or the Executive Committees at both Trusts.	
Item: Capital Expressions of Interest	Level of assurance gained: Good
The proposed submission for the Humber ICS was a full redevelopment of the Scunthorpe hospital, new ward blocks for HRI and CHH and a full redevelopment of Grimsby hospital. This would mean that services could become more flexible for patients. There were 8 schemes available and 30 bids from Trusts had been submitted so far.	
Item: Programme 1 MOU/SLA Update	Level of assurance gained: Good
The wording in the SLA document had been updated to reflect the Clinical Negligence statement of which Trust was liable and this was accepted by the CCG and Capsticks Solicitors. The MOU is also aligned with the SLA.	
Item: Oncology Update	Level of assurance gained: Good
So far the work delivered was Oncology, Haematology, the Lung Health Check and was looking to streamline MDT functions. There was still nervousness about the Oncology move and communications to keep all the wider stakeholders involved was key. The Stakeholder engagement plan would be presented to the next meeting.	

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)220

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Helen Harris, Director of Corporate Governance
CONTACT OFFICER	Helen Harris, Director of Corporate Governance
SUBJECT	Board Development Timetable 2021/22
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	Board development is a key element of good corporate governance and is recognised as such in best practice guidance including NHS Improvement (NHSI) Well-Led Framework, the Healthy NHS Board and Foundation Trust Code of Governance 2013. Board development is also an integral part of and consistent with the People Strategy. The proposed priorities for Board development are informed by a number of drivers: - The publication of the ICS Design Framework - The collaboration and partnership working across the Integrated Care System - The constantly changing and demanding external environment - The key roles of the Board in respect of risk management and patient safety - That the Board leads organization-wide leadership development and models the leadership behaviours. The Board Development Timetable can be reviewed in Appendix 1.

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

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

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

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NHS Foundation Trust

Trust Board 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) **PM:** Stakeholder Mapping, Chaplaincy, liberty protection safeguards
1 February 2022	Formal Board Meeting / Briefing and / or Board Development Activity	**AM:** Formal Board (Public and Private) **PM:** TBC
1 March 2022	Board Briefing and Board Development Activity	**AM:** Freedom to Speak Up (Part 3) **PM:** Board Development: Building Relationships / Team Work (facilitated)

Leadership and Kark Review (To Be Confirmed)
Board to Board Development with HUTH (To Be Confirmed following appointment of Joint Trust Chair)
Digital Transformation (joint with HUTH, facilitated by NHS Providers, following appointment of Joint Trust Chair)

NLG(21)221

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Michael Whitworth, Vice Chair of Audit, Risk & Governance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	Audit Risk & Governance Committee Highlight Report – August 2021 – Extraordinary Meeting
BACKGROUND DOCUMENT (if any)	Audit, Risk & Governance Committee Agenda papers 27 August 2021
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The attached highlight report summarises the key issues presented to, and discussed by the Audit, Risk and Governance Committee at its Extraordinary meeting on 27th August 2021: 1. **Auditors Annual Report 2020/21 including VFM Conclusion**: The External Auditor reported on the conclusion of their VFM work and resulting commentary in their Annual Report 2020/21. The Committee endorsed the report. This allowed the External Auditor to issue their Audit Certificate for inclusion in the Trust's Annual Report which could then be finalised and published accordingly. **For Board to Note.**

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5th October 2021
Report From:	Audit, Risk and Governance Committee held on 27th August 2021 – Extraordinary Meeting.

Highlight Report:

The Extraordinary meeting of the Committee was convened in order to receive and consider the Auditors Annual Report 2020/21, as discussed at the July 2021 ARGC meeting. The Chief Executive was also in attendance for this meeting.

1. **Auditors Annual Report 2020/21 – VFM Conclusion** – The Trust's External Auditor informed the Committee that they had now completed their Annual Report for 2020/21 to incorporate their VFM conclusion and recommendations. The Auditors Annual Report is a public document and will go to the Council of Governors. On issuing the final version the Auditor issues their Audit Certificate (received later that day on 27th August 2021) for inclusion in the Trust's Annual Report. The Auditor informed the Committee that their broad sweeping assessment was that it was a positive story on the Trust's arrangements for financial governance. However, they are still required to issue recommendations for the 2 significant weaknesses identified, albeit that they are not new issues, namely in relation to the Trust remaining in Special Measures and the Trust's financial sustainability. The Auditor commented that these are systemic issues around finances requiring a top down solution, and that they would reiterate the positive elements of their report when taken to the Council of Governors. Following discussion the Committee endorsed the report.

Confirm or Challenge of the Board Assurance Framework:

N/A – Extraordinary meeting to consider Auditors Annual Report 2020/21 only.

Action Required by the Trust Board:

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

Michael Whitworth
Non-Executive Director and Vice Chair of Audit, Risk and Governance Committee

NLG(21)222

DATE OF MEETING	5th October 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Shaun Stacey, Chief Operating Officer
CONTACT OFFICER	Graham Jaques, EPR & Business Continuity Manager/Operations Centre Manger
SUBJECT	Assurance process Statement of Compliance
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	Northern Lincolnshire and Goole NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0. The EPRR assurance rating has come back as Substantial.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	SO1-1.6 The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
	✓				

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

Northern Lincolnshire and Goole NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Northern Lincolnshire and Goole NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Shaun Stacey

Signed by the organisation's Accountable Emergency Officer

10/09/2021

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Ref	Domain	Standard
Domain 1 - Governance		
1	Governance	Senior Leadership
2	Governance	EPRR Policy Statement

3	Governance	EPRR board reports
5	Governance	EPRR Resource
6	Governance	Continuous improvement process
Domain 2 - Duty to risk assess		
7	Duty to risk assess	Risk assessment

8	Duty to risk assess	Risk Management
Domain 3 - Duty to maintain plans		
11	Duty to maintain plans	Critical incident
12	Duty to maintain plans	Major incident
13	Duty to maintain plans	Heatwave
14	Duty to maintain plans	Cold weather

18	**Duty to maintain plans**	**Mass Casualty**
19	**Duty to maintain plans**	**Mass Casualty - patient identification**
20	**Duty to maintain plans**	**Shelter and evacuation**
21	**Duty to maintain plans**	**Lockdown**
22	**Duty to maintain plans**	**Protected individuals**
Domain 4 - Command and control		

24	**Command and control**	**On-call mechanism**
Domain 5 - Training and exercising		
Domain 6 - Response		
30	**Response**	**Incident Co-ordination Centre (ICC)**
32	**Response**	**Management of business continuity incidents**
34	**Response**	**Situation Reports**
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**

36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**
Domain 7 - Warning and informing		
37	**Warning and informing**	**Communication with partners and stakeholders**
38	**Warning and informing**	**Warning and informing**
39	**Warning and informing**	**Media strategy**
Domain 8 - Cooperation		
42	**Cooperation**	**Mutual aid arrangements**
43	**Cooperation**	**Arrangements for multi-region response**

44	Cooperation	Health tripartite working
46	Cooperation	Information sharing
Domain 9 - Business Continuity		
47	Business Continuity	BC policy statement
48	Business Continuity	BCMS scope and objectives
50	Business Continuity	Data Protection and Security Toolkit

51	**Business Continuity**	**Business Continuity Plans**
53	**Business Continuity**	**BC audit**
54	**Business Continuity**	**BCMS continuous improvement process**
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**
Domain 10: CBRN		
56	**CBRN**	**Telephony advice for CBRN exposure**

57	**CBRN**	**HAZMAT / CBRN planning arrangement**
58	**CBRN**	**HAZMAT / CBRN risk assessments**
59	**CBRN**	**Decontamination capability availability 24 /7**

60	**CBRN**	**Equipment and supplies**
62	**CBRN**	**Equipment checks**

63	**CBRN**	**Equipment Preventative Programme of Maintenance**
64	**CBRN**	**PPE disposal arrangements**
65	**CBRN**	**HAZMAT / CBRN training lead**
67	**CBRN**	**HAZMAT / CBRN trained trainers**

68	**CBRN**	**Staff training - decontamination**
69	**CBRN**	**FFP3 access**

Detail	Acute Providers
The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y
The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and	Y

The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y
The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y
The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y
The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y

The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y
In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y
In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y
In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y
In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y

In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y
The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y
In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y
In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y
In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y

A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y
The organisation has Incident Co-ordination Centre (ICC) arrangements	Y
In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y
The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y
Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y

Clinical staff have access to the PHE ‘CBRN incident: Clinical Management and health protection’ guidance.	Y
The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y
The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y
The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y
The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y
Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF)	

Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.	
The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y
The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y
The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y
Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y

The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y
The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y
There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y
The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y
Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y

There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y
HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y
The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y

The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/ https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y
There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y

There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y
There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y
The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y
The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y

Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y
Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y

Evidence - examples listed below
• Name and role of appointed individual
Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.

• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group
• Process explicitly described within the EPRR policy statement
• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register

• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
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• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.
• Business Continuity Response plans
• Documented processes for completing, signing off and submitting SitReps
• Guidance is available to appropriate staff either electronically or hard copies

• Guidance is available to appropriate staff either electronically or hard copies
• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing
• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy
• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs

• Detailed documentation on the process for managing the national health aspects of an emergency
• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 ‘duty to communicate with the public’.

Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement
BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
Statement of compliance

• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation
• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans
• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Staff are aware of the number / process to gain access to advice through appropriate planning arrangements

Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies
• Impact assessment of CBRN decontamination on other key facilities
• Rotas of appropriately trained staff availability 24 /7

• Completed equipment inventories; including completion date
• Record of equipment checks, including date completed and by whom. • Report of any missing equipment

• Completed PPM, including date completed, and by whom
• Organisational policy
• Maintenance of CPD records
• Maintenance of CPD records

• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique

Organisational Evidence

Shaun Stacey , Chief Operating Officer is the AEO, Andrew Smith is the nominated Non-Executive Director for EPRR
EPRR Annual Report-Submitted to the Trust Board annually and includes the Trust's EPRR Work Programme and the EPRR Training Programme. Trust Business Continuity Management Policy. The Trusts Major Incident Plan and ICC Manual provide an overview of the organisation's approach to EPRR. All policies, procedures and plans are controlled through the Trust Document Control Register, ensuring version control, review schedule control and formal approach processes

EPRR Annual Report-Submitted to the Trust Board annually and includes the Trust's EPRR Work Programme and the EPRR Training Programme. NHS England Core Standards for EPRR Self-Assessment is submitted to the Trust Board for sign off annually.

EPRR Team has allocated pay budget. EPRR Team have individual job descriptions. The Trust has a sufficient level of resources to plan, coordinate and respond to emergencies and to discharge its EPRR duties. Roles detailed in Major Incident Plan, Business Continuity Management Policy and ICC Manual. Annual Report for EPRR submitted to Trust Audit, Risk and Governance Committee and Trust Board

Each emergency plan details that post-exercise or post-incident, a debrief is conducted and lessons to be learned are captured and form part of a post-incident action plan. Action plans are monitored through the EPRR Steering Group. All exercise and incidents are discussed at the EPRR Steering Group which includes membership from all Directorates within the Trust.

Trust EPRR Risk Register has a process in place to identify risks and highlighted and peer reviewed through the EPRR Steering group. Trust EPRR Register-Contains all external and internal risks to the Trust. Each risk is added and stored on the SHE Risk Assessment System and are part of the ongoing review schedule. An overview summary of all EPRR risks is submitted to the Trust EPRR Steering Group annually for scrutiny. Risks include those from the National Risk Register, The Humber Community Risk Register, and internal risks identified within the organisation.

Trust's Procedure for the management of the Trusts EPRR Risk Register- The escalation route is to the EPRR Steering Group, with further escalation to the Trust Audit, Risk and Goverence Committee and Trust Board if required, via the
Trusts Critical Incident Plan- As many of the actions are the same as during a Major Incident, the action cards from the Major Incident Plan are utilised and cross referenced. Service level Business Continuity Plans are in place (150+) covering all service functions, critical and non-critical across the organisation. Specific types of critical incident have their own separate emergency plan. Trust Incident Coordination Centre Manual details how the Trust will establish and run an ICC including multi-agency links. The Critical Incident Plan has not been activated to respond to a live incident within the last year.
Major Incident Plan. The trust has robust and tested Major incident plan with clear roles and responsibilities. Trust Incident Coordination Centre Manual details how the Trust will establish and run an ICC including multi-agency links. The Major Incident Plan has been activated to respond to a live incident within the last year in response to the Covid-19 Pandemic and Oxygen capability across
Trust Heatwave Plan- Includes action cards and information in line with the National Heatwave Guidance. The Heatwave Plan has been activated to respond to a live incident within the year at alert level 2. This plan also links in with the national alerting system from PHE and the Met Office
The National Cold weather Plan is used within the Trust including the national action cards. Trust Critical Incident Plan is used to respond to severe cold weather incidents that cause service disruption. Service-level Business Continuity Plans are in place (150+) covering all service functions, critical and non-critical across the organisation. Trust Incident Coordination Centre Manual details how the Trust will establish and run ICC including multi-agency links. The Trust's response to severe cold weather not required to be activated within the

Trust Major Incident Plan. Service-level Business Continuity Plans are in place (150+) covering all service functions, critical and non-critical across the organisation. Trust Incident Coordination Centre Manual details how the Trust establishes and run an ICC including multi-agency links. Humber LRF Mass Casualty Plan. Patient Flow, Escalation and Surge Policy including the Full Capacity Protocol. The Trust participates in the Y&TH Regional Mass Casualty Exercises.
The Trust has a paper based mass casualty attendance and triage sheet which are pre-prepared on clipboards in both EC Centres. The Trust also has Cruciforms at both EC Centres ready for deployment if required.
Trust Full and Partial Site Evacuation Plan which includes evacuation triage, temporary shelter locations and process for onward transfer with patient tracking. Trust Major Incident Plan. Trust Incident Coordination Centre Manual details how the trust establishes and run an ICC including multi-agency links. Regional exercise participated in regarding RACC at Airedale site.
Trust Policy and Procedure for Lockdown Service-level Business Continuity Plans are in place (150+) covering all service functions, critical and non-critical, across the organisation. Trust has conducted a Project Argus exercise (ACT Strategic) in July 2018 and was looking at further CT training during 2020 which had to be cancelled due to the pandemic
The Trust Major Incident Plan contains guidance on how to manage VIP and high profile visitors/patients. East Midlands Ambulance service inform head of EPRR of any high profile events that would fall within the Trusts receiving site.

The Trust Major Incident Plan and Critical Incident Plan contain the Trust wide notification cascades for all types of emergencies. The Trust notification cascades are live tested every six months on both sites in hours and out of hours. Trust wide Gold Executive On-Call and site specific Silver Senior Manager On-Call rotas cover 24/7 365 days a year. Specific plans have their own notification cascades tailored to the response required for specific emergencies (e.g. OPEL escalation)
Trust Incident Coordination Centre Manual details how the Trust will establish and run an ICC including multi-agency links. The ICC Manual includes maps and room diagram’s, pre-set telephone extensions and email addresses. The physical room, telephones including analog phones and equipment is tested every six months or when established for use during a live incident. Printed copies of emergency plans are located in the Major Incident Cupboard within both sites ICC's along with practical items e.g. tabards/log books. Printed copies of all Business Continuity Plans are located in each Operations Centre for quick access during IT/Network outage. The organisation has multiply sites and can run an ICC from either of its two main sites. The ICC was established at the start of the Covid-19 pandemic and has continued to operate fully throughout the pandemic response.
Service-level Business Continuity Plans are in place (150+) covering all service functions, critical and non-critical across the organisation. These where reviewed in relation to EU exit and then further reviewed during the Covid-19 pandemic
SitReps can be received and processed through the Unify system via the Information Team, Resilience Direct via the EPRR Team or via email sent directly to the ICC email address, EPRR Team or Operations Centre routes. SitRep completion has been tested through the whole of the pandemic which has required daily and at time multiple sitreps to be completed and is also incorporated into some exercises.
Guidance is available to appropriate staff either electronically through the Trust Intranet or hard copies located in the EC Centres. Handbook available on the trusts A+E intranet page.

Guidance is available to appropriate staff either electronically through the Trust Intranet or hard copies located in the EC Centres. .
The Trust EPRR website contains multi-agency contact details in a dedicated section. Switchboard holds the multi-agency contact details if required. Trust Incident Coordination Centre Manual details how the Trust will establish and run an ICC including multi-agency links. Each emergency plan contains the relevant multi-agency contact details required for the emergency e.g. CBRNe/HAZMAT Plan contains contact details for specialist advice services at PHE. During the pandemic joint communication working across the HCV area has been implemented at times to ensure same approach working.
Trust EPRR Communications Protocol. The Trust Major Incident Plan and Critical Incident Plant contain the Trust wide notification cascades for all types of emergencies. Humber LRF Communications Protocol. The Trusts communication team regular provide information to the public via several routes including the use of social media platforms. The communication have their own action card within the major incident plan.
Trust Communications and Engagement Strategy. Trust EPRR Communications Protocol. Trusts communication team will provide updates to all staff emails, intranet page; it also has several social media profiles were updates will be posted. During the pandemic a NLAG staff Facebook group was set up to allow the sharing of information
Lincolnshire 4x4 Response MoU. Trust Major Incident Plan section on Mutual Aid. LRF plans contains details on mutual aid between partner agencies. LRF plans contain details on MACA process. During the pandemic mutual aid across the HCV area was utilised on several occasions for stock of PPE
N/A

N/A
The Humber Information Sharing Charter which includes all LRF partner's that form part of the Trust's emergency plan responses. The Trust Information Sharing Operational Procedure. The Major Incident Plan contains a section on information sharing. The Trust's procedure for sharing vulnerable patient data during an emergency includes a section on information
Trust Business Continuity Management Policy
Trust Business Continuity Management Policy includes the process for how BCP's are developed, reviewed and published. Any risks requiring escalation are reported to the Trust EPRR Steering Group and if required escalated through the Trust Audit, Risk and Governance Committee and if required to the Trust Board. All BCP where reviewed inline with EU Exit/Transition and during the Covid pandemic
The Trust's IT department complete the toolkit annually. Statement of Compliance.

Each BCP contains a Business Impact Analysis that follows a set approved template. The template includes sections on People (Key staff, skills required to support service, minimum staffing levels and what resources can be diverted), Premises (Minimum infrastructure, essential power supply, specific equipment to service, specific risks) Processes (Essential and non-essential IT systems, communication systems, legal and target considerations) and interdependencies (Providers to service, customers of service, service specific suppliers and what resources are required for recovery). All BCP's are updated annually as a minimum or whenever a change in service requires a review. All BCP where reviewed inline with EU Exit/Transition and during the Covid pandemic
The Trust has a contracted Internal Auditor which completes internal audits as per an ongoing schedule agreed by the Trust Audit, Risk and Governance Committee. The last EPRR internal audit included business continuity management and the report gave a full compliance with the only area been noted was the poor attendance at the EPRR Steering Group by members.
The Trust Business Continuity Management Policy is part of a review schedule of a minimum of 3 yearly or sooner if required. The BCP template is updated whenever new guidance is issued or post-incident when improvements are identified. All BCP where reviewed inline with EU Exit/Transition and during the Covid pandemic
The Trust's Procurement Department include as a default a request for providers or suppliers to submit their BCP as part of their tender and where appropriate, a review of the BCP forms part of the tender evaluation and scoring. A central hub for relevant providers and suppliers BCP's has been created on the Trust EPRR intranet website where Procurement can upload relevant BCP's.

The Trust's CBRNe/HAZMAT Plan contains telephone numbers for accessing specialist advice. The Trust EPRR website contains telephone numbers for accessing specialist advice. Contact details for each of the COMAH sites and the chemical present on their site are stored on the EPRR website with restricted access by the EP team and Silver and Gold on call manager

The Trust's CBRNe/HAZMAT Plan contains information on all aspects of a CBRNe/HAZMAT response, including telephone numbers for specialist advice, decontamination processes both Dry and Wet, step by step guides, information on equipment available, where to seek advice on contaminated waste disposal, action cards for each role, PPE advice, plan activation and incident triggers, lockdown and cordon control, multi-agency support and stand-down procedures. A full audit of the Trusts CBRNe/HAZMAT capabilities was conducted by EMAS and it was highlighted that there was a lack of face to face training but noted that online training taking place this is due to the pandemic, this has now start to commenced face to face training. Was also noted that a number PRPS suits required serving at DPOW but plan in place to move suits if required from SGH during a live incident
A decontamination process risk assessment has been completed by the EC Centres. A full audit of the Trust's CBRNe/HAZMAT capabilities was conducted by EMAS and was noted that a number PRPS suits required serving at DPOW but plan in place to move suits if required from SGH during a live incident this have now been serviced and brought into operational use
CBRNe/HAZMAT training is provided to all EC Centre medical, nursing staff, HCA's, receptionists and flow coordinators. There have been delays in training staff at one of the sites due to operational difficulties in releasing ECC staff to attend training; it was highlighted that there was a lack of face to face training but noted that online training taking place this is due to the pandemic but plan in place to start to commence face to face when able to. Was also noted that a number PRPS suits required serving at DPOW but plan in place to move suits if required from SGH during a live incident

Regular equipment reviews completed with any gaps identified. EPRR Team support in ordering replacement equipment to ensure suitability and consistency. Equipment checklist used as a guide for equipment reviews. Awaiting national delivery of a further 12 suits per site to bring our live allocation up to the required amount of 24 lives suits
PRPS are part of a set maintenance schedule as detailed per individual suit's recertification dates, these are recertified by the manufacturer Respirex. The decontamination tent, pump and associated equipment is checked every time it is deployed during CBRNe/HAZMAT training and also annually by the Estates PRPS are part of a set maintenance schedule as detailed per individual suit's recertification dates, these are recertified by the manufacturer Respirex. The decontamination tent, pump and associated equipment is checked every time it is deployed during CBRNe/HAZMAT training and also annually by the Estates Department. The RAM Genes are checked during CBRNe/HAZMAT training as well as monthly checks carried out by the CBRN Lead Nurse, and also part of a maintenance schedule with Medical Engineering. For routine checks the EC Centres CBRN Lead Nurse is responsible for checking equipment. For scheduled maintenance, the CBRN Lead Nurse is responsible for ensuring the relevant department (e.g. Medical engineering) completes the checks as per the schedule. During the pandemic the equipment checks lapsed but this has now started been picked up again so are now back on track.

PRPS are part of a set maintenance schedule as detailed per individual suit's recertification dates, these are recertified by the manufacturer Respirex. The decontamination tent, pump and associated equipment is checked every time it is deployed during CBRNe/HAZMAT training and also annually by the Estates PRPS are part of a set maintenance schedule as detailed per individual suit's recertification dates, these are recertified by the manufacturer Respirex. The decontamination tent, pump and associated equipment is checked every time it is deployed during CBRNe/HAZMAT training and also annually by the Estates Department. The RAM Genes are checked during CBRNe/HAZMAT training as well as monthly checks carried out by the CBRN Lead Nurse, and also part of a maintenance schedule with Medical Engineering. For routine checks the EC Centres CBRN Lead Nurse is responsible for checking equipment. For scheduled maintenance, the CBRN Lead Nurse is responsible for ensuring the relevant department (e.g. Medical engineering) completes the checks as per the schedule. During the pandemic the equipment checks lapsed but this has now started been picked up again so are now back on track.
Trust CBRNe/HAZMAT Plan contains guidance on the disposal post-incident and where to seek advice. The Trust EPRR Intranet website contains guidance documents on disposal post-incident.
The EPRR Team provide cascade 'Train the Trainer' training to EC Centre trainers. The EPRR Team have attended NARU PRPS Instructors Course. The EPRR Team has written the Trust's CBRNe/HAZMAT Plan and have created a bespoke CBRNe/HAZMAT Training Session which encompasses national guidance (e.g. STEP123+ and IOR principles) and local arrangements for both theoretical and practical elements. The training records are uploaded onto the Trusts ESR/OLM training system and copies stored
All members of the EPRR Team are trained to deliver CBRNe/HAZMAT Training. The EPRR Team provide cascade 'Train the Trainer' training to EC Centre department trainers, of which are at least one named individual per EC Centre. The training records are uploaded onto the Trusts ESR/OLM training system and copies stored

CBRNe/HAZMAT Training is provided to all EC Centre medical staff, Nursing staff, HCA's, Receptionists and Flow Coordinators. The training includes national elements such as JESIP IOR, Step 123+, Dry and Wet Decontamination including videos. Face to Face recommenced July 21 due to been suspended during the pandemic
Each EC Centre has the required equipment for either high-level PPE or medium-level PPE. Medium-level PPE includes a face mask (or FFP3 mask if issued to the staff member and correctly fit tested). Face masks are stored in the CBRNe/HAZMAT cupboard along with the other items of PPE. FFP3 masks were issued to individual staff are stored in staff lockers. There are a number of powered respirators that staff can access from the Ops centre's when required

Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken
Fully compliant	
Fully compliant	

Fully compliant	
Fully compliant	to support the post of Emergency Planning manager into a full time post. Secure funding for the admin support post at whole time band 3. Partial process in place for funding that has not fully reached a conclusion. Plan for temporary funding and staff resource implemented until march 2022.
Fully compliant	
Fully compliant	

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Fully compliant		

Partially compliant	A training programme has been developed to increase the amount of available training dates. Also communication links with each of the ED's lead nurses to ensure compliance.
Fully compliant	
Partially compliant	Increase numbers of A&E staff attending CBRNe/HAZMAT Training Sessions to increase 24/7 operational response cover, by: • Additional training sessions offered • EPRR Team have stepped in to deliver training • Cross-site training promoted to reduce pull from each A&E

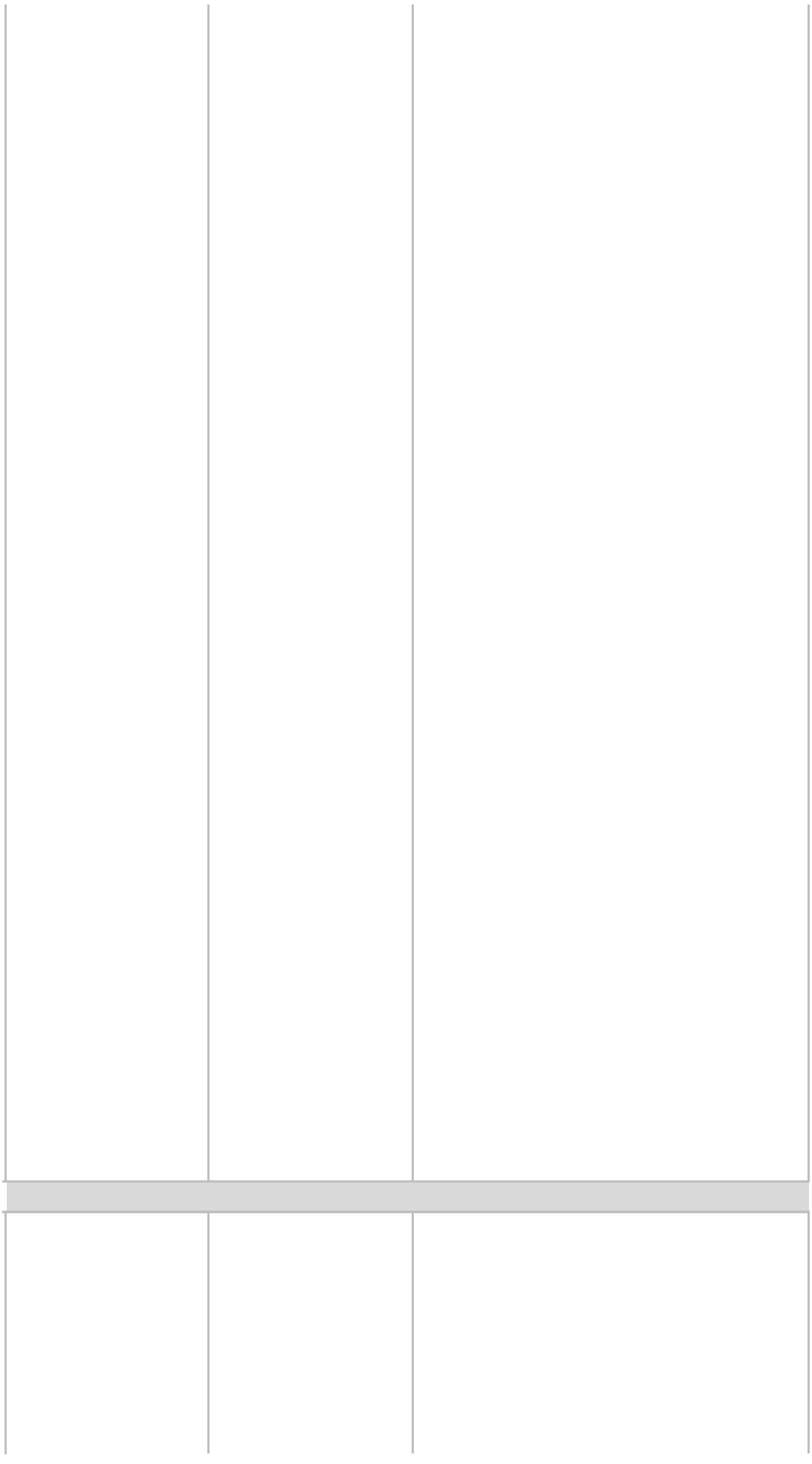
Fully compliant		
Fully compliant		

Fully compliant		
Fully compliant		
Fully compliant		
Fully compliant		

Fully compliant	
Fully compliant	

Lead	Timescale	Comments

John Awuah		The team at present is a training post down, admin support post not been replaced and no plan. Emergency Planning manager post at present only .5 WTE business case to increase into a full time position but lack of funding to allow at present



Ashley Leggott, Natalie Till and Zoe Dutton			
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Ref	Domain	Standard
HART Domain: Capability		
H1	HART	HART tactical capabilities
H2	HART	National Capability Matrices for HART
H3	HART	Compliance with National Standard Operating Procedures
Domain: Human Resources		
H4	HART	Staff competence

H5	**HART**	**Protected training hours**
H6	**HART**	**Training records**
H7	**HART**	**Registration as Paramedics**
H8	**HART**	**Six operational HART staff on duty**
H9	**HART**	**Completion of Physical Competency Assessment**
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**
H11	**HART**	**Returned to duty Physical Competency Assessment**
H12	**HART**	**Commander competence**
Domain: Administration		
H13	**HART**	**Effective deployment policy**

H14	**HART**	**Identification appropriate incidents / patients**
H15	**HART**	**Notification of changes to capability delivery**
H16	**HART**	**Recording resource levels**
H17	**HART**	**Record of compliance with response time standards**
H18	**HART**	**Local risk assessments**
H19	**HART**	**Lessons identified reporting**
H20	**HART**	**Safety reporting**
H21	**HART**	**Receipt and confirmation of safety notifications**
H22	**HART**	**Change Request Process**
Domain: Response time standards		

H23	**HART**	**Initial deployment requirement**
H24	**HART**	**Additional deployment requirement**
H25	**HART**	**Attendance at strategic sites of interest**
H26	**HART**	**Mutual aid**
Domain: Logistics		
H27	**HART**	**Capital depreciation and revenue replacement schemes**
H28	**HART**	**Interoperable equipment**
H29	**HART**	**Equipment procurement via national buying frameworks**
H30	**HART**	**Fleet compliance with national specification**
H31	**HART**	**Equipment maintenance**

H32	**HART**	**Equipment asset register**
H33	**HART**	**Capital estate provision**
MTFA Domain: Capability		
M1	**MTFA**	**Maintenance of national specified MTFA**
M2	**MTFA**	**Compliance with safe system of work**
M3	**MTFA**	**Interoperability**
M4	**MTFA**	**Compliance with Standard Operating Procedures**
Domain: Human Resources		
M5	**MTFA**	**Ten competent MTFA staff on duty**
M6	**MTFA**	**Completion of a Physical Competency Assessment**
M7	**MTFA**	**Staff competency**
M8	**MTFA**	**Training records**

M9	**MTFA**	**Commander competence**
M10	**MTFA**	**Provision of clinical training**
M11	**MTFA**	**Staff training requirements**
Domain: Administration		
M12	**MTFA**	**Effective deployment policy**
M13	**MTFA**	**Identification appropriate incidents / patients**
M14	**MTFA**	**Change Management Process**
M15	**MTFA**	**Record of compliance with response time standards**
M16	**MTFA**	**Notification of changes to capability delivery**
M17	**MTFA**	**Recording resource levels**

M18	**MTFA**	**Local risk assessments**
M19	**MTFA**	**Lessons identified reporting**
M20	**MTFA**	**Safety reporting**
M21	**MTFA**	**Receipt and confirmation of safety notifications**
Domain: Response time standards		
M22	**MTFA**	**Readiness to deploy to Model Response Sites**
M23	**MTFA**	**10minute response time**
Domain: Logistics		
M24	**MTFA**	**PPE availability**
M25	**MTFA**	**Equipment procurement via national buying frameworks**
M26	**MTFA**	**Equipment maintenance**
M27	**MTFA**	**Revenue depreciation scheme**

M28	**MTFA**	**MTFA asset register**
CBRN **Domain: Capability**		
B1	**CBRN**	**Tactical capabilities**
B2	**CBRN**	**National Capability Matrices for CBRN.**
B3	**CBRN**	**Compliance with National Standard Operating Procedures**
B4	**CBRN**	**Access to specialist scientific advice**
Domain: Human resources		
B5	**CBRN**	**Commander competence**
B6	**CBRN**	**Arrangements to manage staff exposure and contamination**
B7	**CBRN**	**Monitoring and recording responder deployment**

B8	**CBRN**	**Adequate CBRN staff establishment**
B9	**CBRN**	**CBRN Lead trainer**
B10	**CBRN**	**CBRN trainers**
B11	**CBRN**	**Training standard**
B12	**CBRN**	**FFP3 access**
B13	**CBRN**	**IOR training for operational staff**
Domain: administration		
B14	**CBRN**	**HAZMAT / CBRN plan**
B15	**CBRN**	**Deployment process for CBRN staff**
B16	**CBRN**	**Identification of locations to establish CBRN facilities**
B17	**CBRN**	**CBRN arrangements alignment with guidance**
B18	**CBRN**	**Communication management**
B19	**CBRN**	**Access to national reserve stocks**
B20	**CBRN**	**Management of hazardous waste**
B21	**CBRN**	**Recovery arrangements**

B22	**CBRN**	**CBRN local risk assessments**
B23	**CBRN**	**Risk assessments for high risk areas**
Domain: Response time standards		
B24	**CBRN**	**Model response locations - deployment**
Domain: logistics		
B25	**CBRN**	**Interoperable equipment**
B26	**CBRN**	**Equipment procurement via national buying frameworks**
B27	**CBRN**	**Equipment maintenance - British or EN standards**
B28	**CBRN**	**Equipment maintenance - National Equipment Data Sheet**
B29	**CBRN**	**Equipment maintenance - assets register**
B30	**CBRN**	**PRPS - minimum number of suits**
B31	**CBRN**	**PRPS - replacement plan**
B32	**CBRN**	**Individual / role responsible fore CBRN assets**
Mass Casualty Vehicles **Domain: Administration**		

V1	MassCas	MCV accommodation
V2	MassCas	Maintenance and insurance
V3	MassCas	Mobilisation arrangements
V4	MassCas	Mass oxygen delivery system
Domain: NHS England Mass Casualties		
V6	MassCas	Mass casualty response arrangements
V7	MassCas	Arrangements to work with NACC
V8	MassCas	EOC arrangements
V9	MassCas	Casualty management arrangements
V10	MassCas	Casualty Clearing Station arrangements
V11	MassCas	Management of non-NHS resource
V12	MassCas	Management of secondary patient transfers
Command and control Domain: General		
C1	C2	Consistency with NHS England EPRR Framework

C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**
C3	**C2**	**NARU notification process**
C4	**C2**	**AEO governance and responsibility**
Domain: Human resource		
C5	**C2**	**Command role availability**
C6	**C2**	**Support role availability**
C7	**C2**	**Recruitment and selection criteria**

C8	**C2**	**Contractual responsibilities of command functions**
C9	**C2**	**Access to PPE**
C10	**C2**	**Suitable communication systems**
Domain: Decision making		
C11	**C2**	**Risk management**
C12	**C2**	**Use of JESIP JDM**
C13	**C2**	**Command decisions**
Domain: Record keeping		
C14	**C2**	**Retaining records**
C15	**C2**	**Decision logging**
C16	**C2**	**Access to loggist**
Domain: Lessons identified		
C17	**C2**	**Lessons identified**
Domain: Competence		

C18	**C2**	**Strategic commander competence - National Occupational Standards**
C19	**C2**	**Strategic commander competence - nationally recognised course**
C20	**C2**	**Tactical commander competence - National Occupational Standards**
C21	**C2**	**Tactical commander competence - nationally recognised course**
C22	**C2**	**Operational commander competence - National Occupational Standards**
C23	**C2**	**Operational commander competence - nationally recognised course**
C24	**C2**	**Commanders - maintenance of CPD**

C25	**C2**	**Commanders - exercise attendance**
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**
C27	**C2**	**Assessment of commander competence and CDP evidence**
C28	**C2**	**NILO / Tactical Advisor - training**
C29	**C2**	**NILO / Tactical Advisor - CPD**
C30	**C2**	**Loggist - training**
C31	**C2**	**Loggist - CPD**
C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**

C33	**C2**	**Medical Advisor of Forward Doctor - exercise attendance**
C34	**C2**	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**
C35	**C2**	**Control room familiarisation with capabilities**
C36	**C2**	**Responders awareness of NARU major incident action cards**
JESIP Domain: Embedding doctrine		
J1	**JESIP**	**Incorporation of JESIP doctrine**
J2	**JESIP**	**Operations procedures commensurate with Doctrine**
J3	**JESIP**	**Five JESIP principles for joint working**
J4	**JESIP**	**Use of METHANE**
J5	**JESIP**	**Joint Decision Model - advocate use of**

J6	**JESIP**	**Review process**
J7	**JESIP**	**Access to JESIP products, tools and guidance**
Domain: Training		
J8	**JESIP**	**Awareness of JESIP - Responders**
J9	**JESIP**	**Awareness of JESIP - control room staff**
J10	**JESIP**	**Awareness of JESIP - Commanders and Control Room managers / supervisors**
J11	**JESIP**	**Training records - staff requiring training**
J12	**JESIP**	**Command function - interoperability command course**
J13	**JESIP**	**Training records - annual refresh**
J14	**JESIP**	**Commanders - interoperability command course**
J15	**JESIP**	**Participation in multiagency exercise**
J16	**JESIP**	**Induction training**
J17	**JESIP**	**Training - review process**

J18	**JESIP**	**JESIP trainers**
Domain: Assurance		
J19	**JESIP**	**JESIP self-assessment survey**
J20	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**
J21	**JESIP**	**Exercise programme - multiagency exercises**
J22	**JESIP**	**Competence assurance policy**
J23	**JESIP**	**Use of JESIP exercise objectives and Umpire**

Detail

Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations
Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.
Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.

Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.

Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week
Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans.
All operational HART personnel must be professionally registered Paramedics.
Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.
All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.
All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.
Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.
Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.

Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.

Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.
In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such
Organisations must record HART resource levels and deployments on the nationally specified system.
Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.
Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.
Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.
Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.
Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.
Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.

Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.
Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.
Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.
Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.

Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.
Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.
Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.
Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.
Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.

Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).
Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.
Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.
Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.
Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.
Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.
Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified
Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.
Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.
Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans.

Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.
The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.
Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff

Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).
Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).
Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.
Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).
In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.
Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.

Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk
Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.
Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.
Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.

Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.
Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.

Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.
Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.
All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national
Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.

Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of
Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures
Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.
Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.
Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).
Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.
Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.
Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time

Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.
Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.
Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.
CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.
Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.
Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).

Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.
Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.
Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.
Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.
Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.
Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).
Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.
Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.

Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.
Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.

Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.

Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.
Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.
Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.
Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.
Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).
Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.
Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.
Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.

Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.
Trusts must insure, maintain and regularly run the mass casualty vehicles.
Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.
Trusts must maintain the mass oxygen delivery system on the vehicles.
Concept of Operations
Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties*.
Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.
Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.
Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.
Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.
Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers
Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.
NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.

NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.
NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are
The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.

NHS Ambulance Service providers must ensure that the command roles defined as part of the ‘chain of command’ structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.
NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.
NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.

Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.
The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.
The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.

NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.
NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.
NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.

C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.
C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.
C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.

The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.

Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.
Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).
Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.
Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.
Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.
Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.
All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.

All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a ‘player’ at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.
Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.
Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.
Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).
Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor
Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control
Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.
The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).

Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a ‘player’ at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.
Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.
Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)
Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.

The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.
All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.
All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.
All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.
All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.

All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.
All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.
All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated
NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.
All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.
NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.
All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.
All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.
Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.
Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.
All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.
All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.

All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.
All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.
All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.
All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE
All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.
All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.

NHS Ambulance Service Providers	Organisational Evidence
Y	
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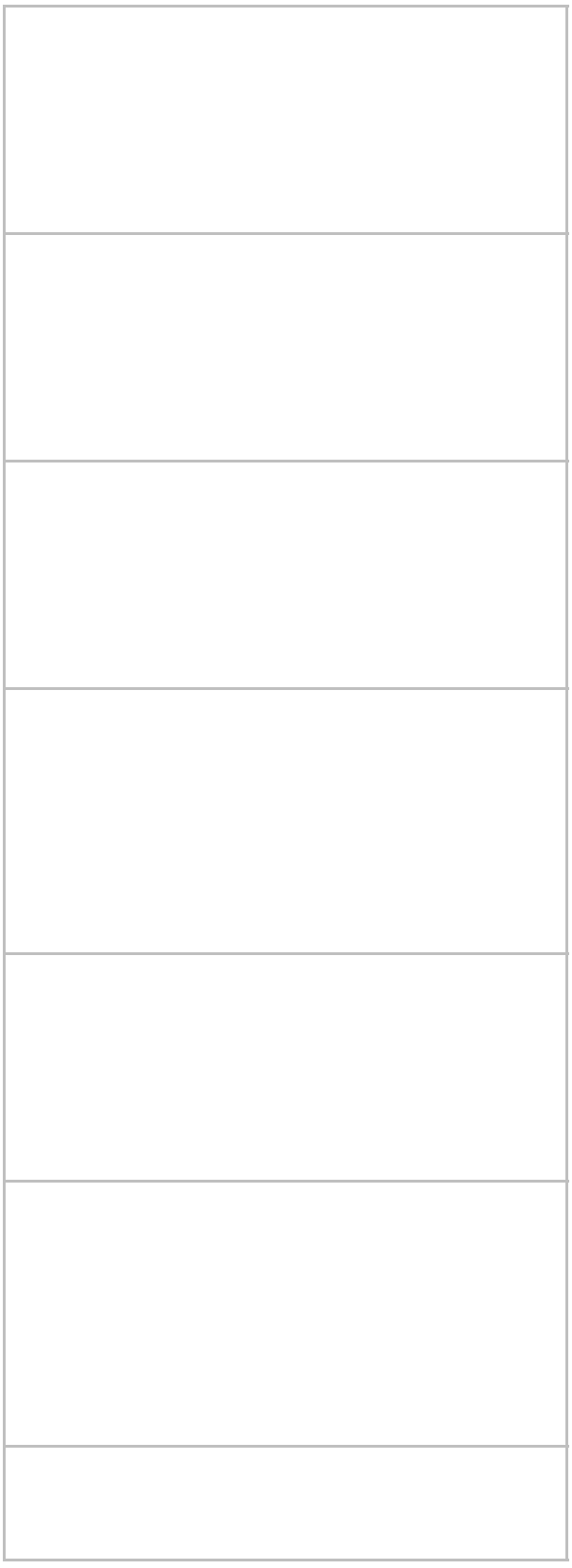
Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	**Action to be taken**

Lead	Timescale

Comments



Ref	Domain	Standard
Deep Dive - Oxygen Supply Domain: Oxygen Suuply		
DD1	**Oxygen Supply**	**Medical gases - governance**

DD2	**Oxygen Supply**	**Medical gases - planning**
DD3	**Oxygen Supply**	**Medical gasses - planning**
DD4	**Oxygen Supply**	**Medical gasses -workforce**

DD5	**Oxygen Supply**	**Oxygen systems - escalation**
DD6	**Oxygen Supply**	**Oxygen systems**
DD7	**Oxygen Supply**	**Oxygen systems**

Detail

The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.

The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases
The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.
The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.

The organisation has a clear escalation plan and processes for management of surge in oxygen demand
Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)
The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6

Evidence - examples listed below

- Committee meets annually as a minimum
- Committee has signed off terms of reference
- Minutes of Committee meetings are maintained
- Actions from the Committee are managed effectively
- Committee reports progress and any issues to the Chief Executive
- Committee develops and maintains organisational policies and procedures
- Committee develops site resilience/contingency plans with related standard operating procedures (SOPs)
- Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate
- The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board

• The organisation has reviewed and updated the plans and are they available for view • The organisation has assessed its maximum anticipated flow rate using the national toolkit • The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. • The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site • The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) • Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies • The organisation has breaching points available to support access for additional equipment as required • The organisation has a developed plan for ward level education and training on good housekeeping practices • The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases
• The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries • The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms • The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes • Organisation has utilised the checklist retrospectively as part of an assurance or audit process
• Job descriptions/person specifications are available to cover each identified role • Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. • Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements • Medical gas training forms part of the induction package for all staff.

• SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds • Staff are informed and aware of the requirements for increasing de-icing of vaporisers • SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO
• Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report
• Organisation has a risk assessment as per section 6.6 of the HTM 02-01 • Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)

Acute Providers	Mental Health Providers	Community Service Providers
Y	If applicable	If applicable

Y	If applicable	If applicable
Y	If applicable	If applicable
Y	If applicable	If applicable

Y	If applicable	If applicable
Y	If applicable	If applicable
Y	If applicable	If applicable

Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.
Medical gas meeting normally meets quarterly increasing frequency as required. Weekly throughout pandemic. The meeting has TOR and is attended by engineering Established escalation routes. Accountable to Safer Medication Group and / or Health and Safety Committee	Fully compliant

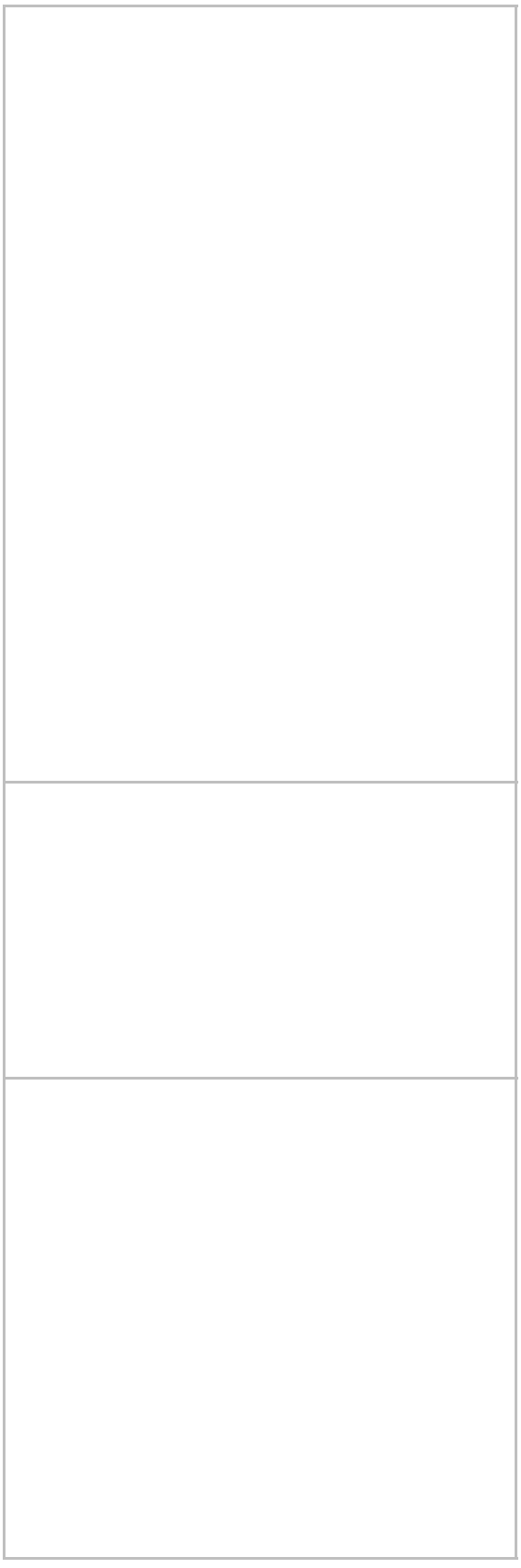
Medical Gases Operations policy established including businesss continuity plans. Live tested during oxygen incident November 2020. Use and safety of cylinders is reviewed routinely. SOPs are included in manadatory and induction training. Medical gas system monitoring is in place. Trust developed oxygen provision plan and live reporting data of oxygen useage visiable on WebV system	Fully compliant
Procedure in place for safe deliveries. VIE is de-iced routinely as part of the maintenance schedule. VIE capability is monitored remotely and alarmed . BOC have a disaster recovery procedure (our supplier)	Fully compliant
Authorised Engineer / Authorised Person / Competent Person roles are established and post-holders are appropriately trained for those roles. Referesher training regime in place and cross site cover is available to ensure availability of key staff. Mandatory training for all staff that use or handle medical gases. Plan are in place for designated nurses for oxygen to be increased	Partially compliant

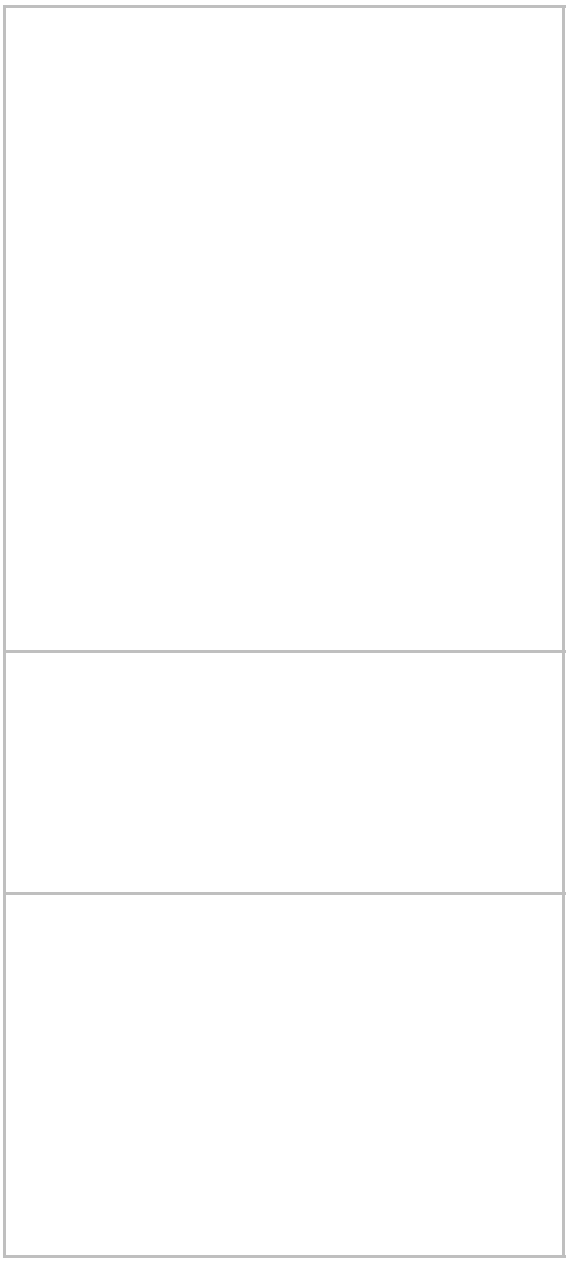
Patient oxygen requirements are reviewed as part of clinical review. VIE maintenance schedule established including de-icing. All clinical areas have daily checklists that includes safety and good housekeeping of medical gases. Demand on gas supply is monitored by estates. In addition the use of oxygen in clinical areas is a standard agenda item of the 3 times daily operational meetings. Routine deployment of concentrators to reive demand in areas of demand nearing	Fully compliant
Medical gas systems are reviewed as part of the annual review. The systems have full technical drawings and are reviewed as aprt of the annual review	Fully compliant
Risk assessment has been completed and informs ongoing maintenance and system development. All 3 sites undertake an annual review of the system last done August 2020. Review planned for DPOW 26th August 2021 / SGH and GDH 23rd August 2021	Fully compliant

Action to be taken	Lead	Timescale

BOC to provide training and refresher training to site managers	Medical Gas Committee	

Comments





Ref	Domain	Standard	Detail	Acute Providers
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y

Evidence - examples listed below	Organisational Evidence
Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	The Trust's CBRNe/HAZMAT Plan contains information on all aspects of a CBRNe/HAZMAT response, including telephone numbers for specialist advice, decontamination processes both Dry and Wet, step by step guides, information on equipment available, where to seek advice on contaminated waste disposal, action cards for each role, PPE advice, plan activation and incident triggers, lockdown and cordon control, multi-agency support and stand-down procedures. A full audit of the Trusts CBRNe/HAZMAT capabilities was conducted by EMAS and it was highlighted that there was a lack of face to face training but noted that online training taking place this is due to the pandemic, this has now start to commenced face to face training. Was also noted that a number PRPS suits required serving at DPOW but plan in place to move suits if required from SGH during a live incident
• Rotas of appropriately trained staff availability 24 /7	CBRNe/HAZMAT training is provided to all EC Centre medical, nursing staff, HCA's, receptionists and flow coordinators. There have been delays in training staff at one of the sites due to operational difficulties in releasing ECC staff to attend training; it was highlighted that there was a lack of face to face training but noted that online training taking place this is due to the pandemic but plan in place to start to commence face to face when able to. Was also noted that a number PRPS suits required serving at DPOW but plan in place to move suits if required from SGH during a live incident

Self assessment RAG Red (not compliant) Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) Fully compliant with core standard.	Action to be taken	Lead	Timescale
Partially compliant	A training programme has been developed to increase the amount of available training dates. Also communication links with each of the ED's lead nurses to ensure compliance.	Ashley Leggott, Natalie Till and Zoe Dutton	
Partially compliant	Increase numbers of A&E staff attending CBRNe/HAZMAT Training Sessions to increase 24/7 operational response cover, by: • Additional training sessions offered • EPRR Team have stepped in to deliver training • Cross-site training promoted to reduce pull from each A&E	Ashley Leggott, Natalie Till and Zoe Dutton	

Comments

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)223

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Gill Ponder, NED / Chair of F&P Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	Finance & Performance Committee – Minutes of meetings held on 30 June & 28 July 2021
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee – Minutes approved at the meetings held on 28 July & 25 August 2021.
EXECUTIVE SUMMARY	Minutes of the Finance & Performance Committee held on 30 June & 28 July 2021 are attached for information.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	BAF Risk SO3 (3.1-3.2) BAF Risk SO1 (1.2-1.6) & SO4				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **30 June 2021 – via Teams Meeting**

PRESENT:	Gill Ponder	Non-Executive Director / Chair of F&P
	Andrew Smith	Non-Executive Director
	Linda Jackson	Vice Chair, NLAG / Associate NED, HUTH
	Stuart Hall	Associate NED, NLAG / Vice Chair, HUTH
	Shaun Stacey	Chief Operating Officer
	Brian Shipley	Deputy Director of Finance
	Ian Reekie	Lead Governor
IN ATTENDANCE:	Simon Tighe	Deputy Director of Estates & Facilities
	Angie Legge	Associate Director of Governance (for item 5.3)
	Jennifer Moverley	Head of Compliance and Assurance (for item 5.3)
	Anne Barker	Finance Admin Manager (Minutes)

Item 1 06/21 **Apologies for Absence**

Apologies for absence were noted from: Lee Bond, Chief Financial Officer (Brian Shipley Deputising); Jug Johal (Simon Tighe Deputising); Ivan McConnell; Shauna McMahon; Peter Reading

A discussion ensued regarding the quoracy of the meeting given the number of apologies from Executive Directors. It was agreed to continue with the meeting, noting that no formal decisions could be made. Gill Ponder would raise concerns about the low level of attendance leading to issues with quoracy and the fact that the Terms of Reference did not count Deputies towards quoracy after the meeting.

Action: Gill Ponder

Gill Ponder welcomed attendees to her first meeting as Chair of the Finance & Performance Committee. Gill Ponder asked that any issues for highlighting to the Trust Board should be raised after each item.

Item 2 06/21 **Declarations of Interest**

There were no declarations of interest made.

Item 3 06/21 **To approve the minutes from the previous meeting held on 26 May 2021**

The minutes from the meeting held on 26 May 2021 were agreed as an accurate record.

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

Item 4 06/21 **Matters Arising**

4.1 Action Log

The action log was reviewed as follows:

5.4 (28 10 20) – CDIP – Update to be brought to the Committee in July

5.1 (26 05 21) – BAF – Discussion between Andrew Smith and Shaun Stacey had not taken place due to diary commitments. An update would be brought to the Committee in July.

5.1 (26 05 21) – BAF – Shaun Stacey to identify areas for review across the year. Completed

5.1 (26 05 21) – Workplan discussion between Gill Ponder, Linda Jackson and Neil Gammon. Completed with draft workplan on agenda for agreement.

6 – (26 05 21) – IPR – SPC charts – analysis of review. Following discussions with NHSI/E, Shaun Stacey confirmed that the required information could be included within the SPC charts. Options for changes to the existing reports would be discussed at the forthcoming Board Development meeting.

Linda Jackson advised that following discussion with Sam Riley NHSI/E, Trust Board would receive further support on the use of SPC charts. It was agreed to add to the action log for review in August with final date of completion in September.

6 – (26 05 21) – Peter Reading to raise with Elaine Criddle to invite Sam Riley back to do further sessions on SPC charts – Completed.

7 – Finance Report – Stuart Hall to collate information for clarification. Stuart Hall advised that following discussion with Brian Shipley there was no further need for clarification, therefore this item was closed.

8 – HASR Programme Update – Ivan McConnell to update on the programme to a NEDs briefing – completed.

Following review the action log was noted.

4.2 Draft F&P Workplan 2021/22

Gill Ponder highlighted that following comments received, the draft workplan was presented today for any further amendments. The workplan would be presented to Trust Board along with the Committee effectiveness review.

Brian Shipley asked that the use of resource is included in October and March; confirming that the model hospital and benchmarking is on the workplan quarterly.

Andrew Smith raised the cross-over with some Committees, noting that F&P and ARG pick up some similar items such as Cyber Security, so clarity on what goes to each Committee was required to prevent duplication or items slipping between Committees. He suggested that items that cross over between Committees should be discussed at the Trust Board in August.

Following discussion, the draft workplan was agreed but it would require approval from other Executive Directors due to the lack of quoracy at the meeting. It was agreed that Gill Ponder would send out the draft workplan following the meeting.

Action: Gill Ponder

Item 6 06/21 Integrated Performance Report (IPR)

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

Unplanned Care

- Operational pressures continue to affect ED performance due to the increased levels of attendances both at NLAG and nationally.
- Continuing to use ECIST to support the organisation around developing improvements.
- External Audits undertaken i.e. Missed Opportunities; and Real Time Point Prevalence Audit. The results highlighted a number of key themes including staffing and workforce, environment and operational process.
- The observation audit highlighted three linked key elements i.e. pathway development, accountability at all levels within the department as well as staffing and workforce issues
- The Real Time Audit showed that most patients had contacted other health care providers prior to attendance at the ED.
- A new delivery board had been set up to take forward the improvements, similar to planned care monthly reviews, to increase accountability.

Questions were invited from the Committee.

Linda Jackson queried the stranded and super-stranded patients noting that all indicators show that something is wrong so the assumption would be that it was having an effect on A&E.

Shaun Stacey agreed and explained that some beds had been lost through refurbishment of Ward 29 but the right pathway was still not being followed. A new approach to discharges had been brought in but there were still issues to manage. One of the challenges was related to 7-14 day stays and getting plans in place early enough to allow patients to go home within that period. Other challenges at SGH were around bed occupancy remaining high resulting in high numbers of individual patient moves. SDEC operational hours were also not ideal.

A review was commenced in April of the bed base that met the requirements of the assessment unit. 100 conditions were considered where hospital admission was not required e.g. frailty patients treated at home rather than admitted. A business case had been prepared outlining a lower number of beds to reflect this practice. There was also the historical tendency for some practitioners to automatically admit patients

Shaun Stacey also explained that the bed base requirement was taking longer to sort due to a number of anxieties around family services; highlighting specifically gynaecology in particular, which is mainly day case and between those and breast surgery four beds a week were needed. Currently there are 26-24 beds across two sites with a number of small wards of 13-14 beds which are expensive as they require the same levels of staffing than larger, more productive wards. However, given the “heat” around reducing beds it had been agreed that, for 12 months, beds would be reinstated to 500-560 acute beds, not including children or ICU. The number had been adjusted to afford family service a small number of beds whilst consultation took place around further sustained improvement.

Linda Jackson asked that once the bed base was confirmed that this is reported to the Committee, which was agreed.

Action: Shaun Stacey

Stuart Hall asked if some of the pressure in ED could be attributed to paediatric patients anticipating been seen sooner by coming into the ED; and also asked about the consultant’s power of admission.

Shaun Stacey stated that there was a small increase attributed to paediatrics but not particularly concerning although noted there are no paediatric specialists within ED. In terms of power of admission, there are various challenges with some specialities seeing more delays than others. Both of these topics were included within the ECIS report.

Following the review and discussion the report was noted.

Highlight Report - The external reviews and enhanced monitoring of recommended actions to improve ED performance and the finalised bed base to be reported back to the July meeting of the Committee.

Item 5 06/21 **Presentations for Assurance**

5.1 Board Assurance Framework 2021/22 (BAF)

There was no update due this month.

5.2 CQC Progress Report

Angie Legge attended the meeting to present this item and introduced Jennifer Moverley who had joined the Trust as Head of Compliance & Assurance. Angie Legge advised that the figures within the report did not reflect the progress that had been made and highlighted the areas that remained red, including the community nurse staffing which should have a better update next month on the progress being made.

Angie Legge went on to explain the work to improve mandatory training compliance, which included individual divisional plans, which were having an impact on the figures; leadership approach through professional routes, with some areas slightly behind so focussing on that; also speaking with POE on the process as some individual training was not appropriate for everybody. However, POE had capacity issues due to Covid so this was also part of the catch up.

Andrew Smith referred to section 4 - *Areas of Learning* and the improvements, once signed off, remaining in place and being embedded.

Stuart Hall also referred to this section and asked who would sign-off the improvements to say they are now “business as usual”. Angie Legge explained that the original plan was to wait for the inspection and take stock after that and this was broadly still the plan. She went on to explain that now Jennifer Moverley was in post this was something that she had already started to look at.

Following the review and discussion the report was noted.

Highlight Report – The arrival of Jennifer Moverley giving additional resource to address the actions going forward. Angie Legge also mentioned the progress with investment but noted that community staffing was still under discussion.

9.58am - Angie Legge and Jennifer Moverley were thanked for attending and they left the meeting.

Item 6 (cont’d) **Integrated Performance Report**

6.2 Integrated Urgent and Emergency Care including Patient Flow

Shaun Stacey highlighted as follows:

- Under performing against H1 in a number of areas; however meeting the 85% threshold requirements to achieve the funding stream.
- Ongoing work to make improvements but challenges due to ill-health with senior clinicians and two unexpected family leave requirements which had affected LOS
- Anaesthetic and surgery capacity is below where expected it to be
- Trying to treat as many cancer patients and long waiters noting 52 week waits had reduced considerably and this was being reviewed weekly
- Fully utilising the independent sector
- Also hoping to use Trent Cliff in North Lincs who can accommodate a number of specialties.

Andrew Smith acknowledged that focussing on cancer patients and long waiters would have an effect in other areas with risks being monitored in other committees but recognised and supported the reasons.

Gill Ponder raised the comment (Slide 8) about redirecting patients to primary care when not appropriate to be in ED and asked how that demand could be redirected. Shaun Stacey explained that streaming remains an important priority but is a challenging area due to finding practitioners with the appropriate skill levels. A number of ideas had been tried including piloting a scheme with GPs which unfortunately had not worked. Shaun Stacey advised that the only Trust that seemed to have success with this was Blackburn and this work would be explored further.

Shaun Stacey also highlighted that GPs are under immense pressure but patients have a perception that they need to be seen face to face by a doctor and when that is not possible they attend ED. Despite an improved 111 system, which does divert patients more appropriately, it is envisaged to set up alternative routes which would help streaming but further training was still required.

Ian Reekie raised the role of the Urgent Treatment Centres and whether there was still a different operating model at each site. Shaun Stacey explained the difficulties of clinicians wanting to make high level decisions and highlighted the extremely successful increased hours in primary care. Shaun Stacey confirmed that there were two operating models; North Lincs piloting a scheme but NEL did not want to use this approach.

Linda Jackson asked if the GPs where overwhelmed as a result of Covid. Shaun Stacey stated that there were a number of reasons including Covid but also planning and poor flow and commissioning approaches. He added that by stopping people coming into ED at the beginning of Covid they are now seeing longer term ailments coming back in.

Stuart Hall questioned ambulatory care and Shaun Stacey explained that whilst there is good work being undertaken it was not showing as a benefit. He went on to advise that EMAS had introduced specialty paramedics in North Lincs between 10.00am-midnight attending incidents, resulting in 960 potential ambulance admissions prevented. The training of specialist paramedics had been stalled during Covid and could take two years to get that skill in place to be able to make better decisions at the scene of incidents which would reduce conveyances in the long term. Getting the public to help themselves and know when it is best to go to GPs and when to go to hospital was however key.

Following review and discussion the report was noted.

Highlight report - To include prioritising patient safety and wellbeing resulting in some minor operations being delayed. Flow of ambulatory care and conveyancing and better and improved pathways; and the public understanding of the need for GP or hospital.

6.3 Planned Care

Shaun Stacey took the paper as read and invited questions from the Committee.

Linda Jackson raised the DM01 indicator and the challenges that were affecting performance in other areas. She also asked if the 50% vacancy rate also included the extra substantive posts within the business case and queried if this needed to be referred to the Workforce Committee.

Shaun Stacey explained the work that had been done including opening up additional scanning capacity, medical recruitment where possible, mobile scanners in the community where possible and maintaining use of mobile units to help with the backlog. DM01 performance was directly related to capacity and demand so need to look at diagnostic capacity in a different way. Other challenges occurred due to prioritising long waiters and cancer patients to the detriment of other less urgent cases.

Linda Jackson commented that it did not appear to be getting any better and asked if it was worth a deep dive in the recruitment area. Shaun Stacey commented that he did not think there would be benefit at this time looking at capacity and modelling as a deep dive and felt there were other areas to deep dive that would make a difference such as community audiometry.

Stuart Hall suggested that it could be initiative overload by trying to do too many things at once without sufficient resources. Shaun Stacey explained that his team were trying to look for answers to the immediate challenges and then go back to the base line work profile. He did not think it was initiative overload stating that possibly positioning some scanners in the local community without using NLAG staff would help, but radiology staff were rare. Shaun Stacey also explained that mobile scanners were not put in place without sufficient staff to run them.

Shaun Stacey added that the resource in the community needed funds to be able to create capacity away from the hospital.

Ian Reekie asked about the independent sector capacity and in particular the reference to Trent Cliff in the North Lincs area. Shaun Stacey explained that whilst some staff had left the Trust and joined Trent Cliff they had the capacity for other specialties including ENT and colo-rectal, whereas St Hugh's tended to favour orthopaedic work only.

Highlight report - Ongoing concerns around diagnostics; recognition of being behind plan for H1 with a plan for recovery. Trent Cliff and prioritisation causing queue problems. Benefit of 52 waits and cancer performance sustained.

Item 7 06/21 **Finance Report – M02**

Brian Shipley presented the report and highlight issues of note as follows:

- On plan against deficit position
- ERF - £3.3m included within plan but ERF income was dependent on the overall ICS position, noting the baseline and gateway conditions were still to be agreed. Given the uncertainty around the income the Trust had prudently accrued for corresponding expenditure. The Trust's submitted financial plan for H1 only included a marginal

value for ERF contribution with the full income and costs included as a memo item. Since the submission all providers have been asked to include the ERF values in their plans. A revised plan including ERF income and expenditure will be reported for the next committee meeting onwards.

- Covid Expenditure remained steady at £1.2m a month. Currently living just within funding received. Bed base and staffing were the biggest challenges and when the base line had been finalised it would be possible to review the figures. Covid was the main focus at PRIMs to review Covid expenditure and where the recurrent costs were to be included as part of H2 process.
- CIP – stepped increase in H2. On plan but expecting a slight shortfall and being prudent for forecasts for H1, with risks still around delivery and recruitment and how that drives agency spend. Delays with potential overseas staffing due to ongoing Covid restrictions. Currently a £1.2m gap. Pipeline and mitigation schemes were being identified but needed to work through to get pipelines to deliverables to address the gap.
- Capital – Currently 10 weeks behind planned schemes. Working through revenue implications and may need to extend scanners to create capacity. EPC funding expected to be able to extend spending to March 2022. ED / AAU schemes were over budget with the biggest cause an increase in material costs. A further update would be provided at the next meeting.

Action: Brian Shipley

Linda Jackson raised the risk adjustments in CIP and asked if the 10-week delay at SGH could be recovered to enable opening on time. Brian Shipley explained that a prudent approach had been taken given it was still early in the year.

Simon Tighe confirmed that the 10 week delay was guaranteed but he would try and work with contractors on the timescale. However a number of unknowns underground had been discovered which needed to be addressed by diverting services to continue operations. Simon Tighe also advised that the original delivery time for spending £40m by September for the energy schemes looked like it could be extended..

Stuart Hall commended the good progress on the CIP programme and asked about ICS and exceeding 85% threshold and the impact of bank incentive schemes.

Brian Shipley explained that work was ongoing on the baselines and gateways but there was nervousness in the centre that the threshold was set too low so expecting to see a tightening up of gateway criteria. An assessment would be undertaken in July and August. In terms of the bank incentive, schemes ceasing would save £555k per year.

Gill Ponder queried the cash flow forecast suggesting that if the trend continued it appeared likely that there might be a cashflow problem by November 2021 and asked for assurance on that. Brian Shipley explained that under normal conditions cash would be a restraint but with Covid income it had become less of an issue. He went on to further explain that some of the trajectory was around the way the capital programme was phased, also there was no ERF included within the trajectory. The Trust were duty bound to not have cash balances below £1.9m and it was expected that the Trust would get back to that point, so whilst this was less of a problem this year it could be a problem going forward; he also highlighted that the trajectory only went up to the end of H1.

Following the review and discussion the report was noted.

Highlight report – highlights from Brian Shipley and that the Committee requested an updated capital plan, with dates and milestones, to gain assurance for Board.

7.2 Capital Investment Board Minutes

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

7.3 Financial Special Measures Update

There were two letters provided for information and Brian Shipley highlighted the work being undertaken on the areas identified to be able to exit FSM. These included the achievement of the H1 plan both as a Trust and a system; refreshed long term financial plan with a focus on reducing Covid expenditure and the underlying run rate, the Cost Improvement Plan delivering according to plan; the planning cycle would be refreshed and included in the finance reports brought to the Committee from August 2021 and Lee Bond was working on the finance team structure. The relevant grip was in place internally and oversight assurance was through F&P Committee and also PRIMs; a revised governance framework was currently being undertaken for PRIMs.

Gill Ponder asked that once the plan was in place, the F&P Committee should monitor the deliverables within that plan which should include timelines and milestones in order to provide assurance on behalf of the Board.

Stuart Hall noted that in the letter it referred to fully exploring consultants' job plans and asked if the Trust was an outlier. Brian Shipley explained that the PAs were more than they should be due to consultants covering vacancies and sick leave so as far as he was aware it was not individual job plans. They were working above the norm so need to see that in the round. Shaun Stacey confirmed that the Trust were working with NHSI/E on job planning and agreed that it needed to be seen in the round. He noted the difficulties in recruitment as some services were provided by primary care in other areas..

Following the discussion the letters were noted and the key points would be included in the highlight report to the Board.

7.4 Use of Resources

Brian Shipley explained that the programme was still being worked through and whilst an assessment was not expected this year, it was good practice to still work through the programme. It was anticipated a paper would be brought to the next F&P Committee following the normal internal process of ET and TMB.

6.4 OPD Transformation Project / Reduction of Follow Up Waiting List Position

Shaun Stacey presented the report which was taken as read and highlighted that the gap in follow-ups was getting larger despite all the work that was being undertaken. Overall balance around prioritisation by clinical need, leaving limited resources to treat less urgent cases. Behind trajectory by 16,500 follow-ups but good robust recovery plan was in place to get back on track to end the year on target at 9,000. Urology over-performed in April and May and hope other services get back on track also.

The Connected Health Network plans would need time to embed which could take 6-8 months for the benefits to be seen.

There were no questions raised.

Highlight report - Behind on follow-ups and Connected Health Network with recovery plans in place. Also highlight the Patient Knows Best initiative.

Item 8 06/21 **Strategic Development**

There was no update for the meeting this month.

Item 9 06/21 **Digital Strategy**

There was no update for the meeting this month.

Item 10 06/21 **Estates & Facilities**

10.1 BAF Risk – Deep Dive – Medical Gases

Simon Tighe attended the meeting to present the report which was taken as read and highlighted issues to note.

Simon Tighe drew the Committee's attention to the embedded action plan (page 11) that, due to the timing of the report, did not show the true picture as a number of actions had been completed in May and June.

Simon Tighe referred to the operational incident in November 2020 and advised that the first draft of the SI report had been received and it was agreed that the final report would be brought to the F&P Committee in September.

The HSIB report focussed on a national level and would be presented to ARG in July for approval/assurance; the question was raised if it should also be seen by F&P for information. Gill Ponder noted that patient safety issues were presented to Q&S Committee and Estates to F&P so was unclear why the report was going to the ARG Committee.

Andrew Smith explained that originally it was thought that this was a substantial risk and points had been made on the overseeing governance so was important to have that cross committee reference.

Stuart Hall raised the issue of scenario planning and asked what the absolute maximum oxygen capacity that the Trust could handle was and if the plan hit that level. Simon Tighe explained the links with Shaun Stacey's team on surge plans which had been revised, noting the finite oxygen points in place before internally diverting became necessary. The surge plans were based on what could be delivered.

Shaun Stacey went on to explain further the three phases including Phase 1 which saw revised plans being completed; Phase 2 reviewed and monitored demand flow and re-evaluated wards' capacity; Phase 3 documented a list of wards and maximum flow of each. The surge plans were still to be signed off by TMB in July and would then be brought to the F&P committee for assurance.

Simon Tighe highlighted £1.5m allocated emergency funding from ICS which would future proof certain areas of the hospital and may require revisiting the surge plans if more capacity became available.

Andrew Smith questioned the report and asked if this was part of a series of deep dives provided to the board on risks as he was concerned that, given all the context of a major incident, two external reviews and ARG looking at specific actions and cross referring to other committees and asked if this report contextualised the issues or whether something further should be provided to articulate the comfort it was giving. Simon Tighe explained that the report was an operational, business as usual report.

Andrew Smith suggested a supplementary note that lessons had been learned in the wake of the incident in November 2020. It was agreed that one-page supplementary paper would be brought to the next F&P Committee to enable triangulation of the completion of actions as a result of learning from the incident.

Shaun Stacey queried the duty nurse and medical officer roles training and if this had been resolved. Simon Tighe confirmed that it had not been completed and had been escalated through the Medical Gases Committee. It was agreed that Shaun Stacey and Simon Tighe would have a discussion outside of the meeting.

Action: Shaun Stacey / Simon Tighe

Following review and discussion the report was noted.

Highlight Report - £1.5m funding and challenge from the Committee to include more information within the report on the learning and actions taken as a result. Agreed to a supplementary paper to further highlight SI and HSIB report and actions taken as a result. Published SI report to F&P in September.

Shaun Stacey commented that whilst no harm to patients had been identified, it should be noted the harm was to the process including regional delays in Hull and Doncaster, who both struggled due to the demands put on them as patients needed to be moved to those sites. A review of the escalation process was being undertaken as the Trust's mutual aid response was not what it should have been.

Item 11 06/21 **Items for Information**

11.1 Performance Letters to Divisions following PRIMs meetings – Letters had been provided for information and no questions were raised.

Item 12 06/21 **Any Other Business**

Reference was made to the last ARG Committee and the ambulance handovers and the inconsistencies in the data published, which had been raised by Stuart Hall from an Internal Audit Report. It had been agreed to refer this issue to F&P and a feedback paper would be brought to the next F&P meeting.

There was no other urgent business raised.

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

There were no issues raised to highlight to other Trust Board Assurance Committees.

Item 14 06/21 **Matters for Escalation to the Trust Board**

Items for highlighting to the Trust Board were agreed throughout the meeting.

Item 15 06/21 **Date and Time of next meeting**

Wednesday, 28 July 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	✓	✓									
Stuart Hall	✓	✓	✓									
Andrew Smith	✓	✓	✓									
Lee Bond	✓	Apols	Apols									
Peter Reading	✓	✓	Apols									
Shaun Stacey	✓	✓	✓									
Jug Johal	✓	✓	Apols									
Ivan McConnell	Apols	✓	Apols									
Shauna McMahon	✓	✓	Apols									
Helen Harris	✓	Apols	-									
Brian Shipley	✓	✓	✓									
Ian Reekie	✓	Apols	✓									
TOTAL ATTENDEES	**12**	**11**	**7**									

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **28 July 2021 – via Teams Meeting**

PRESENT:	Gill Ponder	Non-Executive Director / Chair of F&P
	Michael Whitworth	Non-Executive Director
	Lee Bond	Chief Financial Officer
	Shauna McMahon	Chief Information Officer
	Ivan McConnell	Director of Strategy & Planning
	Brian Shipley	Deputy Director of Finance
	Ian Reekie	Lead Governor
	Simon Tighe	Deputy Director of Estates & Facilities
	Ab Abdi	Deputy Chief Operation Officer
IN ATTENDANCE:	Alison Hurley	Assistant Director of Corporate Services (For Item 5.1)
	Angie Legge	Associate Director of Governance (for item 5.2)
	Jennifer Moverley	Head of Compliance and Assurance (for item 5.2)
	Mike Simpson	Associate Director of Strategic Capital Development and Programme Director for ED & AAU (For Items 8.1 and 8.2)
	Chris Evans	Associate Director for Information Services (For items 9.1; 9.2 and 9.3)
	Howard Davis	Director, Grant Thornton (For items 9.1; 9.2 and 9.3)
	Anne Barker	Finance Admin Manager/PA to CFO (Minutes)

Item 1 07/21 Apologies for absence were noted from: Linda Jackson; Stuart Hall; and Andrew Smith (Michael Whitworth attended to ensure quoracy); Jug Johal (Simon Tighe Deputising); Shaun Stacey (Ab Abdi deputising).

Item 2 07/21 **Declarations of Interest**

There were no declarations of interest made.

Item 3 07/21 **To approve the minutes from the previous meeting held on 30 June 2021**

The minutes from the meeting held on 30 June 2021 were agreed as an accurate record.

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

Item 4 07/21 **Matters Arising**

4.1 Action Log

The action log was reviewed as follows:

5.1 (26 05 21) – BAF – Discussion between Andrew Smith and Shaun Stacey. Due to apologies from both Andrew Smith and Shaun Stacey due to annual leave, Gill Ponder asked Anne Barker to enquire if this had taken place.

6 (30 06 21) – IPR – Finalisation of bed base. Ab Abdi advised that a paper had now been taken to TMB but it had not been approved by TMB in time to present it to F&P. It would be brought to the next meeting in August 2021.

10.1 (30 06 21) – Deep Dive – Medical Gases. Simon Tighe confirmed he had met with Shaun Stacey and confirmed there was a plan in place to deliver the training. This would be included in the medical gases update brought to the Committee in September 2021.

Following review the action log was noted.

4.2 Draft F&P Workplan 2021/22

The draft workplan had been circulated to the Executive Directors following the last meeting. There was one amendment to make in terms of the timing of the TOR and Committee Effectiveness. It was agreed this should be moved to May to allow time to undertake the reviews and present to Trust Board in August.

With the above amendment the workplan was agreed.

4.3 F&P Committee Self-Assessment Results

Lee Bond commented on the lengthy agenda and explained that he had reviewed the TOR, which focussed on performance targets and suggested that it felt like the finance elements sometimes got squeezed; and Estates & Facilities and Digital should also factor and was not sure how to divide the time on the agenda between the four elements.

Michael Whitworth agreed with these comments.

Gill Ponder noted the recent quoracy issues that were reflected in the comments received and she agreed to pull together a draft action plan based on comments received and circulate for review and further comments. Gill Ponder also agreed that at the agenda set meeting a balance of time needed to be considered and reflected in the agenda. Gill Ponder added that with so many late papers there was pressure to ensure due consideration was given to all items and that there was sufficient time for robust scrutiny to gain assurance on behalf of the Trust Board, in view of the number of BAF risks that sat with the F&P Committee.

Action: Gill Ponder

4.4 Review of TOR

Gill Ponder highlighted that a few interim changes had been made to the TOR in an attempt to recognise Lee Bond's role at both Trusts and that Brian Shipley could ably deputise; equally for Shaun Stacey and Jug Johal in Ab Abdi and Simon Tighe respectively. Therefore, the TOR now stated that deputies would count towards quoracy and have similar voting rights to their Executive Directors. It was also noted that Helen Harris was reviewing all sub-committees' TOR to ensure consistency. Lee Bond noted the contents and scope within the TOR were comprehensive.

Gill Ponder highlighted the reference to the relationship of the Committee to the ARG Committee given there were subject matters that overlapped both Committees and planned to pick up that as part of the action plan following the Self-Assessment Review.

The Committee agreed the changes to the TOR. These would be presented to the Trust Board for final ratification along with the self-assessment review in September.

Item 5 Presentations for Assurance
07/21

5.1 Board Assurance Framework 2021/22

Alison Hurley presented the BAF report for the Committee to consider the strategic risk rating scores, particularly those at 20, and whether or not one impacted on another. Consideration would also need to be given to ensuring that any risks remaining at 20 had appropriate controls in place. Alison Hurley advised that Helen Harris met with the Exec Directors or their Deputy on a quarterly basis to review the ratings.

Shauna McMahon joined the meeting

The Committee discussed the BAF in detail with a number of concerns highlighted as follows:

- Gill Ponder noted the majority of the high risk scores had remained high and asked if progress should have been made to lower those scores, noting that some scores appeared to be moving in the wrong direction.
- Simon Tighe noted that some of the risks could actually be issues which had already happened e.g. legionella, roofs at both sites and the water tank at DPOW. These had a serious effect on services and therefore were a high risk. He noted that some engineering organisations had a different way of scoring so it may be that this is not the correct tool for these risks, but it would be helpful if risks and issues could be separated.
- Michael Whitworth acknowledged Simon Tighe's comments but also noted that mitigation to address these issues was in place. Michael Whitworth suggested that the organisation could be used to operating with high risks so maybe needed to identify the residual risks that should have a maximum score of 15.
- Simon Tighe also suggested that ownership of the risks was important which was where the constant internal monitoring of the risks within Estates was undertaken. He added that it was preferable to have that structure within E&F acknowledging that it may not be the same as the corporate risk
- Shauna McMahon agreed and referred to three different elements of risk in Digital but grouped together as one strategic risk so again unclear on issues versus risk.
- Lee Bond noted there was no target to the risk ratings i.e. if a risk was 20 and been at that score for a while there should be a target to work towards during that year.

Gill Ponder noted the number of concerns and added that given the number of risks, particularly with high scores, a thorough review could not be achieved by the committee in the time allocated particularly as the BAF was only brought to the Committee on a quarterly basis. Gill Ponder proposed to either have a deep dive per month on a specific risk, or a separate extra-ordinary meeting to review the BAF.

Michael Whitworth stated that given the number of areas covered by this Committee one item per meeting would probably be the way forward. Michael Whitworth also supported Lee Bond's comment on the requirement for a target to be included within the BAF which would identify the aspiration of the organisation.

Following the discussion it was agreed that the Committee would review one strategic risk on a rotational basis each month. This would ensure that the Committee gained assurance on the risk scores, target scores, controls in place, mitigations and any gaps.

Alison Hurley stated that she had noted all the comments and would take them back to discuss with Helen Harris.

Action: Alison Hurley

Gill Ponder noted that the workplan would also need to be amended to add the BAF back to a monthly basis to review each strategic risk on a rotational basis.

Action: Gill Ponder

Alison Hurley left the meeting.

5.2 CQC Progress Report

Angie Legge and Jennifer Moverley attended to present the CQC Progress report. The report was taken as read and Jennifer Moverley highlighted that eight actions had now moved to green; and one red moved to amber in Diagnostics due to the new scanner. The community nurse staffing remained red. Mandatory training cut across a number of divisions and, following discussions with Dr Kate Wood, this had been broken down per division, per staff group to try and manage completion of the training.

The CQC had asked for a self-assessment on the current position and the divisions were working on that.

Jennifer Moverley described an updated process whereby closed actions were only closed once uploaded to CQC which gave additional reassurance. Quarterly reviews would be undertaken on the closed actions to ensure that they were being maintained. Gill Ponder commended the work on the closed actions to ensure that the improvements had been embedded and were sustained.

Lee Bond commented on conversations with commissioners and NHSE/I and funding for business cases attributed to the CQC action plan. There was still work to do around community nursing and anaesthetic cover in ED. It was unlikely that any additional funding from CCGs would be available that year and issues would be picked up through the 2022/23 planning round.

There were no further questions and Angie Legge and Jennifer Moverley left the meeting.

Item 6 07/21 **Review of NLAG monthly performance and Activity Delivery (IPR)**

Ab Abdi attended the meeting to present the report and highlight specific issues to note.

Unplanned Care

- Covid Wave 3 – Now seeing high numbers of Covid cases particularly at DPOW. Latest figures totalled 31 cases i.e. 25 at DPOW and 6 at SGH (one in critical care)
- Continued challenges with workforce in both medics and nursing due to sickness and self-isolating. Demand was challenging with increased numbers through the front door. Q1 was high with July settling down slightly. An oversight system was in place but the service was fragile.
- Six monthly reviews of the service were undertaken and the Trust were working with EMAS on direct streaming to the service.
- Discharge to assess also had its challenges although continued to be successful and one of the best performers in the region.
- 98% of ward rounds now took place before 10.00am.
- Stranded & Super-stranded patients – early part of that week there were 8.63% of super-stranded patients; the national ambition was 12% so this equated to third best out of 44 hospitals.

- LOS – less than 4 days and again third best. Escalation process was in place for patients in hospital for more than 14 days.
- Streaming - new EMAS direct streaming to SDEC service at both sites. The programmes of work had been established to address streaming.

Lee Bond queried 52 week waits and noted that 1,400 patients had reduced to 600 in four months and asked when this would be zero. Ab Abdi advised that 52 week waits needed to be at zero by March 2022, but acknowledged that at that rate it could be earlier, which would be preferable.

Lee Bond also queried diagnostics and asked how close they were to achieving the 6% target now the new MRI scanner was in place. Ab Abdi advised that assurance had been given to the CQC that the target would be met with the new capacity in place.

Gill Ponder queried the demand through the door of ED and asked what support from system partners was in place to get people seen in the right place. Ab Abdi explained the programme of improvement that was in place including a Task & Finish Group established to look at this system wide. There had been some recent support i.e. out of hours but more pace was needed from the system to further support.

Gill Ponder also noted the improvement in SDEC and offered the Committee's congratulations to the team on the impact this was having.

The following three reports were part of the new workplan to undertake deep dives in specific areas of the IPR.

6.2 Urgent & Emergency Care and Community Response

The report was taken as read and provided for information. The paper described the Community & Therapies approach to Single Point of Access (SPA); Community Response Team GP (CRTGP); 2 hour Urgent Crisis Response (UCR); and Discharge to Assess (D2A). All the processes had been put in place to relieve some of the pressures on the ED and acute care.

Ian Reekie asked to what extent these initiatives had been replicated in North East Lincolnshire (NEL). Ab Abdi explained there was a similar system in NEL for Discharge to Assess as this was a standardised system and NEL were performing slightly better. The 2 hour Urgent Crisis Response was part of national guidelines so more or less the same principles were followed.

Following the review the report was noted.

6.3 Ambulance Handover Data (referral from ARG Committee)

Ab Abdi explained that the paper presented was more extensive than probably required to ensure the Committee had a full overview, noting the Data Quality section (page 11) specifically addressed the issue raised by the ARG Committee.

Gill Ponder noted that EMAS and YAS record the arrival times of ambulances whereas NLAG record the arrival to reception and consequently the times would be different which Ab Abdi confirmed. He added that there could be three different times used i.e. arrival by ambulance; reception time and handover time and the time input on to the system could be different from any of those.

The Committee noted the report.

6.4 Surge, Escalation and Winter Plan – For Information

Ab Abdi highlighted that NLAG were proactive on winter planning and achieving 95+% aligned with national principles. He drew the Committee's attention to the principle framework for Wave 3 (page 7) and highlighted that governance was in place if deviation from those principles was required.

Gill Ponder noted the introduction within the report reference to EU Exit impact on goods, services and borders and asked if that was time expired. Ab Abdi agreed to review.

Action: Ab Abdi

There were no further questions and the report was noted.

6.5 Planned Care

Ab Abdi continued with the presentation of the IPR and highlighted issues to note as follows:

- Progressing 52 week waits and slight improvement seen with 18 weeks. They were already struggling with capacity during wave 2 then wave 3 commenced and added to that the recent Opal 4 position. It should be noted however that no elective work was cancelled because of this.
- Recent cancellations were due to staffing in critical care and also affected theatres.
- Diagnostics was on track with recovery plan and more capacity should be available with new scanners
- Long waiters 52 week waits to get to zero and also have to manage 40 weeks, so the focus was also on the 40 week waits.
- Cancer waiting time – challenges with performance, but with July was better than June. The main challenges were the inter-dependencies with Hull. MDTs and Oncology and PET scans were important factors in achieving cancer targets.
- Over-due and Follow Ups needed to hit 9,000 by the end of March 2022; currently 27,000. Regular meetings were in place with Divisions to offer support to ensure mitigation and actions plans were in place to hit the trajectory. This could be at risk.
- ERF not quite on target. Underachieving in some areas due to workforce but also effectiveness and working with NHSE/I on that.

Lee Bond was concerned with the position with ERF acknowledging the progress made on 52 week waits but noted the struggle with theatre productivity and utilisation which was not included within the IPR. He noted that £6m was planned in the first half of the year and only 56% had been achieved with a lot of volumes but not hitting the case mix for the electives. Lee Bond asked if this could be recovered, noting the difficulty to get income on low value activity. The ICS were only just below the ERF trajectory so more work to do on that. The money of the whole system was dependent on each partner achieving the target. Ab Abdi agreed to include more details on theatre productivity and utilisation in future reports.

Action: Ab Abdi

Ab Abdi stated that Covid and staffing challenges impacted on all specialities and theatres was also a factor which NHSE/I were supporting. There were three work streams i.e. pre-assessment, where excellent work had been done; workforce and culture and productivity were work in progress, with culture the biggest challenge. Lee Bond noted that M01 and M02 were doing well so assumed workforce issues were now causing the problems.

Following the review the IPR was noted.

6.6 Patient Waiting List

This item interlinked with previous items and was discussed at that time. There were no further questions raised.

Gill Ponder thanked Ab Abdi for the standard of papers provided and welcomed further data on theatres as a key enabler for improvement in a number of other areas.

Item 7 07/21 **Finance Report – M03**

Brian Shipley presented the report and highlighted key issues to note as follows:

- In month deficit reported in June of £100k, £200k better than plan.
- Income £12.67m below plan. This included £10.48m adverse donated income excluded from NHSE/I financial performance targets and was also due to the re-profiling of EPC capital funding grants.
- Elective Recovery Funding (ERF) £2.5m adrift where expected to be but off-set with underspend in planned use of independent sector for additional capacity
- Medical Staffing pressures still being seen with vacancies and temporary staffing due to middle grade gaps in the Anaesthetic rota.
- Nursing overspend was £0.9m in month but partly off-set through continued underspends in Midwifery
- Covid expenditure – Incurred £3.9m expenditure which was slightly above the £3.85m income received; this included £0.47m for testing and vaccinations
- Pressures with increase in temporary staffing (£4.3m) predominately through agency use due to Covid increase; bank incentives being stopped and additional sessions. Lee Bond advised that he had requested urgent work by the accountants to determine the drivers associated with these numbers as it was an area of concern.

Gill Ponder queried if this should be passed to the Workforce Committee if one of the main drivers was vacancies and recruitment. Lee Bond agreed there should be closer working between the F&P and Workforce Committee. Michael Whitworth agreed that this would give extra discipline and suggested providing a report for the F&P Committee.

Action: Michael Whitworth

Lee Bond advised that he would be discussing with Exec colleagues and Brian Shipley would also be picking up through PRIMs.

Gill Ponder noted the Covid spend and the risk to the financial plan and exiting special measures and suggested the Committee would benefit from knowing that plans were in place to deliver. Lee Bond explained that the finance team would assess and put challenge back to the divisions but given the anxiety within the workforce about the increase being seen with Covid, he did not think this was the right time to ask to cut costs. Once it was back to business as usual, the Finance team would look at that. It was agreed to bring a progress report to the Committee in September.

Action: Lee Bond

Brian Shipley continued the Finance update.

- Savings programme – Have made good progress and closed the gap in the unidentified schemes; currently just over £400k; main risks around workforce and appointments of nurses and doctors. Ahead of plan mainly due to corporate back office savings. Need to get to recurrent savings otherwise there would be pressure for next year, so good progress but not without risk.

- ERF – Initial plan to deliver £9.8m. The increase to threshold from 85% to 95% would mean the potential income had reduced from £9.8m to £6.9m reducing the potential upside of £3m contribution to £200k.

Following the review and discussion the report was noted.

7.2 Capital Investment Board Minutes

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

7.3 Financial Special Measures (FSM) Update

Lee Bond advised that following conversations with the FSM team and also the Executive Directors, once M06 numbers were finalised the Trust should be in a position to say delivered H1 plan. The ICS and Trust were planning for H2.

In terms of the Finance structure, which was one of the criteria for existing FSM, the changes would be supported by NHSE/I.

The only concern was the H2 planning process and Lee Bond explained it was not yet clear from the Treasury around level of efficiency savings required or funding for Covid and Discharge to Assess.

Lee Bond left and Ivan McConnell joined the meeting.

7.4 Use of Resources

Brian Shipley presented this item and explained that the paper provided had been through TMB. A programme of work would be undertaken to update the use of resources matrix by the end of September. It would be led by Lee Bond with other Exec Directors also having their elements to update. It was agreed that a report would be brought back to the F&P Committee in October.

Action: Brian Shipley

7.5 System Finance Update

This item was for information. Doing well at ICS and Humber Coast & Vale with York doing exceptionally well. All CCGs and providers were on plan or slightly ahead. Some pressures and slippages as an ICS system but no issues to report.

7.6 Assessment of Impact of Updated ERF Threshold

This item was covered during the Finance Update

Item 8 07/21 Strategic Development

8.1 HASR programme Update

Ivan McConnell gave a brief update to the Committee and highlighted that the programme was moving at speed with the pre-consultation business case to be completed by December 2021 and public consultation in May 2022. An expression of interest would be completed to bid for capital to build one of eight new hospitals announced by the Government. Work had commenced in preparation for the expression of interest which would be submitted through the ICS.

Programme 1 was around the governance and leadership and Ivan McConnell highlighted that joint Committees in Common had been established which included delegated authority from both Trust Boards for strategic decisions to be made. Engagement events had been held to include Patients, clinical and staff although staff attendance had been low. To date there had been no media interest but expectedthere would be more in September once it went public.

Ivan McConnell highlighted the review of specialties during 2021/22 noting specifically that Ophthalmology would be a system wide piece of work and would involve the recommissioning of services; and Urology had been pushed back to Phase 3 with more work to do on organisation development.

Ian Reekie referred to the staff engagement and commented that the weekly events for staff were very well presented but attendance was very poor and asked if the content was being reviewed; he also asked what connection with Doncaster had been considered.

Ivan McConnell confirmed that it had been agreed to take a step back and review the content and have a rethink. Would be engaging with Drs through their forums; public engagement had been slightly better.

In terms of Doncaster, Ivan McConnell, stated that discussion would be taking place as they had their capital bid rejected so looking at ways to work with that.

8.2 Capital Planning 2021-2028

Ivan McConnell introduced the report which outlined opportunities through the Humber Acute Service Review (HASR) and an outline of the progress made to date.

Mike Simpson attended the meeting to present a brief update on the ED/AAU projects and explained that the actual programme had not, due to time constraints, developed a costed plan before applying for funding. Instead, they had had to apply for funding and make it fit. Since the outline Business case was submitted in 2020, the actual construction costs had increased by 7%, noting that 5%-10% was the norm so it was within those parameters. Major engineering work was required as part of a statutory requirement due to the limited space available for the build. Some independent benchmarking was undertaken on cost per square metre; if ventilation work had not been required it would have been closer to the original figure.

Mike Simpson went on to explain that a cost pressure of £4.7m had been identified. This had been discussed at a recent Capital Investment Board (CIB) and proposed to use £1.7m per year for the next two years to fund the gap which would leave £2m contingency.

The Committee endorsed the proposal from CIB and recommended to Trust Board for final approval.

Following the update Mike Simpson left the meeting.

Item 9 07/21 **Digital Strategy**

9.1 Clinical Data Improvement Programme

Chris Evans and Howard Davis (Grant Thornton) attended the meeting to present the report which outlined Year 2 delivery of the CDIP Programme.

Chris Evans highlighted that the programme had delivered £8.4m against a target of £6m by the end of Year 2, noting the challenging year with Covid that had created issues. Chris Evans highlighted the difficulties with analysis of the data due to the impact of shifts on case mix. Some detailed work had been undertaken supported by Grant Thornton (GT), explaining that leadership of the programme in Year 2 had transitioned to the Trust with support from Grant Thornton.

Chris Evans highlighted that Year 3 had a remaining target of £600k to achieve in terms of income improvement which he expected would be delivered. Digital prioritisation was a key focus with improved use of EPR processes with collaborative working with HUTH to have a particular focus.

Howard Davis highlighted that whilst the programme initially focused on income the clinical benefits were coming through with more accurate data leading to an improved SHMI position. He noted the main risk was around clinical documentation and engagement, which stalled with the on-set of Covid and would be a recommendation for focus in year 3.

Michael Whitworth declared an interest at this point as he had previously worked with Howard Davis and Chris Evans.

Shauna McMahon explained that the Integrated Performance report would make linkages and some data went through coding groups to ensure that coding was correct, but agreed clinical engagement was key to its success.

Michael Whitworth noted that some of the work undertaken in listening to clinicians helped that engagement. Howard Davis highlighted that Dr Kamath was a champion for mortality and getting that engagement resulted in being able to drive forward on that agenda; so getting more clinical engagement would lead to change. The work in mortality, especially reviewing the drivers behind the outliers led to understanding the care models across the two sites and enabled primary care conversations. Also whilst sharing data with management was key, it was important to get supportive clinical understanding of individual services.

This was a good report and excellent progress was noted by the Committee.

9.2 Digital Programme – Financial Update

The paper presented provided a high-level summary and financial position of the Digital Transformation Programme at Month 3. Chris Evans explained that this was going well but slightly behind planned spend due to a timing issue.

Chris Evans explained the focus had been around the digital aspirant funding which had given the ability to move forward on key projects including equipment, infrastructure and connected services.

In terms of future planning, in the next couple of years the plan was to deliver the overall digital strategy for the Trust and it was detailed in the report (pages 4-5) where future investment would take place. This year had seen the infrastructure and systems in place and moving towards assistive technology and looking at more advanced analytics in Years 2 and 3.

Following the update the report was noted.

9.3 Digital Strategy 6 Month update

Gill Ponder explained that she had spoken with Shauna McMahon about this very late paper and had agreed that Shauna would give an overview for the Committee. The Committee could then review the paper outside of the meeting and feed any questions to Shauna who would collate questions and subsequent answers which would be added to the minutes.

Shauna McMahon explained that the report was a 6-month update and outlined the continued good progress being made on the Digital services agenda. The digital work was being recognised, and referred to the recent commendation from HSJ on the coding work with Grant Thornton had achieved. Patient Care had benefited from the digital work noting that almost 60% of letters and appointments were managed through digital services.

Shauna McMahon drew the Committee's attention to the slides included within the report for more detail and specifically the strategic plan roadmap.

Shauna McMahon highlighted that a recent audit review had received limited assurance due to business continuity which was being progressed.

Action: All – to feed any questions direct to Shauna McMahon
Action: Shauna McMahon – to collate questions and responses and provide for the minutes.

Item 10 07/21 Estates & Facilities

10.1 BAF Risk – Deep Dive – Fire Report

Simon Tighe presented the report and explained that the Annual Fire Report was in a different format to the usual deep dive report as this was a report that had been taken through the ARG Committee and would then be taken to Trust Board. He would look to align differently next year.

Simon Tighe highlighted the direction of fire safety management had been impacted by Covid as well as a number of regulatory reforms related to the Grenfell incident. Compliance for fire training remained at 84%. Simon Tighe highlighted the slight increase in fire calls in Grimsby. Funding had been made available to allow replacement of the fire alarm systems. The work was in three parts i.e. software, hardware in terms of cables and then the detector heads. A number of detector heads requiring replacement had contributed to the number of fire calls. Calls at SGH were predominantly linked to the accommodation service.

There were three calls which related to white goods in ward areas which were contained locally without the need for the fire brigade to respond.

Additional funding provided split between fire and water, which were the two greatest risks. The Trust was the only organisation not to have had or be facing fire enforcement notices which was due mainly to the regular communications with the fire and rescue service on progress with planned improvements.

Following the update the report was noted.

10.2 Decarbonisation Energy Scheme LO1 Extension

Simon Tighe presented the report which required the Committee's endorsement before being presented to Trust Board.

Simon Tighe explained that the Trust were awarded £40.3m as part of the Public Sector Decarbonisation Scheme (PSDS) – the largest single award in the country. The paper presented focused on EPC3 grant funding. Under normal circumstances, a full investment grade audit with the preferred contractor to create a full business case would be undertaken. Given the timescales of 30 September to spend the grant money, a request for an extension had been granted and the £10m underspend referred to in the finance report was the result of that extension to the timing of when money would be spent.

The Trust entered into a legally binding letter of Intent (LOI) for the early design and advanced procurement. Following a recommendation by the programme Board and Capital Investment Board the LOI was signed by the Chief Executive for a value of £1.3m. This allowed the programme to carry on at pace.

The Finance & Performance Committee were requested to recommend to the Trust Board to continue to contract under the legally binding LOI capped at £4.77m.

Brian Shipley confirmed that this had been discussed and agreed at CIB and TMB so had been brought to the Committee for assurance.

Ivan McConnell asked if the Trust would be moving at risk with the LOI. Simon Tighe explained that this was a timing issue so no risk as this was grant funded. He added that the same route would have been taken even without grant money.

The Committee agreed to endorse the proposal and recommend it to the Trust Board.

Item 11 07/21 **Items for Information**

11.1 No letters had been provided for the meeting.

Item 12 07/21 **Any Other Business**

There was no urgent business raised.

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

Cross referral to Workforce Committee regarding progress with recruitment, as this was a critical enabler to achieving planned savings on agency spend.

Action: Michael Whitworth

Item 14 07/21 **Matters for Escalation to the Trust Board**

Gill Ponder agreed to pull together the highlights for the Trust Board and circulate to members of the Committee, noting the tight time scales and asking for timely responses.

Action: Gill Ponder / All

Item 15 07/21 **Date and Time of next meeting**

Wednesday, 25 August 2021 – 9.00am-12.00pm via Teams

Attendance Record 2021/22

Name	Apr 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	March 22
Neil Gammon	✓	✓										
Gill Ponder	✓	✓	✓	✓								
Linda Jackson	Apols	✓	✓	Apols								
Stuart Hall	✓	✓	✓	Apols								
Andrew Smith	✓	✓	✓	Apols								
Michael Whitworth				✓								
Lee Bond	✓	Apols	Apols	✓								
Peter Reading	✓	✓	Apols	Apols								
Shaun Stacey	✓	✓	✓	Apols								
Jug Johal	✓	✓	Apols	Apols								
Ivan McConnell	Apols	✓	Apols	✓								
Shauna McMahon	✓	✓	Apols	✓								
Helen Harris	✓	Apols	-	Apols								
Brian Shipley	✓	✓	✓	✓								
Simon Tighe	-	-	✓	✓								
Ab Abdi	-	-	-	✓								
Ian Reekie	✓	Apols	✓	Apols								
TOTAL ATTENDEES	12	11	8	8								

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)224

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors – Public or Private
REPORT FROM	Mike Proctor, Non-Executive Chair of Quality & Safety Committee
CONTACT OFFICER	Mike Proctor, Chair of Quality & Safety Committee
SUBJECT	Quality & Safety Committee (QSC), minutes July and August
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The paper includes the minutes of the Quality and Safety Committee meetings held between July and September 2021

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Minutes

Meeting: **QUALITY & SAFETY COMMITTEE**
Date: **Friday 16 July 2021**
Time: **9.30am – 11.30am**
Venue: **Virtual meeting via MS Teams**

MINUTES

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

In attendance

Dr Peter Reading	Chief Executive
Dr Kate Wood	Medical Director
Ellie Monkhouse	Chief Nurse
Angie Legge	Associate Director of Quality Governance
Ian Reekie	Governor
Helen Harris (item 159/21)	Trust Secretary
Simon Priestley (item 158/21)	Chief Pharmacist
Kay Fillingham (item 160/21)	Lead Mental Health Nurse
Jo Loughborough (item 170 /21)	Patient Experience Lead
Maurice Madeo (item 171/21)	Assistant Chief Nurse / Deputy Director of Infection & Prevent Control
Jenifer Moverley (item165/21)	Head of Compliance & Assurance
Denise Gale (item 169/21)	Cancer Lead
Jeremy Daws (item 161-164/21)	Head of Quality Assurance
Laura Coo	PA to the Medical Director **(for the minutes)**

151/21 Apologies for Absence: *Shaun Stacey, John Awuah, Anne-Marie Hall, Jan Haxby,*

152/21 Chair's opening remarks:

Discussions had taken place with the Executive team and the Non-Executive Directors about meeting face to face rather than virtually and it had been decided that now was not the time but it would be kept under review.

Mike Proctor was really pleased with how the IPR and BAF were developing and thanked all of the Executive team for their contributions and hard work in this area.

153/21 Declarations of Interest

There were no declarations of interest.

154/21 Minutes of the previous meeting held on 18 June 2021

The minutes were approved as an accurate record of the previous meeting.

On page nine, line two of the quality account section Kate noted that it was brought to the Committee for approval for it to be released to stakeholders.

Matters Arising

155/21 There were no matters arising.

156/21 Review of action log

Mike Proctor was expecting a full Ophthalmology report in August which would include assurance on completion of actions from earlier and current never events

157/21 IPR

Mike Proctor referred to the IPR distributed which was taken as read. Mike's understanding was that this Committee was expected to sign off a number of these that then did not need to go to the Board. Kate Wood agreed that was the case although there were some points noted on the front sheet that she did not necessarily agree with. As well as those items which had been identified as concerns Kate wanted to continue reporting Duty of Candour to the Board, although the Trust was fine with reporting Duty of Candour regarding severe harm, more assurance was required for moderate harm and not providing that narrative would prevent us from being as open and transparent as Kate would want to be as an organisation.

Ellie Monkhouse identified that MSSA infections, Maternity C-section and adult observations were kept and reported to the Board also.
Kate drew people's attention to the massive amount of work that had been done with the IPR but noted it was not a completed and there was still a lot of work going on behind the scenes to pull the information together.

Peter Reading thought the IPR still lacked a succinct, two page summary at the front highlighting the things they were worried about and what the Committee needed to be aware of.

Andrew Smith appreciated the work that had gone into this but thought this would not seem a genuinely meaningful report until it was reported by exception and tied in across to the BAF and did not necessarily think this Committee needed to see the whole report.

Peter thought the same to an extent but believed this Committee needed to see the full report for transparency and noted from previous experience that quite often Executive guidance was important but not sufficient and it was important for them to have the wider information. Andrew agreed that the exceptions should be at the beginning of the report so they can be easily found.

Kate took on board the points made noting it was a very much work in progress and asked if members wanted to discuss any parts in more detail.

Mike referred to the number of patients that die within 24 hours of admissions. Kate informed him that the score card asked for the number of patients but it was presented as a percentage which was less helpful than the actual number.

Mike Proctor found the IPR easier to understand now and could see where the issues were in the organisation and from that perspective thought it was a useful improvement. As an overview it was really helpful, but recognised there was still work to do.

158/21 Follow up to 2019 Northumbria Medicines Management Review

Simon Priestley referred to the report distributed which was taken as read and highlighted the key points. NLaG had commissioned an external review of the Trusts Medicines Management systems and process which took place in late 2019. It focused on the safe and secure storage on medicines and underpinning governance arrangements. A number of actions had been completed, but there were still some things that were an ongoing process. The Quality Improvement process was starting in August which would support actions following the safe and secure report.

Kate noticed that there were a large number of things marked as green as actions complete but from her perspective doing an audit alone did not complete an action, rather it was the completion of the actions themselves that should turn it to a green. The report was positive but there were still a large number of actions to complete.

Simon agreed that a lot of the actions were overseen through the Safer Medication Group and a lot were also discussed through the PRIM. Kate asked who would populate the dashboard as there were many things required for assurance and Kate was concerned that there was not the staff in place to process and support that. In response Simon stated that some of the data was pulled directly from Model Hospital and a data analysist was now working in the team to support the work.

In view of some of the risks and gaps Ellie Monkhouse asked if they were on the Risk Register. Simon thought the majority were but would double check. Ellie's second comment was around the QI project which Ellie suspected would highlight more gaps and thought it would be useful for Simon to provide another update in 12 weeks' time to show what had come out of the QI project.

Simon suggested an update in four months' time as the QI collaborative work would be two thirds of the way through in three months' time and it would be more realistic for him to be able to provide an update on the collaborative work in November. The report was due to go to QGG in August and next in November which tied in nicely.

The Committee noted there had been significant progress but there was still a lot of work and actions to be done

Action: Simon Priestley to provide a further update in four months' time which would enable the Committee to see progress made and understand any gaps in more detail (to be added to the action log)

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Regular Reports

159/21 Board Assurance Framework (BAF)

Helen Harris referred to the report distributed which was taken as read. The Framework had undergone a complete refresh and she was asking the Committee to consider if this was what was wanted and required. Any text in red was to be removed. Blue text was for additions but Helen felt they were in a better position for the Committee to see any gaps and actions.

Kate Wood noted that the risk for Cancer had been reduced but did not understand the process by which that had happened.
Andrew Smith thought it did look much improved and the fact it had a current score for suggested journey was good but thought Kate was right to query the Cancer risk as he was concerned and thought we needed to understand how the risk score was set and it needed to be broken down and dealt with. Michael Whitworth agreed with Andrews comments.

Angie Legge informed the Committee that the scoring was taken from where it was on Datix, as updated by the local team, but they had not had the discussion at the Confirm and Challenge meeting yet. Kate confirmed that she would attend the Confirm and Challenge meeting

The Committee was asked to review the description of the risk to the strategic objective. Kate queried whether the reference to being measured against the highest 'international standards' was appropriate. Following a discussion it was agreed to change the wording to indicate that the treatment care and support should be measured against the highest national standards.

160/21 Mental Health Act & Strategy

Kay Fillingham referred to the reports distributed which were taken as read and highlighted the key points. The report identified the progress made towards achieving the objectives within the Mental Health Act (MHA) and hoped the Committee received some assurance in us working towards this It was noted that the report also included an Internal Audit Report on compliance with the Mental Health Act from earlier in the year which concluded 'Limited Assurance'.

Kay invited any comments or questions.

Ellie Monkhouse thought it was worth noting that the complexity of our mental health patients was increasing and was probably one of the main concerns for waiting times in A&E, whilst the right provisions were eventually found for those patients Ellie thought it was only going to get worse due to increasing presentations of patients with mental health needs which challenged the resources available to meet needs. . Ellie acknowledged the work Kay was doing and thought the Trust was extremely lucky to have a Mental Health Specialist Nurse within our organisation.

Andrew Smith thought it should be recorded that this was a really high quality report, easy to read and very informative and thanked Kay for her efforts on that. Mike Proctor asked whether a re-audit on the Mental Health Act was on the programme for an internal audit report. Kay would need to check whether there would be a re-audit as it made complete sense to revisit that.

Action: Mike to refer to ARG the potential to request Internal Audit to re-examine trust compliance with the provisions of the Mental Health Act.

The committee thanked Kay for providing a very informative report.

Kay Fillingham left the meeting at 10.19am

161/21 Approval of the Quality Account

Jeremy Daws referred to the Quality Account distributed which was taken as read. A lot of work had been done and a revised account was attached for approval. Kate Wood reminded members that the Trust did not receive any national guidance for this until mid-May, which made achievement of the deadline impossible. Kate thanked Jeremy and the stakeholders for their input. Jeremy echoed Kate's comments and noted they had some fantastic comments in terms of the timescales. Jeremy was still waiting for some feedback from N E Lincs and East Riding. Comments would be recorded verbatim but Jeremy noted he had to make sure they were factually accurate. This needed to go to the Board in August regardless of those comments being received. Ian Reekie noted that perhaps Governors should be involved in comments

Action: The Committee would recommend that the Trust Board approve the Quality Account.

162/21 Mid-Year Review Quality Priorities

Jeremy Daws referred to the paper distributed which was taken as read. The front sheet highlighted the key points and there were no new recommendations for the Committee to consider based on 21/22 quality priorities. Jeremy had provided an update instead and noted the six individual indicators.

The Committee received and noted the report**.**

163/21 Deviations NICE Guidance

There were no any deviations of NICE guidance.

164/21 Register of External Agency Visits

Jeremy Daws referred to the paper distributed which was taken as read. This was presented to this Committee for information and assurance, the number of external visits had increased since the Committee received this report in May. All had been brought into line with the Trust policy and Estates and Facilities reporting had been brought into this so it covered the full site. Kate Wood added that the register had ensured there was a far better oversight of what was coming into the organisation but there were a large number of open actions and Kate thought many could be closed so asked how the team were ensuring they were being closed off. Jeremy responded that he was working with the directorates to close them off, they were reviewed quarterly, GIRFT did account for a large number but there were some others they were working with the divisions to close down as appropriate. Kate asked if there were any risks within those that were not closed. Jeremy noted that QGG had asked

for more assurance in relation to a visit from the Royal College of Ophthalmology. From the GIRFT point of view the recommendations were more about making improvements and they had been deliberately left open until the assurance was there.

Jeremy Daws left the meeting at 10.3am

165/21 CQC Framework

Jennifer Moverley referred to the document distributed which was taken as read. There were eight actions turned to green, and one turned from red to amber which was the diagnostic waiting list, due to the new scanner and other mitigations circumstances. Jennifer was putting together a presentation to go to the Quality Board. All actions had been RAG rated, challenges had been included and plans were being put in place to make it sustainable. Another change was that the actions would only be changed to blue once they had gone to the CQC, rather than on sign off by divisions.

Peter Reading thought that was a very strong debut at QSC from Jennifer and updated on some discussions had about potential investments in Community Services.

Mike Proctor thanked Jennifer for the report.

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Jennifer Moverley left the meeting at 10.38am.

166/21 PSIRF Report

Angie Legge referred to the report distributed which was taken as read and provided a brief outline of the paper. The paper outlined the main requirements of the introductory Patient Safety Incident Response Framework (PSIRF) which was published by NHSE/I in March 2020. The intention was that this would replace the current Serious Incident Framework. This was about picking a series of themes from an integrated look through SI's; mortality, complaints and then agreeing with the CCG a final group to look at through the year. Angie noted that some of the top themes may not be appropriate to focus on, such as pressure ulcers, as there was a robust Trust wide action plan, and investing resources in further investigation would not lead to any new understanding of the causes. A list had been put together from that integrated review but Angie was asking for the Committee's permission to go to the CCGs to get this ready for April.

Mike Proctor summarised that effectively the thematic review had come out with a short list of ten and Angie wanted this group's permission to agree the short list of four to take to the CCG's. Mike thought they looked like the key four things but invited and questions or comments.

Kate Wood noted that this was quite a different approach and there need to be some thought into what should be looked at in more detail, i.e. should they look at the same things as they did for the Quality priorities or should it be something completely different to cover more areas. Ellie Monkhouse agreed with Kate and thought members needed to have time to think about it, there were a couple of things on their

part such as pressure ulcers and falls, that were not outliers so Ellie did not think there would be any benefit from having those two on the list. Ellie thought there was the opportunity to make some real changes across the organisation.

The Committee agreed this was not ready for sign off yet but Mike looked forward to hearing what the priorities would be following discussions outside the meeting.

167/21 Key SI Update, including Maternity

Angie Legge referred to the monthly report distributed which was taken as read. Angie drew members attention to the Never events, there had been another one recently, all were for Ophthalmology and that would be followed up. They were taking a look at checklists etc. to ensure they were as robust as possible. Mike Proctor commented that a further never event in Ophthalmology was a huge concern. There were no new or closed SI's in the month.

168/21 Nursing Quality Report

Ellie Monkhouse referred to the report distributed which was taken as read and drew members attention to the fact that their vacancies were starting to reduce and the Trust were getting to a more healthy status on staffing overall, A new model recruit specialist nurses was being implemented and significant support was being wrapped around our international nurses recruits. Ellie noted that patient acuity had increased dramatically Yesterday the Trust moved into a first level surge and had to open a red ward at DPoW, some psychological support had been put on and staffing levels increased as this was an area that was affected by the first surge and staff were incredibly tired.

Mike Proctor thanked Ellie for the update.

169/21 Cancer Update to include learning

Denise Gale referred to the update distributed which was taken as read and highlighted the key points. In terms of the constitutional standards the subsequent surgery and drugs had been reviewed and the Trust was still failing the 28 day screening standard and would be doing for some time. The Cancer Transformation Project would be the key milestone for getting the pathways redesigned and reducing the length of time the patients would be on the pathway. This would not happen overnight and would usually take up to two years but the team had started with the Trust last week and would be working on delivering our constitutional targets. They still needed to understand what was happening with regards to Oncology. Peter Reading noted that all Committee members would have by now received in their emails details of the Oncology changes implemented in Breast and surgery. Peter's suggestion was there would be a report in a month or three months' time or both to understand the impact of the changes on the Breast Service. Peter suggested including a copy of the letter with the distribution of these minutes. Kate Wood had also contacted Purva, the Chief Medical Officer for HUTH to ensure there was a consistent approach to how the message was delivered with appropriate QIA and wanting assurance that there was parity of access to services regardless of postcode.

Ian Reekie pointed out that in Peter's letter to OSC it stated that all patients would be seen by an Oncologist and whilst that was reassuring it suggested we were not

completely confident that was always happening across all services. Peter informed that the Lung Cancer service was currently being audited following a suggestion that access to services was not always equitable.

Denise felt there needed to be constant monitoring of breast cancer patients in particular as there were concerns that with the reduction of Oncologists whether they would have the capacity to see all patients and what their mitigations would be if that did not prove to be the case.

Denise requested to bring the update back to this Committee in September and then for a more in depth report after that. Denise did not want us to lose sight of the fact that Oncology across the board was a very fragile service, in Urology they were seeing a minimum of six weeks wait for a patient to get an appointment with a consultant.

Maneesh Singh was concerned the letter read like it was just shifting the blame (to the tertiary provider). In response Kate advised that there was an SLA with HUTH as NLaG did not provide it ourselves, but there were not enough Oncologists and the Trust was trying to ensure that NLaG patients were not disadvantaged. It was not about blame but about transparency. NLaG did not feel that HUTH were going to be able to solve the problem themselves so the Cancer Alliance had to think differently, and Kate and Peter raised through the NHSE/I Quality Board that there needed to be a different approach. The national shortage on Oncologists was noted Maneesh feared the situation was going to deteriorate further and believed a national strategy was required to resolve the situation.

Mike Proctor added that the reality was that the patients in our locality looked to us for answers and we were trying on behalf of our patients to get the best possible service provided in incredibly difficult circumstances many of which were beyond local control.

170/21 Annual Complaints Report

Jo Loughborough referred to the paper distributed which was taken as read and drew member's attention to the PALS data. The team were still struggling to achieve ideal timescales for PALs responses and were discussing how to remedy this with the quality improvement team. Managing formal complaints and achieving good response times had improved, this was in part due to the lead investigator roles, training and quality improvements for the patients using the service. Covid was featuring heavily in the themes as well as care and treatment. Most complaints were relating to people who were bereaved.

The most important improvement was the cultural change within the service. The quality improvement review highlighted the team felt forgotten but there had been some really positive improvements for them in the last year.

Ellie Monkhouse thanked Jo for getting this to where it was now was fantastic and credit to the hard work put in, the cultural changes had been a really big piece for the team themselves and should not be underestimated.

Mike Proctor thought that dealing with patient complaints full time could get really wearing for individuals and how staff kept the morale going was to be commended. Mike really liked the specific learning which was included within the report and thanked Jo for attending.

171/21 Infection Prevention Control (IPC) update

Maurice Madeo referred to the report distributed which was taken as read. The report was self-explanatory, the risk assessment of the BAF had been updated and the main changes were around hierarchy of controls. PPE should be the last line of control to try to reduce or mitigate the risk to staff. Ventilation was one of the biggest struggles so the team were trying to risk asses where AGPs were undertaken. There were a few other changes for the national guidance from Monday which Maurice thought would have an impact from the public perspective.

Ellie Monkhouse thought that role and physical visibility of the IPC team had increased dramatically but ventilation was a worry and had been picked up at the incident control meeting.

Ellie highlighted some positives; as a Trust there was a very robust process in managing our IPC framework as Maurice kept it updated whenever guidance changed. There were concerns about winter and the effect that may have on the services. The SGH site did not have many isolation units compared to DPoW but neither site had many. There had been a HSJ nomination for the team.

Mike Proctor thought the profile of the infection control team and the work that they did had been magnificent and thanked Maurice for taking the time to attend to provide an update.

Highlight reports

172/21 Mortality Improvement Group (MIG)

Kate Wood referred to the report distributed which was taken as read. The important thing not mentioned within the report was that Colin Farquharson who had been chairing MIG was leaving the organisation to be a Medical Director at ULHT. Colin had made a great impact on mortality but Kate was taking over and hoped that we could keep a sustained approach to mortality although Kate was very aware of the work to do.

173/21 Quality Governance Group (QGG)

Angie Legge noted that it was the concern around Ophthalmology that remained the key issue to highlight.

Items for Information

174/21 Quality Governance Group (QGG) minutes

175/21 Mortality Improvement Group (MIG) minutes

176/21 Any Other Business

None raised.

177/21 Matters to Highlight to Trust Board or refer back to QGG

To refer to the Trust Board;

- IPR issues
- Quality account approval
- Cancer and oncology concerns and intended monitoring
- IPC challenges and how they continue and the estate issues
- Recommendation to ARG about the follow up report on mental health act

178/21 Meeting review

Date and Time of the Next Meeting:

Friday 27 August 2021 at 9:30am - 11:30am to be held virtually

The meeting closed at 11.35am

Northern Lincolnshire and Goole NHS Foundation Trust

Minutes

Meeting: **QUALITY & SAFETY COMMITTEE**
Date: **Friday 27 August 2021**
Time: **9.30am – 11.30am**
Venue: **Virtual meeting via MS Teams**

MINUTES

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

In attendance

Dr Peter Reading	Chief Executive
Dr Kate Wood	Medical Director
Ellie Monkhouse	Chief Nurse
Mr Kishore Sasapu	Deputy Medical Director
Angie Legge	Associate Director of Quality Governance
Shaun Stacey	Chief Operating Officer
Ian Reekie	Governor
Jan Haxby	Director of Quality & Nursing (NELCCG)
Ant Rosevear (Item 186/21)	General Manager Community & Therapies
Peter O'Sullivan	Deputy Head of Nursing, Surgery & Critical Care
Jenifer Moverley (Item 194/21)	Head of Compliance
Tracey Wilson	Secretary to the DMD & ADoQG **(for the minutes)**

179/21 **Apologies for Absence:** Helen Harris, Jeremy Daws

180/21 **Chair's opening remarks:**

Mike Proctor noted that the minutes of the recent extraordinary Quality & Safety Committee needed to be formally reviewed and would be uploaded for the next meeting on 17 September.
In regards to Item 8.4, the Update on Clinical Harm would now be a verbal update and item 8.5 SI Annual Report would be deferred to the next meeting. . Item 8.12, the IPC annual report was deferred to the next meeting as was item 10.2, the MIG highlight report.
There had been some challenge with the submission of papers in a timely manner. this month.

Kate Wood felt the decision perhaps should have been made to stand the committee down the previous month, as there were more clinical pressures at present than they had been in wave 1 of Covid and this appeared to be a contributing factor in the delay in submitting papers. There had been a review of the workplan once again and this could be sent out once more as a reminder.
Angie Legge confirmed that process would be looked at to see if improvements could be made.

181/21 Declarations of Interest

There were no declarations of interest.

182/21 Minutes of the previous meeting held on 16 July 2021

On Page 4 under BAF, Kate Wood had attended the Risk Register Confirm or challenge meeting and had intended to query the reduced risk for Cancer Services but there had been no representative from the Cancer team. Kate reminded the Committee that Cancer Cervices were struggling due to the number of Oncologists in Hull having reduced. Breast Oncology was now a merged service with HUTH. PTLS were merged to ensure patients had equity and timeliness of care but Oncology challenges remained very significant and the Committee still needed to understand why the risk had been reduced.
Ian Reekie would like Page 7 of the minutes amended so the final sentence read “all patients would be given priority by clinical need, regardless of referral source”. Ian also requested that Page 5 section 161/21, the final sentence should read that Ian Reekie “suggested and Kate Wood agreed that feedback from Governors should be listed in the BAF among the strategic objective 1 controls”.

Mike Proctor asked that item 161/21 could be updated to add that the Quality Account had subsequently been approved by the Trust Board.

Mike Proctor requested in relation to item 169/21 that an update on how the single cancer service was progressing and its impact on the service.

Peter Reading commented that the joint committee in Hull had received this report and wondered if this work needed to be duplicated. Mike Proctor asked for a copy of the report which Peter agreed to.

Action: Peter Reading to provide a copy of the Cancer Services report to QSC.

The minutes were approved as an accurate record of the previous meeting with the above amendments.

183/21 Matters Arising

There were no matters arising.

184/21 Review of action log

There were no actions to review.

185/21 Ophthalmology Update

Mike Proctor updated the Committee that this had been an item on the agenda for some time related to the approximately 9000 patients who were overdue their outpatient appointment and had no date.

Shaun Stacey led the team through the report. The situation was much healthier, every patient in Ophthalmology now had a diagnostic code and this indicated the treatment journey they were on and enabled them to be effectively risk assessed. The majority of follow-ups in Ophthalmology were due to long term conditions, which could lead to complete sight loss over time and hence follow-ups were very important. The service had a greater demand than capacity, and therefore patient trackers were introduced 18 months ago. Risk stratification was significantly improved and to date 8825 had been risk stratified with 794 identified as high risk patients and these would be managed very closely. The paper also explained internal improvements related to equipment and workforce changes to sustain the high demands on the service.

Mike asked for information on the extent of clinical harm on those patients had that been identified as high risk. Shaun felt that as it may take time to assess clinical harm, any harm identified would be better dealt with using the SI process. Kate Wood agreed with Shaun, as the Ophthalmologists were always open with identifying harm and agreed that the SI process was the correct escalation route. Mike asked for thanks to be passed on for the huge amount of work involved in the improvements so far.

Fiona Osborne asked if the issue was with the support from the independent sector, who were only offering support with cataract patients, which also was temporary.

Shaun explained that the contract with the independent sector providers was a low complexity, high volume contract, which would not care for people with medical complications. The service struggled because the demand that had been contracted for had already been delivered and due to Covid the demand had increased. The contract had been adjusted to enable more work to go through the provider. The second issue was that the independent provider had issues with access to clinicians in the same way that the Trust did. The third element was patient choice, as they may choose not to go to the independent sector. Nationally there was a drive to change this, so that complex cases could be referred into the independent sector, but this would take a long time to achieve.

The biggest concern at present was sickness absence and Covid absence in the Ophthalmology team.

Mike summarised that the committee was far more assured at this stage that the patients were being seen and risk assessed appropriately.

Regular Reports

186/21 Community and End of Life

The report was taken as read. Ant Rosevear attended to take any comments and questions.

Mike Proctor commented that it appeared pressure ulcers were directly affected by staffing issues. Kate commented that the pain assessments on End of Life patients were overseen by Community and Therapies (C&T) division. C&T and S&CC had worked closely and the transformation in the pain assessments had been dramatic and Kate thanked Ant and the C&T and S&CC teams for helping to facilitate that.

Kate noted that the rollout of ReSPECT and EPACS had been complex and Jan Haxby was well sighted on this.

Finally Kate commented on the area of concern that was Community nursing but there was a lot that was going on to improve this which was a testament to the hard work of the team.

Mike explained that the success of moving treatment to the Community had increased the pressure on the division, as the block contract arrangement did not compensate for increases in activity. Negotiations were taking place to address this.

Mike thanked Ant for the report.

187/21 IPR

Kate Wood informed the committee that the production of IPR was a work in progress, but that there was improved oversight on the information provided. There had been a slight improvement in VTE assessments, but the challenge to the teams at PRIMS indicated substantial improvement was required, as patients needed to be assessed and protected. In 2 weeks' time it was hoped the EPMA solution would be approved, which would provide a block to prevent any prescriptions being accessed without first addressing the VTE assessment.

Mike thanked Kate for the summary and invited questions and comments.

Fiona Osborne commented that it appeared things were moving well but there were some items with no target. Kate agreed that there were some items with no targets, for example incidents, where a high level of these being reported demonstrated a culture of feeling able to flag these along with good with opportunities for learning.

Mike asked Ellie Monkhouse if some aspects of the nursing quality report could be included in the IPR, eg pressure ulcers and falls, or whether these should remain in the nursing quality report. Ellie noted that these were on the nursing dashboard, there was concern for duplication and felt that the detailed information should remain in the nursing quality report.

Peter Reading commented that the IPR that had been presented to the last board and had hit the highest and lowest points of development. It had been noted there was triplication of reporting of some things, however the quality of the information in the SPC charts was superior to previous reporting arrangements. Peter reported that as the Corporate Governance Team, led by Helen Harris, did not have the capacity to update the IPR, this was transferring to Shauna McMahon and the Information Team and development would continue. It was anticipated by the October Board Meeting the IPR would be complete. The Exec reports would also be streamlined alongside the number of indicators in the Quality Report and it was intended that falls and pressure ulcers would be included in this.

188/21 Quality Priorities for 2022/2023

Angie Legge explained that the report was here for awareness of the development of the Long List of Quality Priorities to take forward and to invite the Committee to contribute to that list based on concerns which may arise from this Committee. Out of

Hospital SHMI, escalation of NEWS and sepsis screening and use of the sepsis screening tool were all likely to be continued into 2022/2023.
Angie advised that should members have anything to suggest for addition to the Long List, this could be emailed directly to her.
Kate Wood reminded the committee that there was a 5 year Quality Strategy and the priorities were feeding into that to ensure the strategy was delivered. This would be circulated after the meeting as a reminder.

Action: The Quality Strategy to be circulated to Committee attendees

189/21 Clinical Harm Update

Kishore Sasapu led the committee through the latest clinical harm information. The issue continued to be that the capacity was not always there for the care that was required, which in turn risked harm.
Kishore reported that the triggers remained 52-104 week non-cancer patients, 104 week wait patients, 104+ day cancer patients and the high risk patients.
The pandemic had exacerbated the problem as prior to the pandemic there were zero 52 week wait patients. However, 52 week wait patients had been halved over the last 6 months, if this was maintained then these could be eliminated by the end of 2021, along with the Category 2 patients, who needed to be treated within 4 weeks. Category 3 and 4 patient were still a risk, plus those outpatients waiting for diagnostics.

Inpatient PTL were reducing and this was monitored at PRIMS and OMG and weekly PTL meetings. The independent sector was being utilised to increase capacity. There was a risk related to the huge volume of routine outpatient referrals on the books. There was currently a 37 week wait for a routine outpatient appointment. This led to the 52 week wait being a challenge. A Clinical Leads forum had been set up to help drive change with related to quality challenges.
Cancer figures were optimistic as 104+ day numbers had plateaued and the 62 day position was difficult but workable. The cancer board monitored this alongside PRIMS. 104+ day cases were those with suspected cancer and complex pathways or diagnosed cancers with treatments outside of NLAG. Much of the delay was complications related to diagnostic tests and complex pathways. It was hoped the Clinical Lead forum and Kishore's link with the cancer board would help drive this forward.
Kishore reported that although the figures for risk stratification appeared worrying, they were improving. For example, Ophthalmology had completely risk stratified the 10000 overdue patients. There were an additional 300 extra patients a week who became overdue and these were being dealt with as they occurred.

Mike thanked Kishore for the summary.

Kate Wood thanked Kishore for the update and confirmed that the focus would be on assurance of the outcome rather than the process.

Maneesh Singh had a concern on how flu season and Covid season would affect those improvements that had been put in place and how they would be sustained. Kishore reiterated that capacity and demand were the main issues but these were long terms issues. There needed to be assurance that those that were referred to secondary care really needed to be referred and the primary: secondary care interface

was key to this. The issue with Ophthalmology patients was that the majority of patients were under long term review, however monitoring could be undertaken in primary care and patients referred back into secondary care where required.
Jan Haxby agreed the pathways needed to look at between primary, community and acute care. Jan queried if Clinical Leads from all areas would be included in the forum but Kate explained this was an internal group that would feed into the Primary Secondary Care Interface Group.

Mike thanked Kishore again, welcomed him to the committee and looked forward to his ongoing contribution.

190/21 Annual Report & Key SI Update, including Maternity

The SI Annual Report was deferred to ensure the data included in the report was accurate.
Angie Legge led the committee through key points. STEIS 16254, had been requested for delog as HSIB had rejected the investigation. There was a further HSIB investigation due to a maternal death due to Covid. The Stop the Clock on the previous report had been accepted as a delog.

Mike thanked Angie and commented on the Ophthalmology Never Event and whether there was confidence that all staff felt empowered to challenge practice outside protocol. Angie commented this was on-going work, most staff were challenging such things, but it was needed to ensure than newer staff felt empowered to challenge.
Kate Wood added that new staff could feel intimidated and it was reiterated to all staff that there should feel empowered to challenge and speak up. However this was a continual piece of work that would never be finished. The Never Events had been in two different organisations and the processes were different however, none of the consultants involved felt able to speak up on this at the time so this issue was not limited to junior staff. This was why these had been included in the recommendations.

191/21 Nursing Quality Report

Ellie Monkhouse gave the position in relation to the recent Covid outbreak, as there were significant outbreaks at DPOW and visiting continued to be suspended. Four wards had been closed, 2 had reopened but visiting was still suspended, the position remained difficult with regards to Covid.

Staffing was a problem, there were various mechanisms to manage this, acuity had increased and this had been highlighted in the recent establishment review.
The new complaints process was delivering 79% within the timeframe, which was excellent news as this had been maintained for 3 months.
The AFLOAT falls risk flag had been rolled out on WebV, however there had been 3 catastrophic falls.

Mike thanked Ellie and asked Ellie to clarify whether the wards that were closed were closed and empty or closed to admissions. Ellie confirmed that they did have to be closed for a deep clean, remained open but closed to new admissions.
Shaun Stacey commented that as front door staff were under pressure, there was an intention to transfer services to more ambulatory care for medical patients by 2023, with the help of IAAU and 2 weeks ago it had been agreed to accelerate this improvement work.

Mike Proctor was concerned about the capacity for domiciliary care, the compulsory vaccination process was due to come into place and also the night nursing staffing issues and asked Ellie to clarify this. Ellie confirmed she would not tolerate low levels of nursing care onwards, beds would be closed rather than that happen. There would be 2 trained nurses on every ward. There was an increase in agency staff overnight but many of these had worked at NLAG long term. Mike thanked Ellie for this assurance.

192/21 Deviations NICE Guidance

There were none.

193/21 Quality Impact Assessments (QIA)

Mike explained this was a process put in place to enable scrutiny of the quality impacts of changes proposed efficiency changes. The process was led by the Chief Nurse and Medical Director.

The Committee note the report and the fact that the proposal to change to an alternative Nursing Agency Provider had been rejected as the provider had struggled to recruit in other Trusts.

194/21 CQC Update

Jennifer Moverley brought the paper to the committee. Jennifer highlighted that there had been two actions completed, however this hadn't been reflected in the report as they hadn't been completed and uploaded to the CQC.The quarterly reviews were going well and assurance had been gained of continued compliance.

The red actions were community nurse staffing, mandatory training and PADRs, this work was ongoing. These would be the focus at the next CQC engagement meeting.

Mike thanked Jennifer for attending.

195/21 Sub-committee review

Mike updated that there had not been a lot of response to the review and asked for further comments; there were none.

Action: For onward submission to the Board of Directors

196/21 PSIRF Report

Angie Legge explained that this would replace the Serious Incident Framework and would be in place by April 2022. The principle was that there would be fewer SI investigations to enable a better quality of investigation and lead to improved identification of root causes and actions. It gave trust more autonomy on what was declared as an SI, so in future, while Never Events and HSIB investigations would automatically be declared an SI, the others would be based on themes or where the Trust felt there was a significant benefit in the resource investment from an SI investigation. The themes would need to be agreed with commissioners, 3 or 4 themes would be identified and within those themes, not all incidents would require investigations. It had been suggested that the themes the Trust would recommend or use would be Discharges, Medication, End of Life and Results Acknowledgement Fiona Osborne queried the rationale for choosing themes. Angie stated these themes were from the integrated intelligence and held the greatest capacity for learning. Kate Wood added that another rationale was to ensure the work was aligned to the Quality Strategy.

Fiona wholly supported a focus on looking at the streams more closely to get results and felt these themes were the right direction.
Jan Haxby felt that there would be no concern from commissioners on those suggested themes.
The Committee supported the approach proposed.

197/21 IPC Annual Report - Deferred

Highlight reports

198/21 Mortality Improvement Group (MIG) - Deferred

199/21 Quality Governance Group (QGG)

Angie Legge reported that Ophthalmology remained an issue and although there had been good work done, it was still considered *'work in progress'*. Angie drew the committee's attention to the annual Organ Donation report, which was worked on by a very small team. From 8 consented donors, the Trust facilitated 6 organ donors resulting in 12 patients receiving a transplant over the year. The work had led to some investment from NHSBT in this financial year and further investment was anticipated next year. Kate Wood said this needed to be mentioned in the highlight report to board.

Mike commented on the oxygen alarms in critical care and Kate confirmed there was short medium and long term work ongoing. In the short term, the patients on oxygen were reviewed regularly, the alarms had been going off due to the new monitors which had more sensitive alarms associated with them, giving an early warning of potential problems. Monitoring was both through WebV and the site team tracking supply. Pipe work was being assessed at DPOW medium term, pending funding.

200/21 Serious Incident Review Group (SIRG) – Deferred as meeting cancelled due to organisational pressures.

201/21 Patient Safety Champions

Angie Legge reported this was progressing well, there was a lot of guidance had been recently released on national patient safety work. There was currently work on national objectives which should be ready for the next meeting. There had been positive assurance from the Humber Strategic Pressure Ulcer Group for example. There was also a framework on Patient Safety Partners and Angie was in discussions on how to take this forward.

Items for Information

202/21 Quality Governance Group (QGG) minutes

203/21 Mortality Improvement Group (MIG) minutes – deferred

204/21 Any Other Business

Quality & Safety Committee (QSC) ToR

Mike reported that there was due to be a broader review of all Terms of Reference. Peter Reading informed the committee that there was a standard ToR being developed with standardised approaches to quroacy, deputising etc. This would be agreed by the committee on local membership and purposes and responsibilities. Mike thanked Peter for this update.

205/21 Matters to Highlight to Trust Board or refer back to QGG

There were no matters to highlight.

206/21 Meeting review

Ian Reekie commented on the bulletin that had just been emailed out to all staff in lack of blood tubes and asked how sustainable a 25% cut in bloods tests was. Kate Wood responded that over-testing was a constant issue and it was hoped that this shortage would mean staff would reflect on the necessity or otherwise of ordering blood tests,. However, there were concerns from primary care, as they had been asked to stop almost all blood tests. Kate felt that the safety impact was potentially more difficult for Primary Care Colleagues.

Date and Time of the Next Meeting:

Friday 17 September 2021 at 9:30am - 11:30am to be held virtually

The meeting closed at 11.35am

NLG(21)225

DATE OF MEETING	Tuesday 5 October 2021
REPORT FOR	Trust Board - Public
REPORT FROM	Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Jenny Hinchliffe, Deputy Chief Nurse Melanie Sharp, Deputy Chief Nurse
SUBJECT	Nursing Assurance Report
BACKGROUND DOCUMENT (if any)	This is a routine report in accordance with the requirements of the updated National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance (July 2016), the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014 and Developing Workforce Safeguards (2018).
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Quality & Safety Committee
EXECUTIVE SUMMARY	CHPPD is 8.3 compared to a national median of 9.1 and peer median of 8.9. The combined fill rate has dropped to 93.3% from 95% for May and June. Family services saw a fill rate of 83.0% which was a drop of 9.7% Eight wards had CHPPD below 6.0 in July; this is an increase from the four wards in June and seven in May. Ward 28 had CHPPD below 6.0 for the seventh consecutive month. Vacancies on the inpatient wards in July for Registered Nurses showed an increase of 9.2wte and 9.9wte for Healthcare Assistants. Community has seen a slight decrease in RN vacancy rates from 8.04% in June to 6.88% in July. HCA vacancies showed an increase from 12.82% in June to 13.74%. Escalation beds were open on 3 wards at DPOW (IAAU, ITU, C3) plus 3 Wards at SGH (Disney, ICU and 25) and 1 ward at GDH (Ward 3). This equated to 472 bed days – 233 at DPOW, 183 at SGH and 56 at GDH. The availability of staff remains reduced due to the Covid pandemic. A “spike” was seen at the beginning of July and then decreased.

	The Midwife: Birth ratio was 1:24.9 in July and has been maintained between 1:22 - 1:26 over the last 12 months which is below 1:28 and in line with national guidance. 111 nurse staffing incidents were reported compared to 19 in June and 44 in May- the largest increase was in Maternity. Following a relaunch of staffing red flags in June there were a total of 107 red flags reported in July 2021 compared to 23 in June. 32 Community Nursing red flags were reported, an increase of 20 since June, 27 were relate to staffing levels. In Maternity there were 22 red flags which is an increase of three from June. The total number of falls reported has increased for the first time in 5 months. Two falls were reported with harm. The number of hospital acquired category 2 and 3 pressure ulcers reported has reduced. The incidence of pressures ulcers in the community has not reduced, however there has been a reduction in the total numbers reported for July with the majority being category 2 plus a noticeable reduction of category 3 pressure ulcers. 15 Steps Challenges continued in July, however saw six cancelled visits due to self-isolation and sickness – all have been rescheduled. Page 1 of 3 7.3. The total number of open complaints in July is 54, which is a 31% decrease from June. 60 complaints were closed in July. The KPI to achieve 85% of all complaints closed within agreed timescale was achieved. The QI team continue to progress with a number of posts out to advert with a view to been a fully established team in post by Oct/Nov 2021. Work continues to develop our improvement offer and support improvement efforts across the trust. Background Information and/or Supporting Document(s) (if applicable).

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	**SO 1 – 1.2** **SO 1 – 1.3** **SO 1 – 1.6**				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓		✓	

1.0 Introduction

This is a routine report in accordance with the requirements of the updated National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance (July 2016), the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014 and Developing Workforce Safeguards (2018). Trusts must ensure the three components are used in their safe staffing processes:

- evidence-based tools (where they exist)
- professional judgement
- outcomes

The Trust is committed to providing safe, effective, caring, responsive and well led care that meets the needs of our patients. It is recognised that decisions in relation to safe clinical staffing require a triangulated approach which consider Care Hours per Patient Day (CHPPD) together with staffing data, acuity, patient outcomes and clinical oversight. This report provides evidence that processes are in place to record and manage nursing and midwifery staffing levels on a shift by shift basis across both hospital and community settings, and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care, thus enabling the Trust to demonstrate compliance with safer staffing guidance. It also seeks to provide information on vacancy rates and nursing metrics across all ward areas.

Oversight continues to be provided to the Quality and Safety Committee on nursing and safe staffing. The changes to ward configurations and zoning throughout the pandemic has made it challenging to make comparisons and benchmark. It is worth noting that this will affect any Model Hospital metric comparisons.

As we continue to reset ward configurations, any data should be viewed with caution, for this reason we continue to review individual metrics and apply professional judgement.

The Nursing Metrics Review Panel is chaired by the Chief Nurse, meets monthly and is attended by the senior nursing team for the organisation. The panel review the information provided by the nursing dashboard and commission any work required to investigate and support any areas of concern. A matrix has been developed to identify and record risk ratings for all ward areas in order that progress can be tracked against actions and the re-assessment of risk monthly.

2.0 Safe Staffing

2.1 Shift Fill Rates and Care Hours per Patient Day (CHPPD)

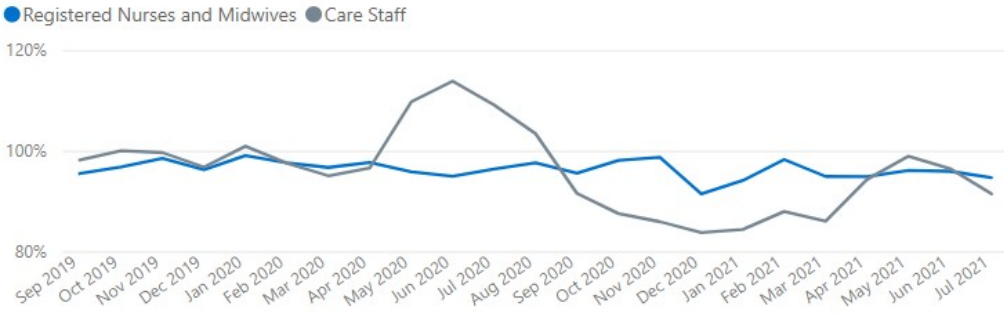
The information presented shows data on inpatient wards only.

Shift Fill Rates Summary Jul 2021

Overall	Registered Nurses and ...	Care Staff	Nursing Associates
93.3% ▼ -2.8%	94.6% ▼ -1.3%	91.4% ▼ -5.0%	64.9% ▼ -22.2%

Overall Fill Rate

Fill Rate by Staff Group



Overall Fill Rate by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jul 2021	DPoW	93.0%	-3.0%	96.0%	
Jul 2021	GDH	96.7%	1.1%	95.6%	
Jul 2021	SGH	93.2%	-2.9%	96.1%	

Overall Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jul 2021	Medicine	96.2%	-3.4%	99.6%	
Jul 2021	Surgery & Critical Care	95.1%	3.5%	91.6%	
Jul 2021	Women & Children's	82.0%	-9.7%	91.7%	

Shift fill rate data is used to populate the monthly Hard Truths return which is submitted to NHS Digital. The data is taken from the Allocate Eroster system and is used to calculate the Care Hours per Patient Day. The fill rate submission currently requires information on in-patient areas only. Ambulatory Care, Short Stay and Emergency Departments are excluded.

Shift fill rates are reported against ward establishments. During the pandemic, our wards and bed bases have undergone extensive changes and moves, this has involved ward changes of speciality as well as demographic and bed base. Establishments have been reviewed consistently during this time and staffing reviews take place at intervals throughout the day, including a trust wide review of SafeCare Live information at 10am. At each ward reconfiguration, the Chief Nurse has reviewed the establishment based on a set of principles as we have been unable to apply the robust process that would normally be undertaken. A document published in February, Deployment and Assurance of Clinical Nursing Workforce during Covid 19 emergency, identifies the above principles remain key for ensuring safe staffing and skill mix, but also identify that any staffing reconfigurations going forward should be subject to a Quality Impact Assessment with final sign-off from the Chief Nurse and Medical Director.

The Chief Nurse has been undertaking an establishment review to re-set baseline establishments now that work has been undertaken to reset the bed base. Collection of the Safer Nursing Care Tool data was undertaken during April and May and then meetings were held with ward and department managers so that recommendations can be made. A recommendation will be presented to Board in October 2021.

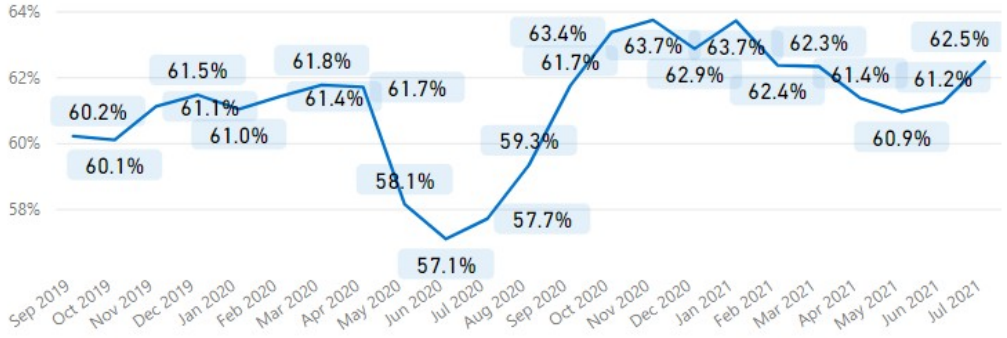
The graphs above show the fill rate trends from the Nursing Assurance Dashboard. The combined fill rate is has dropped to 93.3%. A 5% decrease in fill rate is seen for care staff and a 22.2% drop for nursing associates (nursing associates are a small cohort of staff therefore this is not a concern)). Women's & Children (Family Services) saw a further drop of 9.7% showing a fill rate of 83.0%. This can be attributed to a high number of midwifery staff required to isolate due to Covid contact in July and is being kept under review.

RNMW Ratio Summary Jul 2021

RNMW Ratio

62.5% ▲ 1.2%

RNMW Ratio



RNMW Ratio by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jul 2021	DPoW	61.0%	0.9%	60.1%	
Jul 2021	GDH	56.7%	-0.2%	56.9%	
Jul 2021	SGH	64.8%	1.8%	63.0%	

RNMW Ratio by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jul 2021	Medicine	56.9%	1.1%	55.7%	
Jul 2021	Surgery & Critical Care	71.5%	2.0%	69.4%	
Jul 2021	Women & Children's	66.5%	-1.0%	67.5%	

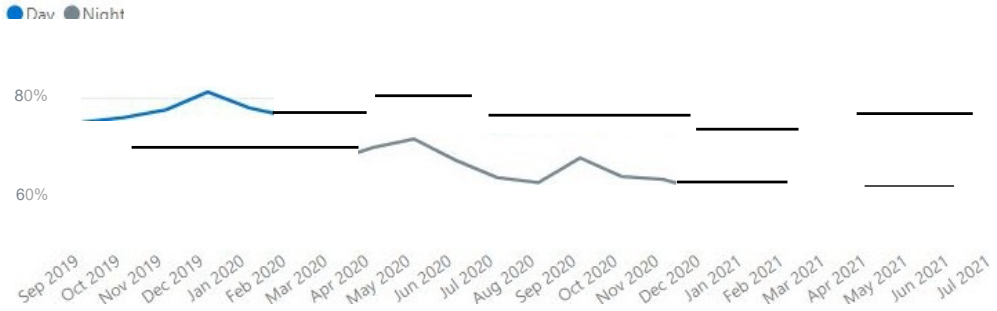
We aim for a skill mix split of 60:40, with a higher skill mix for midwifery. Registered Nurse and Midwife to HCSW ratio for the Trust has been above 60% for the last eleven months. Medicine had the lowest RN ratio in July at 56.9%.

Substantive Fill Rates Summary

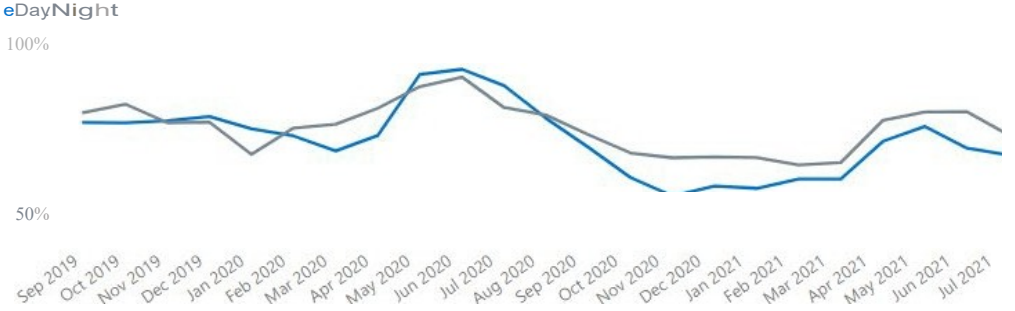
Jul 2021

RNMW- Day	RNMW- Night	Care Staff - Day	Care Staff - Night
71.4% Y -4.8%	56.2% Y -4.3%	68.7% Y -2.0%	74.5% Y -6.9%

Registered Nurses and Midwives Substantive Fill Rate%



Care Staff Substantive Fill Rate %



Wards with Substantive Fill Rate Below 50% **Jul 2021**

Staff	Registered Nurses and Midwives	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
WARD 24 SGH	39.9%	▲ 2.3%
Ward 19	39.7%	▼ -9.3%
Disney SGH	38.3%	▼ -16.8%
WARD B4 DPoW	29.1%	▼ -7.5%
WARD 18 SGH	2.5%	

Staff	Registered Nurses and Midwives	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
Ward 19	48.9%	▲ 3.3%
Ward A1	44.2%	▲ 4.2%
WARD 3 GDH	43.5%	▲ 13.5%
WARD B3 DPoW	43.2%	▼ -2.2%
Amethyst	43.2%	▼ -0.5%
Rainforest DPoW	41.8%	▲ 10.1%
WARD 16 SGH	41.0%	▲ 4.5%
WARD C6 DPoW	38.1%	▼ -4.6%
WARD 17 SGH	37.5%	▼ -24.8%
WARD C5 DPoW	33.9%	▼ -7.7%
WARD 23 SGH	33.5%	▼ -20.4%
Disney SGH	28.7%	▼ -20.4%
WARD 28 SGH	24.5%	▼ -4.4%
WARD 22 SGH	24.3%	▼ -1.9%
WARD 24 SGH	23.2%	▲ 9.2%
WARD B4 DPoW	12.9%	▼ -11.5%

Staff	Care Staff	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
Stroke Unit SGH	47.5%	▼ -22.0%
WARD C2	47.3%	▼ -15.5%
WARD 28 SGH	33.3%	▲ 9.7%
WARD B4 DPoW	7.5%	▼ -17.5%

Staff	Care Staff	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
Amethyst	48.4%	▼ -4.9%
WARD 28 SGH	21.1%	▲ 1.1%
WARD B4 DPoW	13.5%	▼ -23.6%

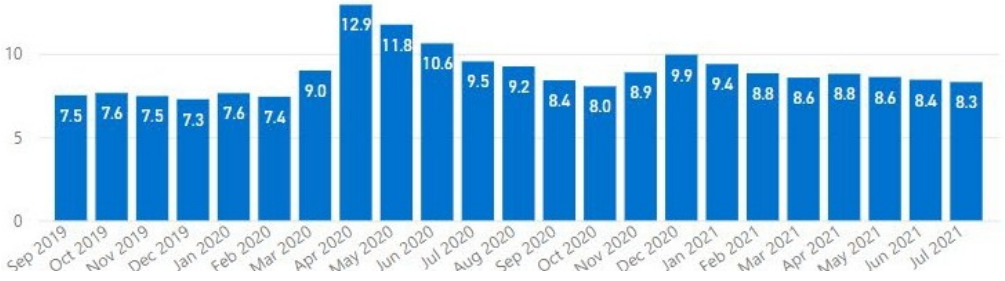
Substantive versus temporary staff fill rate is monitored and a decrease in substantive staff fill rate is seen for both RNs and HCAs across both days and nights. Night shifts continue to be the shift with the lowest substantive fill rate for RNs, with 16 wards with RN substantive fill rates below 50%. This is in part due to vacancies, the increased number of staff having to isolate due to Covid contact, and the increase in unplanned activity and admissions being experienced resulting in increased use of unestablished escalation beds.

This risk is in part mitigated by the block booking of regular agency nurses who are familiar with the ward, however remains a concern and continues to be monitored. Ward B4, with the lowest RN substantive fill rate on nights, was opened temporarily to support re-establishment of elective activity and will close at the end of August as the new bed base plan is implemented.

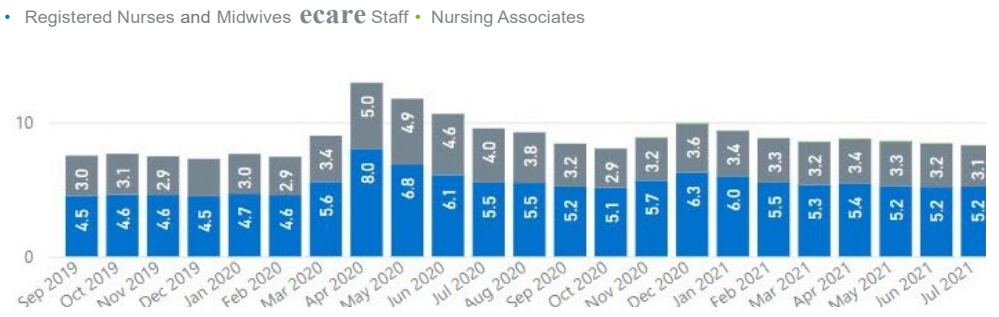
CHPPD Summary Jul 2021

Overall	Registered Nurse...	Care Staff	Nursing Associates
8.3 ¥ -0.14	5.2 A 0.01	3.1 ¥ -0.15	0.0 ¥ -0.01

Overall CHPPD



CHPPD by Staff Group



CHPPD by Site

Latest Month	Site	Result	Variance to Previous	Previous Month
Jul 2021	DPoW	8.4	0-0.2	8.6
Jul 2021	GDH	10.6	O0.1	10.4
Jul 2021	SGH	8.1	0-0.1	8.1

CHPPD by Division

		Result	Previous	Month	Trend
Jul 2021	Medicine	7.3	0-0.3	7.6	
Jul 2021	Surgery & Critical Care	9.3	0-0.1	9.5	
Jul 2021	Women& Children's	11.7	O0.1	11.0	

Wards with CHPPD Below 6.0 **Jul 2021**

Staff	Registered Nurses and Midwives		Care Staff		Nursing Associates		**Total**	
Ward name	CHPPD	Change	CHPPD	Change	CHPPD	Change	**CHPPD**	**Change**
WARD B7 DPoW	3.1	▲ 0.15	2.6	▼ -0.39			**5.8**	**▼ -0.24**
WARD 16 SGH	3.1	▼ -0.04	2.6	▼ -0.09			**5.7**	**▼ -0.13**
Amethyst	3.2	▼ -0.11	2.5	▲ 0.09			**5.7**	**▼ -0.03**
WARD 22 SGH	2.9	▼ -0.05	2.7	▼ -0.12			**5.6**	**▼ -0.17**
WARD 25 SGH	3.0	▼ -0.29	2.5	▼ -0.35	0.0		**5.5**	**▼ -0.64**
WARD B6 DPoW	2.8	▼ -0.22	2.6	▼ -0.67			**5.4**	**▼ -0.90**
WARD C2	2.8	▼ -0.08	2.6	▼ -0.64			**5.4**	**▼ -0.72**
WARD 28 SGH	3.0	▲ 0.09	1.8	▼ -0.38			**4.8**	**▼ -0.29**

The Care Hours per Patient Day (CHPPD) data is reported monthly and is included in the Trust's NHS Digital return. CHPPD is the total hours per day of Registered Nurses (RN), Midwives (MW) and care staff divided by the number of patients in the ward/department at 23.59 hours each night. This provides a score of the average care hours per patient per day. There are many factors that can affect the care hours required, for example, the proportion of single rooms.

The graphs above shows an increase in CHPPD which was seen in the first wave of Covid when bed numbers were reduced to support management of the pandemic and increased patient acuity, and the workforce was being supported by third year student nurses on paid placements. A reduction was then seen due to increased sickness and absence.

The latest model hospital data for May 2021 indicates a national median of 9.1 and peer median of 8.9 against the trust CHPPD of 8.6 (8.6 is quartile 2 – mid- low 25%). It remains difficult to benchmark using this data due to changes in ward demographic and acuity over the past 15 months.

Eight wards had CHPPD below 6.0 in July; this is an increase from the four wards in June and seven in May. Ward 28 had CHPPD below 6.0 for the seventh consecutive month and does have a high number of vacancies and absence level.

2.2 Escalation Beds

During July escalation beds where open on IAAU, ITU and ward C3 at DPOW and Disney, ICU, ward 25 at SGH and ward 3 at Goole. The total number of escalation beds open in July equated to 472 bed days: 233 at DPOW, 183 at SGH and 56 at Goole. Staffing for these beds has to be found form existing staff which contributes to the decrease in fill rates, CHPPD and substantive fill rates (information taken from SITREP report).

Maternity Staffing

2.3.1 Midwife: Birth Ratio

The Midwife: Birth ratio was 1:24.9 in July and has been maintained between 1:22 - 1:25 over the last 12 months which is below 1:28 and in line with national guidance. This calculation is derived from the Birthrate Plus tool and is based upon an understanding of the total midwifery time required to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the Birthrate Plus methodologies are consistent with the recommendations in the National Institute for Health and Care Excellence (NICE) safe staffing guideline for midwives in maternity settings which have been endorsed by the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists. Maternity staffing and Red Flag incidents continue to be monitored on a daily basis.

The Chief Nurse undertook a desktop maternity staffing establishment review in early March 2021 and the increases in establishments identified have been included in the Trust's Ockenden Immediate and Essential Actions submission. An establishment review using BirthRate Plus is currently underway.

2.3.2 Maternity Fill Rates and CHPPD

Maternity Wards Fill Rates and CHPPD Jul 2021

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**90.3%**	**-5.2%**	**81.2%**	**-8.5%**	**12.1**	**0.29**
Registered Nurses and Midwives	92.1%	-8.5%	83.8%	-11.2%	7.7	-0.11
Care Staff	87.3%	0.5%	76.8%	-4.1%	4.4	0.40
Central Delivery Suite	**86.8%**	**-4.4%**	**81.0%**	**-0.7%**	**28.8**	**1.61**
Registered Nurses and Midwives	85.0%	-6.9%	78.5%	-1.3%	22.7	1.18
Care Staff	94.2%	5.4%	91.4%	2.6%	6.1	0.43
Jasmine & Honeysuckle	**95.3%**	**3.2%**	**77.7%**	**3.0%**	**10.6**	**-1.22**
Registered Nurses and Midwives	95.4%	7.3%	77.3%	8.4%	7.1	-0.46
Care Staff	95.2%	-5.1%	78.5%	-7.9%	3.5	-0.75
Ward 26 SGH	**79.7%**	**-8.8%**	**63.1%**	**-11.3%**	**8.2**	**1.85**
Registered Nurses and Midwives	80.4%	-8.3%	60.1%	-13.4%	6.0	1.41
Care Staff	77.8%	-10.2%	71.1%	-5.7%	2.1	0.44
Total	**88.6%**	**-3.5%**	**76.2%**	**-4.2%**	**12.0**	**0.95**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	63.5%	-2.5%
Central Delivery Suite	78.8%	-0.3%
Jasmine & Honeysuckle	66.9%	3.0%
Ward 26 SGH	73.9%	0.7%
Total	**70.0%**	**0.3%**

Blueberry/Holly, Central Delivery Suite, Jasmine and Honeysuckle and Ward 26 reported a fill rate of < 95% for Registered Midwife in July. The difference in CHPPD for the maternity wards across sites can be attributed to different models of care at each hospital. Jasmine and Blueberry wards have a labour, delivery, recovery and postpartum (LDRP) model where the ladies stay on the ward throughout their stay. Scunthorpe has a Central Delivery Suite (CDS) model where the ladies transfer to the delivery suite to give birth. From April 2021 babies have been included in CHPPD calculations now include babies along with the women. All wards except wards have seen a slight decrease in the CHPPD.

Midwifery staffing at DPOW has been affected by shielding as a result of contact tracing and at SGH as a result of long term sickness and vacancies. Escalation processes and plans are in place with daily oversight from the head of Midwifery.

2.4 Staffing Indicators

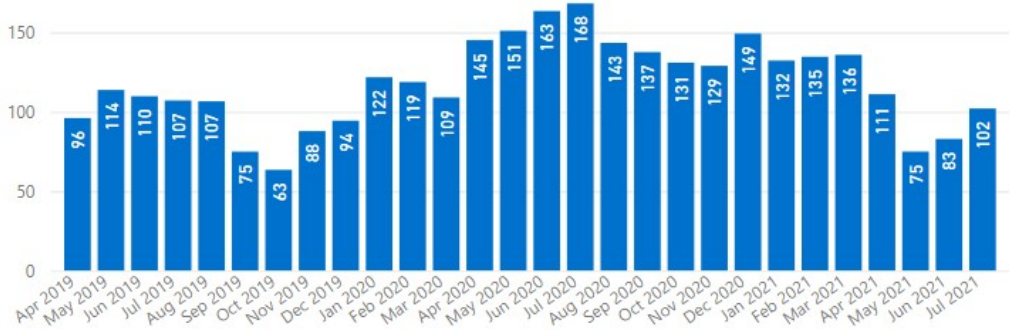
2.4.1 Vacancies

The information presented below shows data on inpatient wards only.

Vacancies Summary Jul 2021

Vacancies - Total	Vacancies - Qualified	Vacancies - Unqualified
102.0 ▲ 19.2	73.9 ▲ 9.2	28.1 ▲ 9.9

Vacancies



Vacancies by Staff Group

Vacancies - Qualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2021	DPOW	24.9	! 3.6	21.3	
Jul 2021	GDH	18.2	✓ -0.6	18.8	
Jul 2021	SGH	30.8	! 6.2	24.6	

Vacancies - Qualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2021	C&T	2.5	◆ 0.0	2.5	
Jul 2021	Family Services	4.6	✓ -0.7	5.3	
Jul 2021	Medicine	48.9	! 5.7	43.2	
Jul 2021	Surgery	17.9	! 4.2	13.7	

Vacancies - Unqualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2021	DPOW	15.5	4.7	10.8	
Jul 2021	GDH	-3.7	-0.8	-2.9	
Jul 2021	SGH	16.3	6.1	10.2	

Vacancies - Unqualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2021	C&T	-0.4	-0.8	0.4	
Jul 2021	Family Services	1.9	1.1	0.8	
Jul 2021	Medicine	19.8	5.8	14.0	
Jul 2021	Surgery	6.8	3.8	3.0	

Vacancies on the inpatient wards in July for Registered Nurses showed an increase of 9.2 WTE. B4 Registered Nursing Associates and B4 overseas Pre-registration nurses are included in the monthly ward established RN position which understates the actual RN vacancy position.

Healthcare Assistant vacancy showed an increase of 9.9 WTE. Further appointments have been made which are not yet showing in the figures, and active recruitment continues to recruit to the HCA Pool to ensure swift recruitment to replace any leavers. HCSW turnover has increased over the last two months and work is underway to understand the reasons for this.

C2, ward 17, A1, ward 24, ward 27 all have over 20% RN vacancies, with ward 24 having 63% and ward 27 having 53% RN vacancies. Our newly qualified nurses will be joining us over the next 3 months and our international recruitment campaign continues. Although not reported in the ward data is should be noted that SGH ED has a B5 RN vacancy of over 32%. They have 9 new starters over next 8 weeks; however this will still leave a B5 vacancy of 8 WTE.

The overseas Pre-registration nurses who have joined the Trust continue to progress through their OSCE preparation and induction programme and improvements in exam pass rate on the first attempt continue to be seen.

Cohort	Start date	Number of Pre-registration nurses	OSCE 1st attempt pass rate	OCSE 1st resitpass rate	OCSE 2nd resit pass rate
1	Oct 2020	20	58%	100%	NA
2	Dec 2020	19 (+ 1 shielding)	42%	91%	100%
3	Feb 2021	10	100%	NA	NA
4	Mar 2021	25	84%	75%	100%
	Apr 2021	3	100%	NA	NA
5	July 2021	7	100%	NA	NA
TOTAL		85			

The Trust has been working with Yeovil Trust to source our next cohort of overseas nurses as the trust works to build a diverse pipeline of candidates and improve our recruitment and selection processes. Accelerated recruitment and on- boarding is being supported through successful bids for funding to NHSE/I and oversight from the task project group continues.

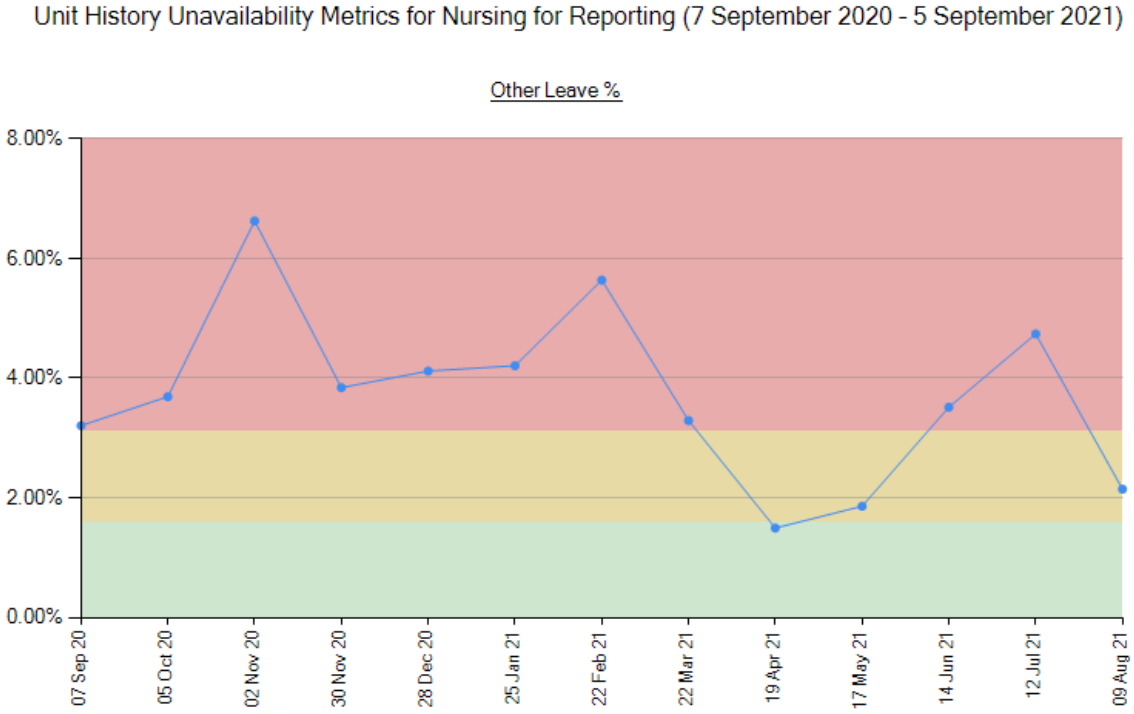
A workforce plan and RN forecast has been developed with finance and workforce colleagues to support recruitment initiatives going forward. Based on the month 1 positon, forecast starters and leavers, and planned recruitment activity, the forecast suggests that the trust will have 15.72 WTE Band 5 vacancies by March 2022.

It is hoped that the trust will be able to offer RN degree apprenticeships and trainee Nursing Associate apprenticeships later in the year, subject to business case approval, which will be factored into the pipeline going forward.

2.4.2 Staff Availability

The availability of staff remains reduced as a result of the Covid pandemic. Absence due to Covid is reported under 'Other Leave'. A spike can be seen in the beginning of July and has subsequently decreased, as can be seen in graph below and is now 2.1%

Other leave for Nursing for Reporting - %:



2.4.3 Staffing Incidents

The information presented below shows data on inpatient wards only.

Staffing Incidents Summary Jul 2021

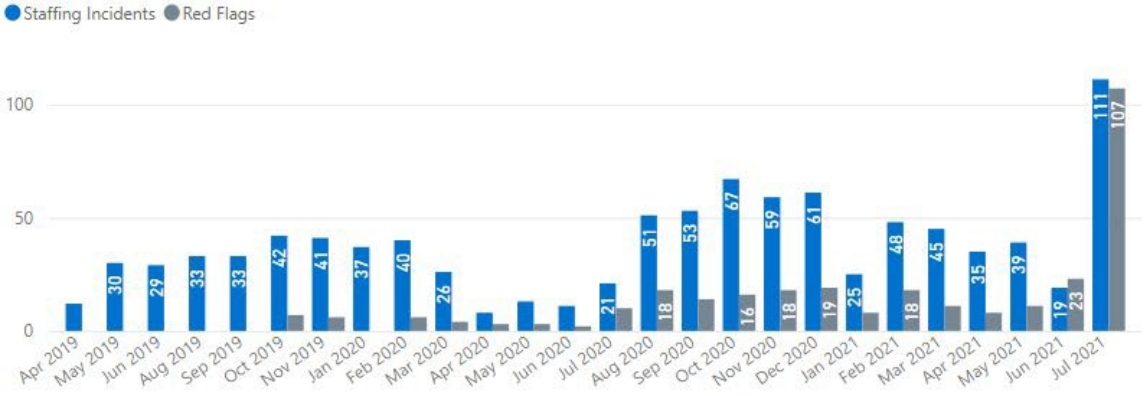
Staffing Incidents

111 ▲ 92

Red Flags

107 ▲ 84

Staffing Incidents and Red Flags



Wards with Incidents

Indicator	Staffing Incidents		Red Flags	
Site - Ward	Value	Change	Value	Change
DPOW - A1	1	▲ 1	5	▲ 5
DPOW - Amethyst	2	▲ 1	4	▼ -4
DPOW - B2 Assessment Unit	1	▲ 1	0	▼ -1
DPOW - B3	2	▲ 2	2	0
DPOW - B6	0	0	3	▲ 3
DPOW - B7	1	▲ 1	1	▲ 1
DPOW - C1 Glover	2	▲ 2	1	0
DPOW - C2	8	▲ 8	10	▲ 9
DPOW - C3 Short Stay	5	▲ 5	21	▲ 21
DPOW - C5	1	▲ 1	4	▲ 4
DPOW - HDU	0	0	2	▲ 1
DPOW - Maternity	18	▲ 13	0	0
DPOW - NICU DPW	0	0	4	▲ 2
DPOW - Rainforest	1	▲ 1	1	▲ 1
DPOW - Stroke DPW	0	0	1	▼ -1
GDH - GNRC	3	▲ 2	3	▲ 2
SGH - CDS	27	▲ 19	0	0
SGH - ICU	0	0	4	▲ 4
SGH - NICU SGH	2	▲ 2	0	0
SGH - Stroke SGH	1	0	1	0
SGH - Ward 17	7	▲ 7	7	▲ 7
SGH - Ward 19	1	▲ 1	12	▲ 12
SGH - Ward 22	1	▲ 1	0	0
SGH - Ward 23 Short Stay	8	▲ 7	9	▲ 8
SGH - Ward 24 Assessment Unit	0	▼ -1	2	0
SGH - Ward 25	3	▲ 3	5	▲ 5
SGH - Ward 26	12	▲ 11	1	▲ 1
SGH - Ward 29	4	▲ 4	4	▲ 4

One hundred and eleven nurse staffing incidents were reported in July on the Datix system compared to 19 in June and 44 in May. This is a large increase; the largest increase can be seen in the maternity where there have been increased staffing pressures. We are seeing an increased number of wards reporting staffing incidents which is a result of the focus on safe staffing in July, wards are actively reporting now were as in previous months there have been staffing incidents that were not always reported.

2.4.4 Red Flags

Staffing red flags were updated and relaunched in June. As part of this there is a switch in reporting from Datix to Safecare Live to support ease of reporting for staff, however, until there is assurance that all staff are using Safecare for reporting, validation will be undertaken across both systems Of the 111 incidents reported via Datix 34 were reported as nursing red flags on inpatient wards, an additional 74 red flags were reported on Safecare Live. There were 22 maternity red flags reported on Datix. A total of 107 red flags were reported in July 2021.

Red flag type	July 2021	Wards
Delay in administration of IV medications by 1 hour to more than 3 patients	1	C3 short stay
Delay in medicine rounds by 1 hour	1	Ward 29
Delay of more than 30 minutes to provide acute pain relief	1	B3
More than 50% of staff under 12 months qualified	11	Amethyst, C1 glover, C2 (n5), C3 short stay (n3), ward 29
Less than 2 trained nurses on a clinical area	14	B3, B6, C2, Neuro rehab (n3), ward 23 short stay (n4), stroke unit SGH, ward 25 (n2), ward 17
Trained nurse less than 12 months qualified, or still in preceptorship left in charge	9	C2 (n2), C5, Ward 19 (n5), ward 23 short stay
Less than 50% substantive staff on a shift	25	Amethyst (n2), C3 short stay (n3), C5 (n3), Ward 23 (n3), ward 17 (n5), ward 19 (n7), ward 24, ward 25
Below safe staffing levels	33	A1 (n4), amethyst, B6 (n2), B7, C2 (n2), C3 short stay (n11), ICU SGH (n2),NICU DPoW (n4), rainforest , ward 17, ward 23, ward 25 (n2), ward 29
Patient transfer 2200-0600 for due to bed pressures	3	C3 short stay (n2), stroke unit DPoW
Coordinators Non Supernumerary	3	ICU SGH (n2), ward 24
Covid-19 +ve pts on ward	3	HDU DPoW (n2), A1
Failure to deliver one to one care	1	C3 short stay
Missed medication	1	Ward 26
Missed or delayed care	1	Ward 29

All red flags are reviewed by the ward manager and matron for the actual or potential impact. Mitigating actions taken are also reviewed where this has been possible.

2.4.5 Community Nursing

Community Nursing Assurance Dashboard

Jul 2021

Key indicators by team

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Indicator Category	Activity		Safety & Quality					Staffing	Infection Control	Friends & Family	End of Life Care
Team	Contacts Actual	Contacts Planned	Red Flags	Falls - Total	Community Acquired PU - Total	Complaints	Weekly Assurance Tools	Vacancies - Total	Hand Hygiene %	FFT Recommended Rate %	Deaths with Care in Last Days of Life %
West Network	3159.0 ↗		13.0 ↗	0.0	15.0 ↘	0.0	4.0 ↘	1.2 ↘			
East Network	4160.0 ↗		8.0 ↗	0.0	8.0 ↘	0.0	2.0 ↘	3.6 ↗			
South Network	5114.0 ↗		0.0 ↘	1.0 ↗	13.0 ↘	0.0	4.0 ↘	1.7 ↘			
West, East & South Networks		11659.0 ↗									
Unscheduled Care Team (UCT) (incl rapid response)	426.0 ↗		1.0 ↗	0.0	0.0	0.0	0.0 ↘	1.5			
Macmillan Health Care Team	1629.0 ↗		0.0	0.0	0.0	0.0	1.0 ↗	3.5 ↗			
Specialist Palliative Care Nurses (SPC)			0.0	0.0	0.0	0.0	1.0 ↗	0.0			
Palliative Care			0.0	0.0	0.0	0.0	1.0 ↗	0.2 ↗			
Palliative Care (incl specialist nurses)	364.0 ↘										
Single Point of Access (SPA)			9.0 ↗	0.0	0.0	0.0	0.0	2.1			
Continence Team	194.0 ↗		0.0	0.0	0.0	0.0	0.0	0.2			
Tissue Viability Team	29.0 ↗		0.0	0.0	0.0 ↘	0.0	0.0	0.4 ↗			
Long Term Conditions / Complex Care Matrons (Comm Matrons)	415.0 ↘		0.0	0.0	0.0	0.0	1.0 ↗	1.0			
Intermediate Care Services (ICS) + Core Therapy	835.0 ↘		0.0	0.0	8.0 ↗	0.0	0.0	1.2			
Discharge Liaison Team	37.0 ↗		0.0	0.0	0.0	0.0	1.0 ↗				
Locality Co-ordinators	82.0 ↗		1.0 ↗	0.0	0.0	0.0	0.0	0.0			
Evening / Night Service			0.0	0.0	0.0	0.0	0.0	2.2 ↗			
Chronic Wound Team	412.0 ↘		0.0	0.0	0.0	0.0	0.0	0.2	100.0		
Virtual Ward			0.0	0.0	0.0	0.0	1.0 ↗				
DN Students			0.0	0.0	0.0	0.0		0.0			
Community Nursing										100.0	29.4 ↘

Community Nursing Overview Dashboard

Jul2D21

Totals and averages (median team value) for all indicators

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nd Goo e
i;r-.ation'Tnd\

Indicators based on total values

IMieatot Ca 9ory	Value	target
Activity		
CoJ'llacts Actual	16856.0	"
S f.ty & Quality Cotta-.ns Fulfilled	71659.0	"
Red Flags	32.0	71
lialls - No Harm	0..0	
Fall<.; • With Harm	1.0	"
Falls - Total	7.0	
Community A(;quired P1J - Cat 2	3-3.0	"M
Community Acquired P1J - Cat 3	3.0	"ll
Community Acquired Pll • Cat 4	,.O	"ll
Commu11ify Acquired P\J - Lin tageable	7.0	"
Community Acquired Pll - Total	44.0	"M
Community Acquired PU - Sl	0.0	"ll
Complaints	0.0	
Weekly Assurance Tool5	16.0	"
Staffing		
va,ancies - C\l lilied	S..O	
ViKancies - Unqualified	11.0	"
Friends & family Vacancies - Total	19.0	
FFT ResPQnses	3,1.0	
End of Life Cilre		
De-aths with Care in Last Days of life	10.0	

Indicators based on median team value

Ind[a1tor CMegory	Value	'forget
Safety & Quality		
We-eldy As5A.1rarlte TQQI 'l'o	100.0	':ll
Infe<ction Control		
Hand 1-tygiene 91.	,00.0	95.0
Friem:ls 8! Fami'ly		
FH Re<:omme d R.!te 'lG	100.0	
End of Life Care		
Oealhs w1th *Care* in Laf>t Days of Life 9E,	29..4	'!ill

Increases and Decreases

Jul2021

Over the last 3 consecutive months

Indicators with 3 Consecutive Month Increases

Calendar Month / Team	Jul 2021 Month -3	Month -2	Month -1	Month	Increase
East Network					
Contacts Actual	3760.0	3829.0	4046.0	4.160.0	,i 400.0
Single Point of Access (SPA)					
Red Flags	0.0	1.0	4.0	9.0	,i 9.0

Indicators with 3 Consecutive Month Decreases

Calendar Month
Team

2.4.5.1 Community Nursing Workforce

There has been an increase in absence across all nursing teams but particularly in the nursing networks throughout July. Sickness has been an issue which is being managed as required by the team leaders, but the impact of self-isolation due to track and trace and school 'bubbles' bursting' has also impacted on absence rates. Other services in the division have regularly been supporting the nursing networks during the last month to mitigate the risk and to ensure patient safety.

There has been a slight decrease in our Registered Nurse vacancy rates in month from 8.04% in June 21 to 6.88% in July 21. The nursing networks are due to have 6 newly qualified nurses commencing with the division in September 2021, there is a period of planned induction and supervision to ensure they have the support needed. All nursing vacancies are out to advert or are in the recruitment pipeline awaiting the required checks to be undertaken and/or start dates. A bespoke recruitment campaign is being planned with support of the Talent Acquisition Team.

Unregistered nurse vacancy is showing an increase in month from 12.82% in June to 13.74% in July. Further work is being undertaken with the Matrons/Operational Leads and finance team to understand and explore this position further. There are a number of staff waiting to commence in post who are currently in the recruitment pipeline.

2.4.5.2 Community Nursing Activity

Activity remains high particularly in the nursing networks with an increase in contacts for July 2021. Most of the other services in community and therapies have also seen an increase in contacts during July and a number of these services have also provided daily support to the networks to mitigate the risks to patients because of increases in staff absence. The implementation of Malinko, the new electronic allocation system on 21st September 21 should make allocation of patient visits much easier and therefore enable more time with patients. Malinko will provide more accurate information about allocated work, reduce the time nurses spend allocating visits, support agile working and increase visibility of capacity and demand.

2.4.5.3 Community Nursing Red Flag incidents

The total Nursing Red flag incidents for the month of July are 32, which is an increase of 20 since June 21, with 27 of those being around staffing levels. 7 incidents related to staffing levels in June 21.
The Failure to administer incidents relate to two insulin visits cancelled in error.
Insufficient numbers of healthcare professionals incident relates to no Unscheduled Care Practitioner cover between 12 midnight and 4am.
Expired medication/fluid relates to medication which was out of date at a care home and is still under investigation

2.4.6 Maternity Dashboard and Red Flag Incidents

DRAFT DPOW Maternity Dashboard

NHS
Northern Lincolnshir
and Gool
NHS Foundation Tru

Indicator	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021
Midwife to Birth Ratio	26.0	26.0	26.0	25.0 ↘	25.0	23.0 ↘	26.0 ↗	26.0	24.0 ↘	24.0	24.9 ↗	25.8 ↗
Red Flags	7.0 ↘	3.0 ↘	10.0 ↗	2.0 ↘	1.0 ↘	0.0 ↘	3.0 ↗	3.0	7.0 ↗	4.0 ↘	6.0 ↗	17.0 ↗
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	2.0	0.0 ↘	2.0 ↗	2.0	0.0 ↘	0.0	2.0 ↗	1.0 ↘	4.0 ↗	2.0 ↘	1.0 ↘	6.0 ↗
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0 ↗
(c) Missed medication during an admission to hospital	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0 ↗	0.0 ↘	0.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0 ↗
(f) Full clinical examination not carried out when presenting in labour	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0 ↗
(g) Delay of 2 hours or more between admission for induction and beginning of process	0.0 ↘	0.0	3.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	2.0 ↗	0.0 ↘	1.0 ↗	4.0 ↗
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	4.0 ↗	3.0 ↘	5.0 ↗	0.0 ↘	1.0 ↗	0.0 ↘	1.0 ↗	0.0 ↘	1.0 ↗	2.0 ↗	4.0 ↗	4.0
In Receipt of %											12.0	13.0 ↗
CoC In Receipt of %										79.6	81.3 ↗	87.0 ↗
Continuity Team Caseload											350.0	
Divert / Unit Closures	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	102.7 ↘	102.0 ↘	98.6 ↘	101.7 ↗	94.7 ↘	102.4 ↗	101.7 ↘	102.7 ↗	96.3 ↘	92.4 ↘	91.8 ↘	89.4 ↘
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0		100.0	100.0	100.0	100.0			
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies											11.7	11.5 ↘
Vacancies - Registered											9.9	10.9 ↗
Vacancies - Unregistered											1.9	0.6 ↘

DRAFT SGH Maternity Dashboard

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Northern Lincolnshi,-
and Goole
NtrS t-

Indicator	ug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 20 2 1	F eb 2021	Mar 2021	Apr2021	May 2021	JJun 2021	Jul 2021
Midwife to Binh Ratio	21.0	22.0 '9	22.0	23.0 "	21.0	21.0	2S.O "	2S.O	22.0	22.0	23.3 "	23.9 "
Red Flags	4.0	9.0 ;ill	11.0 "	8.0	4.0	2.0	16.0 "	18.0 "	8.0	21.0 ;ill	13.0	20.0 "
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours. Erner or EI LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	1.0 ,i	0.0	6.0 "	2.0	3.0 ;ill	1.0	10.0 ,i	12.0 ,i	6.0	10.0 ;ill	0.0	1.0 ,i
(b) Missed ordelayed care (e.g. delay of 60 minutes or more in washing and suturing)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0 "	0.0	0.0	1.0	4.0
(c)Missed medication during an admission to hospital	0.0	0.0	0.0	1.0 "	0.0	1.0 "	1.0	0.0	1.0 "	0.0	0.0	1.0
(d) Delay of more than 30minutes in providing pain relief	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(e)Delay of 30minutesor more between presentation onto the ward andbeing seen	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) *Oefay* of 2 hours or more between admission for induction and beginning of process	0.0	3.0 "	3.0	4.0 "	0.0	0.0	0.0	0.0	0.0	6.0 "	S.O	7.0
(h) Delayed recognition of and action onabnormal vital signs (e.g. sepsis or urine output)	0.0	1.0 ,u	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able toprovide contjnuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0 "	0.0	1.0 "	0.0
0) Community staff have been called in to work on the unit.	3.0 ;i	5.0 "	2.0	1.0	1.0	0.0	S.O ;i	S.O	0.0	5.0 "	6.0	7.0 ;i
fn Receipt of%											1S.O	3.0
CoC In Receipt of%												
Continuity Team Caseload										17.0	31.0 " 167.0	24.0 16S.O
Divert *I* Unit Closures	0.0	0.0	0.0 "	0.0	0.0	0.0	1.0 "	0.0	0.0	0.0	0.0	0.0
Actual V Planned Staffing %	100.0	100.0	100.0	110.S " 100.0	100.2 100.0	101.6 " 100.0	107.7 100.0	96.9 100.0	94.4 lit 98.3	9S.4 " 98.4 "	92.6	86.1 lit
Labour Co·ordinator Supernumerary Status%	10S.6											
1:1 Care in Labour%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies											6.1	9.6 "
Vacancies - Registered											5.9	9.4 "
Vacancies - Unregistered											0.2	0.2

DRAFT Trustwide Maternity Dashboard

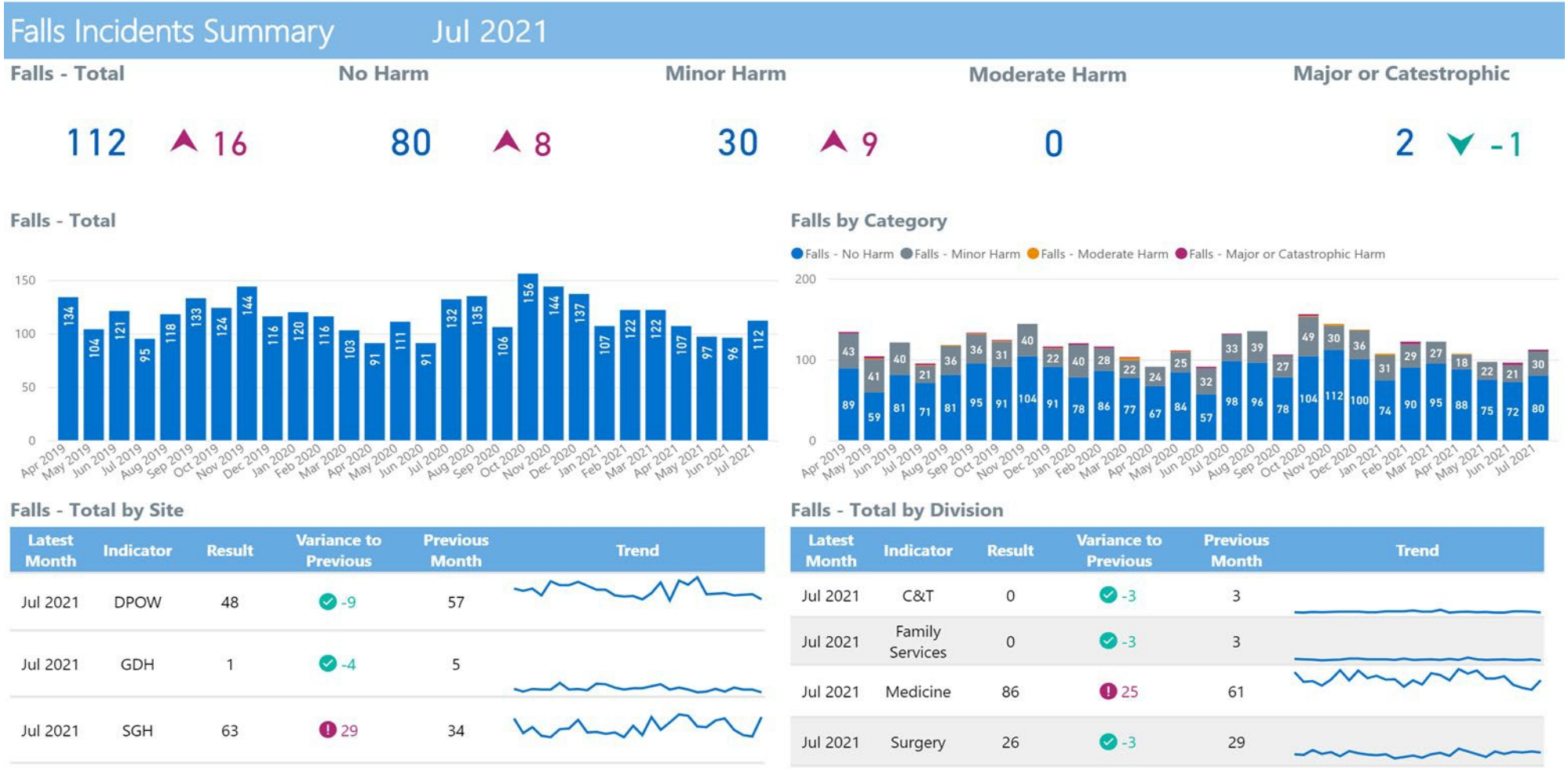
Indteator	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	1Jan2021	Feb2021	Mar 2021	Apr 20.21	May2021	Jun 2021	Jul2021
Midwife to Binh Ratio	23.0	24.0	24.0	23.0	23.0	22.0	25.0	25.0	23.0	23.0	24.2	24.9
Red Flags	11.0	12.0	21.0	10.0	5.0	2.0	19.0	21.0	15.0	25.0	19.0	37.0
(a)Delayed *or* cancelled time critical activity (delay in IOL >24 hours. Erner or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	3.0	0.0	8.0	**4.0**	**3.0**	1.0	12.0	**13.0**	10.0	12.0	**1.0**	7.0
(b) Missed ordelayed care(e.g. delay of 60 minutes or more in washing and suturing)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**1.0**	0.0	0.0	**1.0**	5.0
(c)Missed medication during an admission to hos.pita!	0.0	0.0	0.0	1.0	0.0	1.0	1.0	2.0	1.0	0.0	0.0	1.0
(d) Defay of more than 30minutes in providing pain relief	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(e) Delay of 30 minutesor more between presentation onto the ward andbeing seen	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
(f) Full c.linical examination not carried out when presenting inlabour	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
(9) Delay of 2 hours or more between admission forinduction and beginning of process	0.0	**3.0**	6.0	4.0	0.0	0.0	0.0	0.0	2.0	6.0	6.0	11.0
(h) Delayed recognition of and action onabnormal vital signs (e.g. sepsis or urine output)	1.0	**1.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able toprovide contjnuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	**1.0**	0.0
0) Community staff have been called in to work on theunit.	7.0	**8.0**	7.0	1.0	2.0	0.0	6.0	**5.0**	1.0	7.0	10.0	11.0
Continuity of Carer%	**42.3**	48.4	**43.1**	**40.8**	*342*	40.8	42.9	36.2	36.0	36.6	**3S.8**	
fn Receipt of%									16.0	13.0	**13.0**	**8.0**
CoC In Receipt of%										42.9	**44.8**	64.6 *11*
Continuity Team Caseload											S17.0	
Diven/ Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
Actual V Planned Staffing %							104.2	100.2	95.5	93.7	92.2	**89.9**
Labour Co-ordinator Supernumerary Status%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	**99.2**	**98.4**		
1:1 Care in Labour%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies											17.8	21.1
Vacancies - Registered												
Vacancies - Unregistered												
S icknessAbseoc:e (Division) %	4.5	4.7 *11*	4.7	5.4	6.S	6.1	6.0	5.7	4.7	5.1		
New Complaints(Division)	4.0	12.0 *11*	7.0	5.0	4.0	5.0						
New PALS(Division)	9.0	26.0 *11*	14.0	15.0	15.0	13.0	7.0	4.0	3.0	7.0	6.0	17.0

The maternity dashboard this month highlights an increase in the Red Flag incidents which have occurred due to staffing demands and subsequently delays in induction of labours, staffing being less than establishment and the necessity of calling in the on-call community midwife to ensure that the service continues to run safely. Staffing shortages have been as a result of pandemic isolation, contact tracing, long term sickness and vacancies. There has been no fill from agency requests and therefore a piece of work has been undertaken to explore the entire agency market for midwives with some success. It has been possible to block book one midwife for 8 weeks at Scunthorpe. Unfortunately it is only the off framework agency, Thornbury, that has a number of midwives on their payroll. It has been agreed that any midwifery request will be sent immediately to them rather than the usual trust process of working through the agency tiers. Additionally, a specific weekend maternity plan has been introduced which includes not only staffing detail, but also looking forward to expected admissions (Induction of Labours), medical staffing shortages, current workload including any complex safeguarding issues etc. This is shared with the triumvirate, consultant on-call, labour co-ordinators, site managers, and silver and gold on-call managers to provide a greater level of assurance. Active recruitment is on-going.

3.0 Quality

3.1 Reported Falls Incidents

The information presented shows data for inpatient wards only and is the standard throughout the report.



The total number of falls reported has increased for the first time in five months.
There has been a significant increase in reported falls at the Scunthorpe site where activity during July was high and escalation beds opened. This impacted upon the staffing levels across the wards as staff were redeployed to support the opening of additional beds. This may have impacted upon the ability of staff to observe patients, therefore resulting in a higher number of reported falls.

During July 2021, two falls were reported with major harm where both patients sustained fractures to the femur. MDT huddles were held for both incidents. Following the huddles, both incidents identified concerns relating to staffing at the time of the falls. Full investigations are being undertaken for both incidents to understand the root causes and identify learning and actions. Both incidents occurred on Ward 25 at Scunthorpe. Following an urgent review by the Chief Nurse the escalation beds on the ward were closed to reduce the risks.

Bedside huddles continue to identify the following themes for patients who have more than one in-patient fall;

- The majority of patients have a cognitive impairment
- Mental capacity is not always formally assessed or considered
- Person-centered interventions are not always considered
- Risk assessments are completed in line with Trust policy

Serious incident reports for falls with harm from April 2020 to March 2021 have now been reviewed. A total of four completed and assured reports were included. Different root causes were identified in all four incidents. The following themes and trends were identified from the contributory causes;

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

The falls policy, risk assessments and care plans have been reviewed and updated to support person centered interventions to reduce the risk of falls. Once approved, the new falls documentation will be rolled out during the autumn alongside the supportive care policy and associated documentation.

3.2 Falls per 1,000 Bed Days

Falls per 1,000 Bed Days Summary Jul 2021

Falls per 1,000 bed days

5.8 ▲ 0.6

Falls per 1,000 Bed Days

Falls per 1,000 Bed Days by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2021	DPOW	4.8	-1.2	6.0	
Jul 2021	GDH	1.4	-5.4	6.7	
Jul 2021	SGH	7.3	3.2	4.1	

Falls per 1,000 Bed Days by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2021	C&T	0.0	-8.4	8.4	
Jul 2021	Family Services	0.0	-1.3	1.3	
Jul 2021	Medicine	7.4	1.9	5.5	
Jul 2021	Surgery	5.1	-1.0	6.1	

The data demonstrates only slight increase in the falls per 1000 bed days across the Trust. There is a significant increase at the Scunthorpe site where the highest number of vacancies are.

3.3 Wards with Highest Incidence of Falls

Highest Reporting Wards with Falls Incidents Jul 2021

Indicator	Falls - No Harm		Falls - Minor Harm		Falls - Moderate Harm		Falls - Major or Catastrophic Harm		Falls - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
SGH - Stroke SGH	9	▲ 4	7	▲ 6	0	0	0	0	16	▲ 10
SGH - Ward 25	12	▲ 5	2	▲ 2	0	0	2	▲ 1	16	▲ 8
SGH - Ward 22	8	▲ 7	0	▼ -2	0	0	0	0	8	▲ 5
DPOW - B2 Assessment Unit	6	▲ 5	1	▲ 1	0	0	0	0	7	▲ 6
DPOW - Stroke DPW	4	0	3	▲ 3	0	0	0	0	7	▲ 3
SGH - Ward 16	6	▲ 4	1	0	0	0	0	0	7	▲ 4

Highest Reporting Wards - Falls per 1,000 Bed Days

Site - Ward	Falls per 1000 Bed Days	Change
SGH - Stroke SGH	28.2	▲ 16.9
SGH - Ward 25	18.8	▲ 9.0
SGH - Ward 16	9.9	▲ 5.5
DPOW - B2 Assessment Unit	9.8	▲ 8.1
SGH - Ward 22	9.7	▲ 5.9

The three highest reporting wards during July 2021 were all at the Scunthorpe site. Triangulation with the staffing data for the Stroke Unit and Ward 22 demonstrates low fill rates and unfilled supportive care shifts. This will potentially have impacted upon the ability of staff to provide the appropriate level of observation, therefore resulting in a higher number of reported falls.

All areas detailed above will be reviewed alongside other metrics at the Nursing Metrics Panel.

3.4 Areas of Concern and Improvement

Recent developments to the Nursing Dashboard now allow areas of improvement and deterioration to be identified. In July 2021, Ward B2 at Grimsby demonstrated an improvement and Ward B6 at Grimsby a deterioration in the number of falls reported per 1000 occupied bed days over the previous three months.

Wards with 3 Consecutive Month Decreases

Calendar Month	Jun 2021				
Site - Ward	Month -3	Month -2	Month -1	Month	Decrease
DPOW - B2 Assessment Unit	13.3	7.9	3.2	1.7	↘ -11.6

Wards with 3 Consecutive Month Increases

Calendar Month	Jun 2021				
Site - Ward	Month -3	Month -2	Month -1	Month	Increase
DPOW - B6	0.0	8.1	9.4	10.0	↗ 10.0

4.0 Pressure Ulcers

4.1 Hospital Acquired Pressure Ulcer Incidents

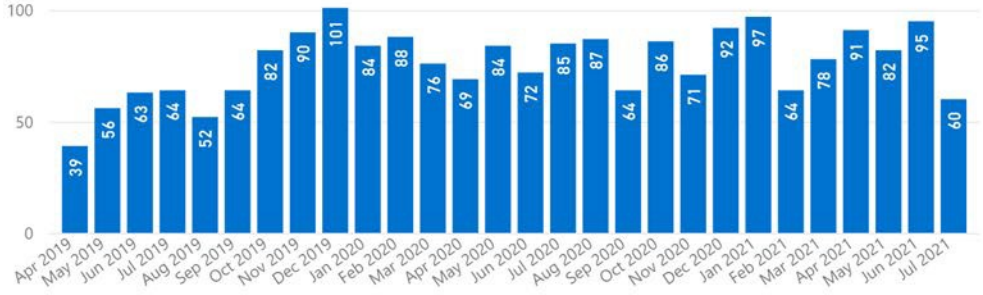
The data includes hospital acquired category 2, 3, 4 and unstageable pressure ulcers and is the standard throughout the report.

Data changes from month to month due to ongoing validation and these figures may contain un-validated pressure ulcers.

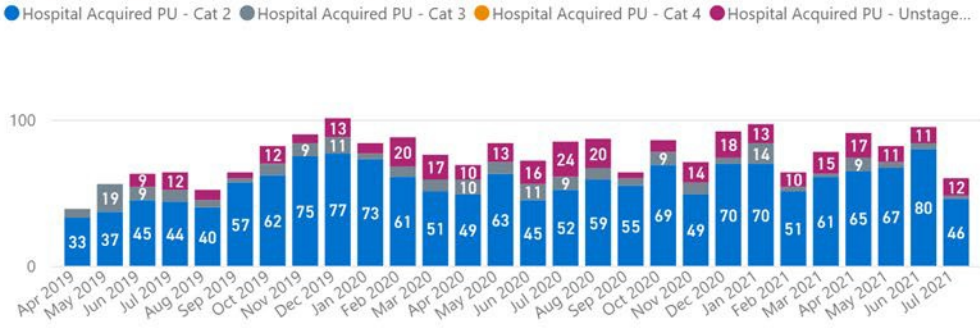
Hospital Acquired PU Incidents Summary Jul 2021

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
60 ▼ -35	46 ▼ -34	2 ▼ -2	0	12 ▲ 1

Hospital Acquired PU - Total



Hospital Acquired PU by Category



Hospital Acquired PU - Total by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jul 2021	DPOW	33	▼ -22	55	
Jul 2021	GDH	0	▼ -1	1	
Jul 2021	SGH	27	▼ -12	39	

Hospital Acquired PU - Total by Division

Latest Month	Divison	Result	Variance to Previous	Previous Month	Trend
Jul 2021	C&T	0	◆ 0		
Jul 2021	Family Services	1	▲ 1		
Jul 2021	Medicine	45	▼ -16	61	
Jul 2021	Surgery	14	▼ -20	34	

A review of reported pressure ulcers has now been completed and the data has been analysed to understand the impact of validation upon the final categorisation of the pressure ulcer. Support is being offered to areas where there is potential for improvement and training reviewed to ensure staff are

confident in categorisation.

Data for July 2021 shows a significant decrease in the number of pressure ulcer incidents reported. There was a small increase in the number of unstageable pressure ulcers reported. The number of category 2 and 3 pressure ulcers reported has decreased significantly.

Both the Grimsby site (DPOW) and the Medicine division continue to report higher numbers of pressure ulcers.

A review of the pressure ulcer serious incidents reported between April 2020 and April 2021 has been undertaken. The key root causes remain unchanged and are detailed below:

- There was a lack of RN oversight of pressure area care
- There were problems sourcing or using the correct equipment
- The risk assessment was not accurate
- Staffing impacted upon care
- The care plan was not followed/accurate

Trust wide action plan has been revised and updated to ensure that appropriate actions are in place.

4.2 Hospital Acquired Pressure Ulcers per 1,000 Bed Days

The data demonstrates the reported incidence of pressure ulcers per 1000 occupied bed days.

Hospital Acquired PU per 1,000 Bed Days Summary — Jul 2021

PU per 1,000 bed days

3.1 ▼ -2.0

PU per 1,000 Bed Days

PU per 1,000 Bed Days by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jul 2021	DPOW	3.3	▼ -2.5	5.8	
Jul 2021	GDH	0.0	▼ -1.3	1.3	
Jul 2021	SGH	3.1	▼ -1.6	4.7	

PU per 1,000 Bed Days by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jul 2021	C&T	0.0	◆ 0.0		
Jul 2021	Family Services	0.4	▲ 0.4		
Jul 2021	Medicine	3.9	▼ -1.6	5.5	
Jul 2021	Surgery	2.7	▼ -4.4	7.2	

The incidence of reported pressure ulcers per 1000 occupied bed days has decreased in July 2021 and remains slightly higher at the Grimsby site.

4.3 Wards with the Highest Incidence

Highest Reporting Wards with PU Incidents Jul 2021

Indicator	Hospital Acquired PU - Cat 2		Hospital Acquired PU - Cat 3		Hospital Acquired PU - Cat 4		Hospital Acquired PU - Unstageable		Hospital Acquired PU - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
DPOW - C2	6	▲ 2	0	0	0	0	0	▼ -1	6	▲ 1
SGH - Stroke SGH	4	▲ 3	0	0	0	0	1	▲ 1	5	▲ 4
SGH - Ward 16	4	▲ 2	0	0	0	0	1	0	5	▲ 2
DPOW - B2 Assessment Unit	3	▲ 1			0	0	1	▲ 1	4	▲ 2
DPOW - B7	3	▼ -1	0	0	0	0	1	▲ 1	4	0
DPOW - Stroke DPW	2	▼ -5	1	▲ 1	0	0	1	0	4	▼ -4

Highest Reporting Wards - PU per 1,000 Bed Days

Site - Ward	Hospital Acquired PU per 1000 Bed Days	Change
SGH - Stroke SGH	8.8	▲ 6.9
DPOW - C2	7.5	▲ 1.1
SGH - Ward 16	7.1	▲ 2.7
DPOW - B7	6.2	▼ -0.3
DPOW - ITU	5.8	▼ -26.4

The Stroke Unit and Ward 16 at Scunthorpe and Ward C2 at Grimsby have all reported a higher number of pressure ulcers per 1000 bed days during July 2021. The total numbers reported by each area is less than in previous months. It can be noted that the majority of pressure ulcers reported were category 2 pressure ulcers. This is suggestive that appropriate preventative measures and early intervention occurred to prevent further deterioration.

4.4 Areas of Concern

Recent developments to the Nursing Dashboard now allow areas of improvement and deterioration to be identified. In July 2021, no wards demonstrated an improvement. Ward 17 at Scunthorpe and Ward B6 at Grimsby demonstrated deterioration in the number of pressure ulcers reported per 1000 occupied bed days over the previous three months.

Wards with 3 Consecutive Month Increases

Calendar Month	Jun 2021				
Site - Ward	Month -3	Month -2	Month -1	Month	Increase
SGH - Ward 17	0.0	2.4	6.1	10.6	↗ 10.6
DPOW - B6	0.0	1.6	3.1	3.3	↗ 3.3

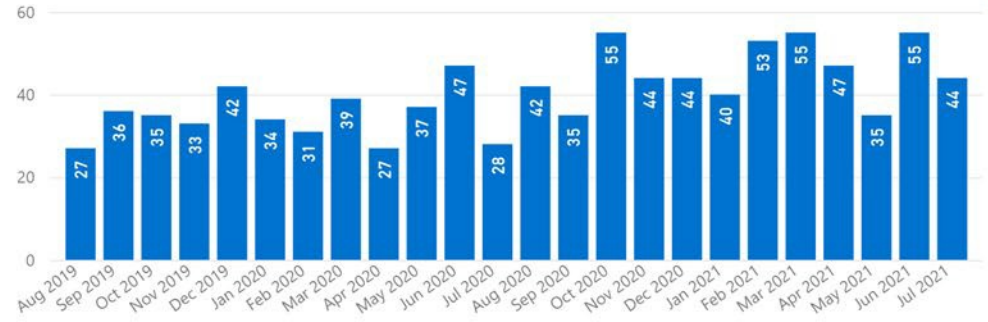
4.5 Community (Acquired on Caseload) Pressure Ulcer Incidents

The information presented shows data on pressure ulcers acquired on community caseload. Please note this does not include category 1, suspected deep tissue injuries or moisture lesions. Data changes from month to month due to ongoing validation and these figures may contain un-validated pressure ulcers.

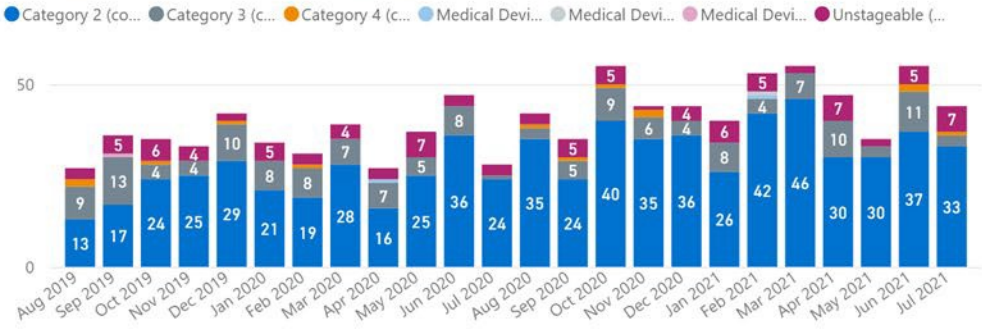
Community (Acquired on Caseload) PU Incidents Summary Jul 2021

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
44 ▼ -11	33 ▼ -4	3 ▼ -8	1 ▼ -1	7 ▲ 2

PU Acquired on Caseload - Total



PU Acquired on Caseload by Category



PU Acquired on Caseload by Specialty Jul 2021

Specialty Responsible Description	Category 2 (community acquired)	Category 3 (community acquired)	Category 4 (community acquired)	Unstageable (community acquired)	Total
West Network	10	1	1	3	**15**
South Network	12			1	**13**
Community - Intermediate Care Team	5	1		2	**8**
East Network	6	1		1	**8**
Total	**33**	**3**	**1**	**7**	**44**

The incidence of pressure ulcers is not significantly reducing despite a community wide action plan; however, there has been a reduction in the total number of pressure ulcers reported in month. Progress against the plan is slow as staffing remains a significant challenge in the community with challenges increasing during July, this impacted on the patient caseloads and the frequency of patient reassessments. There has also been a high

turnover in the React to Red team that provide support and education to Care Homes. The vacancies have been recruited to however there is a period of induction, support and supervision for the new starters to provide them with the required skills and knowledge.

The data demonstrates the reported incidence of pressure ulcers has reduced for the month of July. The majority of reported pressure ulcers are category 2 which is a consistent theme however there has been a noticeable reduction in the number of category 3 pressure ulcers this month. This is suggestive that preventative interventions put in place by network teams have impacted on further deterioration of category 2 pressure ulcers. A new Tissue Viability Nurse for Community has been in post since the end of May and is now validating category 3, category 4 and the unstageable pressure ulcers. As part of this validation, low level education into the network teams is being provided by the Tissue Viability Nurse to feedback on any interventions that need to be considered. Themes from the review of pressure ulcers at the Pressure Ulcer Scrutiny Panel are being fed back to the community nursing network teams in particular, the review of equipment when a patient's condition deteriorates and ensuring this is followed up.

Both South and West networks have the highest number of pressure ulcer incidents this month whilst East Network has seen a reduction in pressure ulcers reported. Last month all networks reported similar numbers of pressure ulcers, this decrease in pressure ulcers may be reflective of the supportive input the Community Tissue Viability Nurse has had with this network over the past month. The Intermediate Care Team has also seen an increase in month in the number of pressure ulcers reported. On review of the incidents, 5 of the 8 reported were patients residing in Sandhills Residential Home which was under a serious Safeguarding review in July 2021 because of staffing levels and this may have contributed to this increase.

5.0 15 Steps

Three 15 steps visits were undertaken during July. Six visits were cancelled due to the team isolating and sickness. All six visits have been re-scheduled.

Themes

	Themes Identified	Actions Taken
Standard 1: Observations	• Large amounts of equipment stored in corridor- struggling to fit it all in • Equipment at fire exit- impedes the exit • Missed CD check • Broken medication fridge -awaiting delivery new fridge. • Call bell not working for 2 months in bay A- mitigation plan in place • Ward would benefit from a paint refresh. • No green tape in use on any equipment • Clumps of dust on equipment within treatment rooms • Patient documentation not securely stored – accessible behind nurses station • Staff not wearing ID badges or yellow badges	• Declutter days advertised within Hospitals for unused equipment. • Immediately cleared • Staff made aware at the time of daily checks • Ward using adjacent ward's fridge • Had been reported- action followed up • Request placed for renewal of paintwork • Staff made aware at the time • Nurse in charge and H.S.A aware • Shift lead aware and will cascade to all staff
Standard 2: Documentation	• X1 bowel output not recorded - no clinical reason recorded • Food charts not consistently completed • X1 PAC risk not completed on transfer to ward • EPMA undertaken well- except for oxygen signatures	• Discussed with Staff Nurse responsible • Team discussion held on importance • Discussed with Staff Nurse responsible • A theme emerging across majority of wards
Standard 3: Patient Feedback	• Patients had multiple moves • Patients unaware where call bell is • Noisy at night – staff chatting	• This is a re-occurring theme • Patients shown call bell and staff reminded • All staff made aware of the impact to patients
Standard 4: Staff Feedback	• Staff were not sure on how to report abuse • Staff were unsure about red flags poster • Staff unsure about recent complaints	• Educated at the time and new red flag posters re-issued

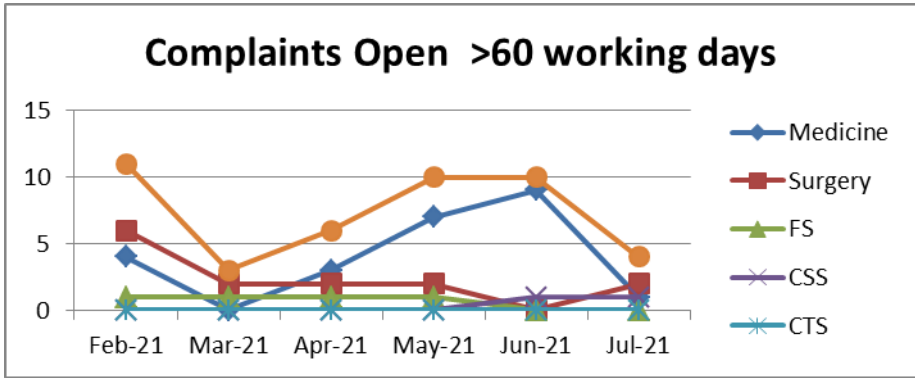
6.0 Patient Experience

6.1 Complaints

Trust wide the total number of new complaints received in July is 29 which is in line with the previous month data. The total number of open complaints is 54 which is a 31% decrease from last month. The KPI to achieve 85% of all complaints closed within timescale was successfully achieved at 87%. There were 60 complaints closed in July, with the average length of open timescale being recorded at 41 days.

The number of open complaints outside of the Trust timescale are 4, 1 within Medicine Division , which is an improvement since last month. There is an addtional 1 in CSS , and 2 in Surgery and Critical Care. This can be seen been seen in Graph X below. All complaints continued to be reviewed at the central team weekly Support and Challenge meeting for robust oversight.

Graph X

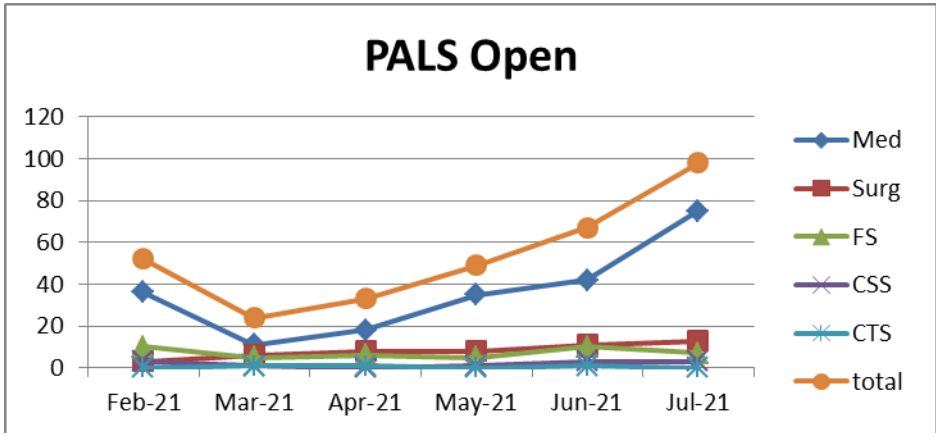


6.2 PALS

Trust wide the total number of open Pals was reported at 98, this is another increase since last month's reporting. This increase is directly correlated to the sharp increase in Medicine Pals concerns; this can be seen in Graph Y below.

The predominance of these concerns are attributed to the ECC department at DPOW and central complaints team are currently exploring how the department can best be supported to understand the themes through deep dive reporting, and be assigned some supporting Pals hours to work with them to manage their current situation.

Graph Y



The Chief Nurse has secured an extension to the Family Liaison Assistant (FLA) roles until January 31st 2022 which has been followed by a short term bid to ensure FLA cover more widely across the Trust, and a supporting long term business case is in development .The continued positive feedback regarding the role has detailed not only the positive impact on communication in the areas where FLA's are present, but there is increasing soft intelligence of non measureable patient experience outcomes such as :-

- De-escalation of concerns at ward level
- Mental and emotional wellbeing support – through bedside conversation and activities
- Reduction in potential harm through increased oversight of vulnerable patients

The difficulties of measuring this data are that the work is preventative, but can be witnessed on a daily basis in an observational approach.

6.2 Patient Feedback

The collection of local inpatient survey data continues through the INSIGHTS program. This will now contribute to Nursing Metrics discussions with research indicating that poor patient experience metrics can be an early indicator for clinical effectiveness and safety outcomes (Doyle et al 2013). This is hoped to support improved discussions on which area to focus on prior to clinical metrics being evident.

The current summary of July FFT data submitted can be seen below:

There is a slight increase in response rates but progress to achieve representative data remains poor. All areas within the Trust have access to multiple methodologies and through the monthly FFT Oversight group rate improvement ideas are being shared. Areas with FLA support appear to be more successful and the use of a survey volunteer role is being explored. SmS rates in ECC and Maternity are at only 3%. IWANTGREATCARE report that "click rate "(people opening the survey) is logged at 12-13%, but completion is only 3%. They are going to launch a tracking tool to monitor at which point people are dropping out of the survey which will guide the next steps. In the interim the SmSs are being sent out daily, rather than 3 times per week, and the opening script has been changed along with providing reassurance about the message received.

There is opportunity within the Patient Experience team for a newly devised 6 month temporary Patient Experience manager post; this will support the Lead Nurse Patient Experience. FFT will form part of their priority work.

July saw three 2020 national survey reports, which were delayed due to Covid 19, now available for Trust review:-

- National Inpatient Survey
- Children and Young People
- Urgent and Emergency Care

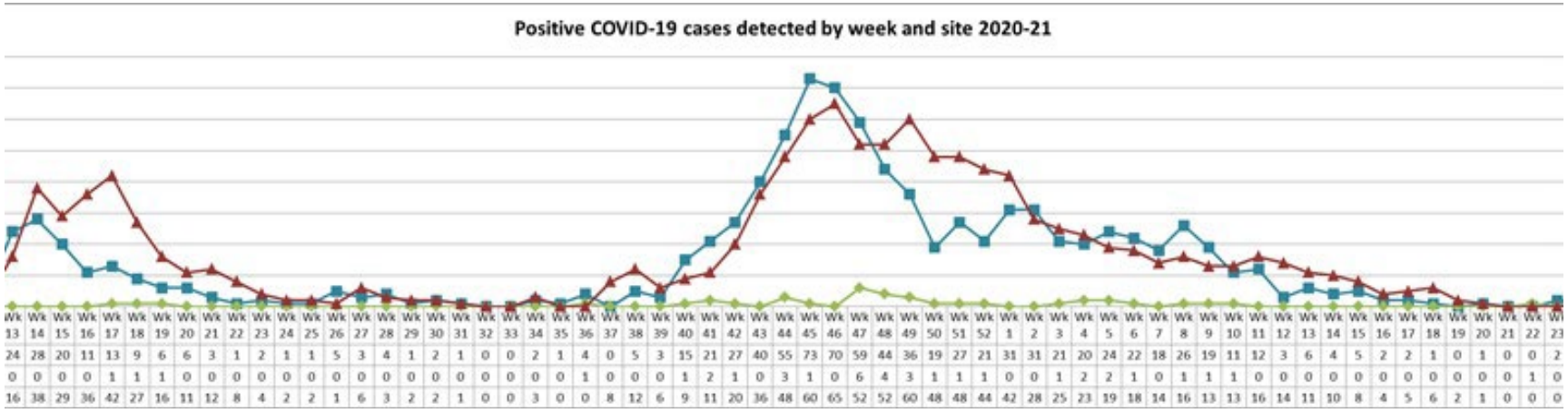
Results continued to be embargoed outside of the organisation. Detailed headline reports have been shared with the divisions involved and direct quarterly reporting on actions and updates will be through Patient Experience Group.

The Volunteering services newly recruited post holder has impacted positively on recruitment of new volunteers who are being prioritised into wayfinding roles as the significant site building works are reported to be negatively affecting the patient experience, evidenced through direct feedback . This is especially apparent at the DPOW site, and a total of 10 way finders will be in place by the end of August to support patients navigating their way to wards and departments from the varied drop off points. A volunteer reset is also being undertaken to ensure that existing volunteers are safely able to return into volunteering posts, and are fully aware of the changing needs of volunteer roles. Support is being offered to those volunteers who may not be able to return to their preferred roles, but focus must be on creating a service that supports the requirements of the Trust and the new volunteering strategy.

** Please note a data error was reported in July's report where Total number complaints were reported as 28, this was in fact the number of new complaints received, 78 was the correct total number of open complaints.

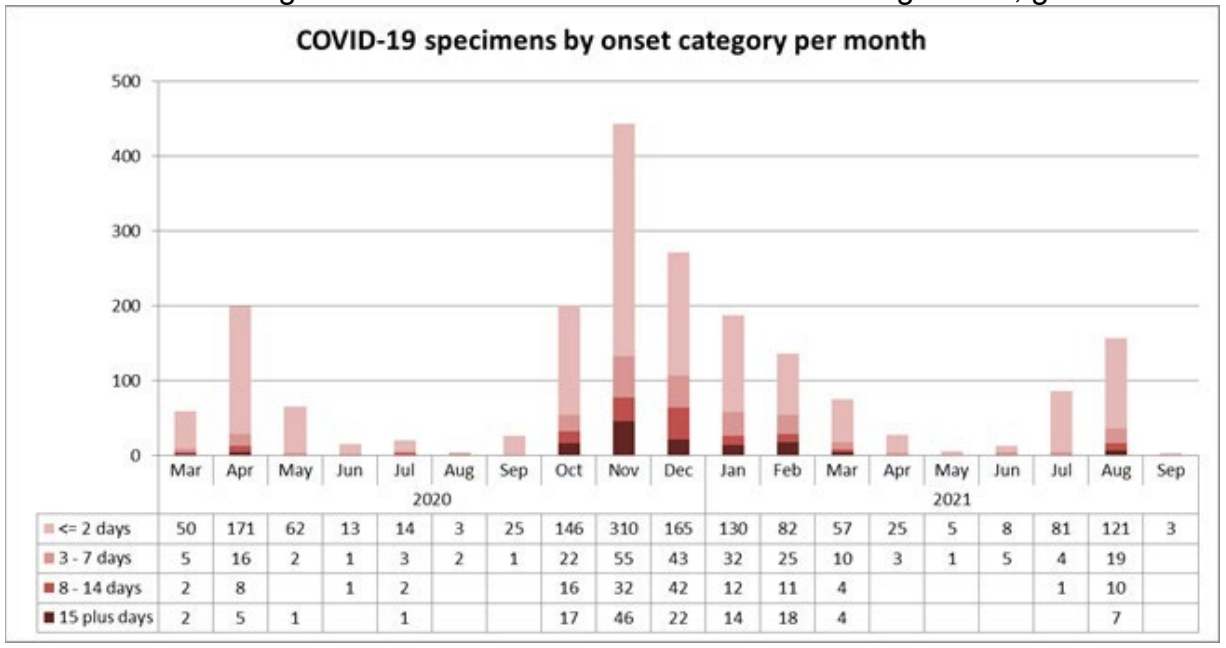
7.0 Infection Prevention and Control

In August, as predicted the number of COVID-19 cases is escalating requiring the introduction of a full COVID ward on the SGH site. There has also been extensive pressure on critical care units requiting overflow into the main operating theatres to manage COVID patients requiring specialist care.



	Wk 13	Wk 14	Wk 15	Wk 16	Wk 17	Wk 18	Wk 19	Wk 20	Wk 21	Wk 22	Wk 23	Wk 24	Wk 25	Wk 26	Wk 27	Wk 28	Wk 29	Wk 30	Wk 31	Wk 32	Wk 33	Wk 34	Wk 35	Wk 36	Wk 37	Wk 38	Wk 39	Wk 40	Wk 41	Wk 42	Wk 43	Wk 44	Wk 45	Wk 46	Wk 47	Wk 48	Wk 49	Wk 50	Wk 51	Wk 52	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10	Wk 11	Wk 12	Wk 13	Wk 14	Wk 15	Wk 16	Wk 17	Wk 18	Wk 19	Wk 20	Wk 21	Wk 22	Wk 23
	24	28	20	11	13	9	6	6	3	1	2	1	1	5	3	4	1	2	1	0	0	2	1	4	0	5	3	15	21	27	40	55	73	70	59	44	36	19	27	21	31	31	21	20	24	22	18	26	19	11	12	3	6	4	5	2	2	1	0	1	0	0	2
	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	2	1	0	3	1	0	6	4	3	1	1	1	0	0	1	2	2	1	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0
	16	38	29	36	42	27	16	11	12	8	4	2	2	1	6	3	2	2	1	0	0	3	0	0	8	12	6	9	11	20	36	48	60	65	52	52	60	48	48	44	42	28	25	23	19	18	14	16	13	13	16	14	11	10	8	4	5	6	2	1	0	0	0

Unfortunately we have seen a number of outbreaks develop on B6, B7, C2, Amethyst, and B3. The wards were closed and staff and patient screening introduced to manage the situation. Given the number of staffing issues, greater movement of staff may have been a factor in the dissemination.



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	2020										2021								
<= 2 days	50	171	62	13	14	3	25	146	310	165	130	82	57	25	5	8	81	121	3
3 - 7 days	5	16	2	1	3	2	1	22	55	43	32	25	10	3	1	5	4	19	
8 - 14 days	2	8		1	2			16	32	42	12	11	4				1	10	
15 plus days	2	5	1		1			17	46	22	14	18	4					7	

From the mandatory alert organism reporting there has been a rise in the number of hospital onset C.difficile cases to x5. These were detected on wards 17, ICU, 22, 23, and 24. PIRs are taking place where there is an issue detected and antimicrobial usage is a theme.

The Trust also reported x1 case of community onset MRSA bacteraemia from a dialysis patient.

Ongoing work in place to arrange the COVID booster programme and influenza vaccination campaign.

8.0 Quality Improvement

- The QI team is starting to take shape with a number of posts out to advert with a view to been a fully established team in post by Oct/Nov 2021. In the meantime work continues to develop our improvement offer and support improvement efforts across the trust.

- Current work the QI Team are supporting includes:

√ Neonatal Repeat Blood spot collaborative – currently at PDSA cycle stage and implementing 4 PDSA cycles with all Maternity Teams. This has resulted in an improvement from a repeat rate of 10% in Dec 2020 down to confirmed level of 2.6% for Augusts reporting period. This is really positive and has seen the number of babies having a repeat reduce by 60% releasing staff time by 29 hours over the period.
√ Safe & Secure Medications – Preliminary work has started to scope a QI collaborative event to focus on improving our position around handling and storage of medications. The project team are working to gain a 360 degree view of the problem reviewing Datix, audits and other intelligence. A process mapping session will be held in September to understand the end to end process and identify any problems or opportunities for improvement.
√ Reducing attendance of DVT patients to ED / SDEC – The community team, from a staff idea, are using QI methodologies to test using PDSA how they can see more DVT patient within the community to avoid ED/SDEC attendances.
√ The Critical Care Outreach team have begun to develop a QI project to ensure appropriate and timely referral to the Critical Care Outreach team once the NEWS score threshold is triggered.
√ Occupational Health has commenced a QI project to reduce the time taken from referral (wellbeing referrals) into the service to date of 1st appointment offered to 15 days by 31/12/2022.
√ Our second QSIR Virtual cohort 2 has completed the learning phase of the program and over the next 4 weeks are applying their learning to their QI projects. The outcomes of which will be showcased at a celebration event.

9.0 Conclusion

Due to the regular ward re-configuration over the last year, data comparisons remain difficult for some ward areas, however areas are highlighted through triangulation of data and receive deep dives where required.

The Nursing dashboard is being continuously developed by the nursing data analyst with the recent publication of the community dashboard to enable easier analysis and triangulation. The maternity dashboard is presented her in draft format and is currently being finalised.

Vacancies on the inpatient wards in July for Registered Nurses and Healthcare Assistants has increased and a workforce plan has been developed with a forecast suggesting our Trust will have 15.72WTE band 5 vacancies by March 2022; however work is ongoing to ensure the impact of ward reconfigurations are captured in the forecast.

Community has seen a slight decrease in RNs vacancy rates and has a further 6 RNs commencing in post in September. HCA vacancies have increased, however a number of staff are waiting to commence in post. A bespoke recruitment campaign is planned for the community.

Escalation beds have been opened to support the increased activity on all three sites. Staffing these unestablished beds remains challenging and puts increased pressures on substantive staff.

We have seen an increased number of wards actively reporting staffing and red flag incidents. 107 red flags incidents were reported in the acute setting and 31 in community.

The total number of falls reported has increased for the first time in 5 months with an increase noted at SGH along with increased activity and open escalation beds. Two falls were reported with harm and safety huddles were undertaken with concerns identified related to staffing.

There was a decrease in the numbers of category 2 and 3 pressure ulcers reported which is positive for the acute setting. In Community the focus continues and progress has been made with a reduction in the total numbers reported. A new Tissue Viability Nurse has been validating pressure ulcers and undertaking education to network teams.

The number of COVID-19 cases continued to increase with extensive pressure witnessed on critical care units requiting overflow into the main operating theatres to manage COVID patients requiring level 3 care.

The total number of open complaints in July is 54, which is a 31% decrease from June. 60 complaints were closed in July. The KPI to achieve 85% of all complaints closed within agreed timescale was achieved.

The Family Liaison Assistants role has been extended until end of January 2022 with an application for a further short term bid to roll this out across all wards and some departments.

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)226

DATE OF MEETING	05 October 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Michael Whitworth, NED & Chair of Workforce Committee
CONTACT OFFICER	Michael Whitworth, NED & Chair of Workforce Committee
SUBJECT	Workforce Committee Minutes from 27 July 2021
BACKGROUND DOCUMENT (if any)	Not applicable
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Workforce Committee – 27 July 2021
EXECUTIVE SUMMARY	Minutes of the Workforce Committee meeting held on 27 July 2021 and approved at its meeting on 28 September 2021

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients. The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday 27 July 2021 at 2.00 pm via Microsoft Teams

Present:

Michael Whitworth	Non-Executive Director (Chair)
Christine Brereton	Director of People
Linda Jackson	Vice Chair
Claire Low	Deputy Director of People
Robert Pickersgill	Governor, Membership Office
Michael Proctor	Non-Executive Director
Maneesh Singh	Non-Executive Director
Kate Wood	Medical Director

In Attendance:

Abolfazl Abdi	Deputy Chief Operating Officer
Wendy Stokes	Executive Personal Assistant to Director of People *(taking minutes)*

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1 Apologies for absence:

Paul Bunyan, Stuart Hall, Helen Harris, Ellie Monkhouse, Peter Reading and Shaun Stacey

2 Declarations of Interest:

The Chair invited members to bring to the attention of the committee any conflicts of interest relating to specific agenda items. There were no declarations of interest.

3 Minutes of the previous public meeting held on Tuesday, 27 April 2021:

Page 3, paragraph 3, second line should read: because Health Education England commissions that. With this one amendment the minutes from the previous meeting held on Tuesday, 27 April 2021 were accepted as a true and accurate record.

4 Matters arising from the previous minutes:

4.1 Updated and final Annual Workplan

The workplan had been updated and the Chair agreed that had now been approved by the Committee as a working document. This will continue to be reviewed to ensure that it remains fit for purpose and takes account of the relevant business of the Committee and reflects its terms of reference.

Agenda item 5 – Action 89 – Pride and Respect (P&R)

It was noted that the action was around the P&R training that got suspended because of COVID. Linda Jackson highlighted that this item had been removed from the action log at the last meeting and will be included in the workplan when the next phase had been confirmed. Christine Brereton explained that P&R will be integrated with wider OD interventions and it is the intention to develop a wider Culture infrastructure which will incorporate the next stages of P&R, FTSU, OD, leadership and EDI. Funding had been received from NHSI to extend Mrs Bagga's contract for one year to support P&R and wider OD interventions. Linda asked Christine Brereton for an update at the next

meeting. Christine confirmed that Culture and Leadership Deep Dive is on the agenda for the September meeting as per the workplan.
Action: Christine Brereton

Agenda item 13 – Any other urgent business
Claire Low reported that the following appointments had been made to the People Directorate and both commence in post on Monday 09 August 2021:

- Alison Dubbins, Associate Director Leadership, Culture and OD
- Nico Batinica, Head of People Systems and Governance (workforce planner and analyst)

5 Review of action log:
Action 90 – Invite a BAME staff representative to join the Workforce Committee
The Chair stated that he wanted to consider the wider inclusiveness issues and how this could be linked into the Committee. To be discussed at a future meeting and as part of the wider EDI agenda.
Action: Chair to consider with Christine Brereton

6 People Strategy – Annual Delivery Implementation Plan – Quarterly Progress update:
This is the first Q1 update on the People Strategy Annual Delivery Implementation Plan to provide assurance to the committee. Linda Jackson felt the update was really useful, important and easy to read.

She requested a copy of the new organisational structure for the People Directorate with names in boxes to be presented at the next meeting. Christine Brereton stated that the two new senior people in the People Directorate would be part of this committee and agreed to provide an organisational structure chart once the restructure for the People Directorate had been finalised.
Action: Claire Low

Linda also queried the junior doctor fill rate of 80% and asked what that was last time. Kate Wood confirmed that in August 2017 it was 63% and has increased year on year and the best ever year was last August when it was around 89% to 91%. This figure is reliant on doctors being placed by Health Education England and doctors wanting to come to NLaG. Fortunately this year there are MT1 colleagues coming in (trainees from overseas) and there wasn't any last year so percentages may go up a little. Maneesh Singh asked how the 80% fill rate affects rosters. Kate Wood highlighted there are always problems covering and NLaG relies on locum positions and it also asks its own staff to provide cover. The Chair commented if the trust is getting substantives to replace bank/agency and there are key vacancies that cannot be filled that needs to be highlighted.

Kate Wood stated that the trust is always going to have vacancies in medical staffing and it needs to think differently. Shaun Stacey, Ellie Monkhouse, Christine Brereton and Kate Wood are looking at how to manage staff in the future and this includes alternative roles such as physicians' associates, workforce planning and what skills mix will be needed for the future. The Chair added the committee needs to understand the thinking about what the trust is doing and perhaps have deep dives to look into specific topics. Some gaps will be filled through HASR, international recruitment, the trust growing its own and working with the education sector.

The Chair asked about the productive work that is ongoing with the trade unions as highlighted in the progress update. Christine Brereton confirmed a lot of positive work is going on but there is more to be done. There have been a number of complaints from trade unions and independent external people have been brought in to investigate them. In a meeting with Peter Reading, Christine Brereton and the trade unions there was agreement from all sides regarding

the need to improve partnership working. The trust is working more closely with trade unions on the job evaluation process. Christine and Claire attended a dispute meeting and made some positive steps and put an offer on the table that trade unions are considering. A paper is going to TMB to support the principle of facility time to give trade union reps the time to engage with the trust on other things. Plans are being put in place with ACAS for later in the year.

Robert Pickersgill asked about the different disciplines of the leadership development strategy. Christine Brereton confirmed this is for leaders at all levels and is a key priority for Alison Dubbins when she starts in post. There will be different strands needed for different professions and this needs to be NLaG specific around trust values. Kate Wood highlighted they currently have two leadership programmes in place for medical staff. One has been in place for 18 to 24 months and is for DCDs and clinical leaders. The second cohort is now running and it focuses on those medical staff in leadership positions to give them additional skills. The other programme started earlier this year and is for new consultants, aspiring clinical leaders and clinical leaders new to the organisation. The Chair felt this needed to be multidisciplinary and good value for money and he agreed that developing leadership is vital to the organisation.

7 People Strategy Deep Dive - Workforce:

Claire Low shared a presentation with a focus on Workforce.

She reported that recruitment activity has increased by 25% from the recruitment team with no additional staff during COVID. This includes permanent new staff, part time staff and fixed term staff but not bank or agency. There are challenges with hard to recruit to posts although there is a strong pipeline of international nurses. There have also been visa and border control challenges during COVID.

Michael Proctor felt that retention is as equally important as recruitment and that is helped by providing career progression opportunities for such as HCAs with potential to seek a route into registration. Claire Low stated it is also about how the trust best uses the apprenticeship levy particularly in nursing, making that accessible and providing a pathway to convert talent and skills moving forward. Linda Jackson supported the approach of the talent acquisition team for hard to recruit clinicians' posts. She asked if the review of the recruitment process included the Trac system as there is background noise that the system is difficult to use. Claire Low replied that a review had previously been undertaken and it had found that blockages were not directly related to the Trac system, but with users, for example, managers not shortlisting on time, which was understandable on occasions given operational challenges, but that did impact on recruitment timelines. Christine Brereton has commissioned a review of the recruitment process being led by Paul Bunyan and Dave Sprawka, with a focus on diversity to respond to the asks of the NHS People Plan. Claire Low and Lauren Wilkinson are to present the improvements in ESR to the Exec Team and this will also improve recruitment further on. The Chair liked the format of the report and felt that the conversation was very useful.

8 NHS People Plan – Progress Report:

Christine Brereton presented an update to show progress and provide assurance on a number of objectives in the national NHS People Plan.

Workforce planning is difficult without confidence in the data therefore; workforce planning and analytics will be useful and the directorate will be using five key metrics that it knows are a true and accurate indication of the data. In terms of what the workforce needs will be in five years' time, the directorate will continue to use ESR as the main master version of the trust, with workforce governance and workforce planner support. The directorate is moving to SPC charts and the IPR overview will come through this committee prior to going to Trust Board. The Chair highlighted that

good progress has been made and workforce planning is now a core element of business planning which is a cultural change. Abolfazl Abdi added that part of business planning is the structure of how divisions formulate those plans. They are having weekly/fortnightly workforce planning forums where clinical leads, operation managers and nursing discuss plans from short to long term. It is a good framework translated into the business planning cycle and becoming part of business as usual.

Claire Low reported that the directorate is working with trade union colleagues on a just and learning culture. They have had a workshop with unions including the BMA and are reviewing a policy in a way that has never been done before which was really encouraging. This will build a platform on how to transform policies in the future.

Christine Brereton highlighted that the People Directorate Consultation focuses on improving and enhancing the organisational development (OD) offer in order to be more proactive as opposed to reactive. She is working with the current HRBPs to step up and work with the directorate on this.

9 Freedom to Speak Up Guardian Report – Quarter 1:

Liz Houchin reported there were no concerns and no cases given anonymously. There were 33 cases, slightly below last year's number, and the main themes are behaviour, process and worker safety. A new category being reported on is psychological safety and asking whether staff feel that they can speak up. The Q1 report will also be shared with all HRBPs to take into their areas for further discussion. This will form part of a suite of wider information on workforce for HRBPs to share with their divisions.

Michael Proctor felt there is potential for FTSU Guardians to find themselves in the middle of some issues. A group of staff have a number of concerns they brought to Liz because they didn't want to meet their management team. There was a written response and what was clear is that cannot be a substitute for mangers and staff talking to each other. This is a worry and a misuse of this particular service and this individual and cannot be a substitute for managers and staff not being able to work their problems out.

Liz Houchin added there has to be more than one route for staff to speak up and she gets them to try and think of solutions and often they can get a better result when managers and staff meet face to face. Christine Brereton agreed this is not about Liz solving everybody's problems; the trust must start to enhance the role of the leader and the manager. Christine state that she was keen that the culture task and finish group will gather all of the intelligence together to find out what the issues are and then solutions could be put in place as part of wider OD plans.

Linda Jackson stated that the trust is in the top quartile for patient safety and she asked what happened to the data and how it is triangulated. Liz replied that she deals with each individual case and that is linked in with the governance team and possibly Kate Wood and Ellie Monkhouse so that the trust is learning as an organisation. Linda Jackson added that people have gone to Liz because they cannot go through the main routes. It was highlighted that the trust doesn't want to miss any potential safety incidents. Unless the trust knows and understands the issues it cannot fully look into them and get actions from them. Kate Wood added that someone in patient safety needs to look at patient safety concerns to make sure issues are addressed.

The Chair felt that in some ways Liz Houchin is a victim of her own success in making FTSU so visible and important and she also reports to this committee and Trust Board on her findings. Christine stated that the main thing is that people are reporting issues and if they raise issues through FTSU the trust must look into that complaint, but it was very important that we were linking wherever possible to existing processes to avoid duplication. Liz added that a lot of patient safety

issues are linked to staffing levels, inappropriate skill mix or not enough staff. Staff must be encouraged to put a Datix in and going forward that needs to be articulated in the report for assurance. Linda Jackson stated she would be happy with some additional narrative to say that issues have been acted on. The Chair confirmed that the trust is in the upper quartile and the committee found the discussion really helpful.
Action: Christine Brereton/Liz Houchin to ensure that future reports reflect how FTSU complaints are linked into existing processes, where this is relevant.

10 Workforce Race Equality Standards (WRES) – Annual Report:
Claire Low reported that the data for WRES was due to be submitted by the Trust by the end of August. As the time of the Workforce Committee is a month ahead of submission date, the data was not yet finalised. Claire requested that the report/data be circulated to all Committee members outside of the Committee. The Chair confirmed agreement to this.

11 Disability equality Standards (DES) – Annual Report:
The Chair confirmed agreement as detailed above.

12 Workforce Performance Report – Trust and Directorate:
Christine Brereton explained that the current performance report for Workforce (reported to this Committee and to Trust Board) covers five KPIs, including sickness, vacancy rates by groups and turnover. She confirmed that the directorate is confident with the data for these areas as it comes from ESR. The committee should focus on things outside of the normal such as nursing and doctor vacancies. Sickness absence is a bit of an outlier at present due to the pinging around self-isolation but the trust has taken a number of measures and the numbers seem to be coming down. There is the question of where do the targets come from and what is and is not included in the data. Christine Brereton is meeting with NHSI to discuss benchmark data, where targets get set and what do the SOPs look like. As highlighted by Michael Proctor at the last meeting Robert Pickersgill agreed that any increase in establishment should be included in the charts to show against the vacancies. Christine Brereton agreed where the establishment has gone up that needs to be included in the narrative and the SPC chart.

Linda Jackson felt that part of the problem lies in establishments and Ellie Monkhouse has had a massive job to finalise numbers. With regard to unregistered nursing Linda is concerned about healthcare workers final PADRs and when thinking about the CQCs imminent visit there has been no change and the variance shows the trust is consistently failing. Christine Brereton stated that with PADRs and statutory mandatory training it is a real opportunity to complete those. She is trying to get a report to the next TMB to look at areas with low compliance and then provide support to the team in order to help with the problem and make managers take the ownership of that. The ESR team and training and development are working with ICT to pull together a dashboard. They are working hard to enable the directors and senior managers to drill down to a name to check compliance and it may only be two members of staff in one department. Kate Wood agreed it is an area of key concern and it is in the CQC action slides. If taken down to divisional level for each division they can put in a plan for compliance and sustainability. The same has been done for appraisals to see what divisions are doing about it. The Chair summarised that the trust continues to target and consider an escalation process. Claire Low added that through PRIMs and work with HRBPs Family Services has piloted a tool where they write individually to members of teams who are not compliant. They have a set period of time and then if not completed it is escalated through to the SMT. Taking a formal reactive approach by letter has been really effective in women's and children's.
Christine Brereton added that if this model works in one area it may be adopted in other areas. This is not a HR or training issue, the people directorate can provide the data and support through the HRBPs. Abolfazl Abdi highlighted it is multi-factorial and there does remain serious

challenges with capacity. Robert Pickersgill felt that the targets for consultants and specialty doctors looks high and when you look at the actuals they are more alarming. He went on to ask if targets vary across specialisms. Christine Brereton stated that the targets are aspirational and the trust is keen to meet the targets annually.

12.1 Vacancy Position
Discussed under item 12

12.2 Turnover
Discussed under item 12

12.3 Sickness Absence
Discussed under item 12

12.4 Mandatory/Statutory Training Completion
Discussed under item 12

12.5 PADR Completion
Discussed under item 12

13 Workforce Policy and Procedures:

Claire Low met with Helen Harris and from a governance perspective; she has extended policies and procedures to be compliant whilst she is undertaking a thorough review of what constitutes a controlled document and guidance. Christine Brereton highlighted that back in May 2019 the Dido Harding letter regarding the disciplinary policy states trusts should make sure they take account of things in a lessons learned review, report that through to Trust Board or Sub-Committee and put that onto its website. The policy has been reviewed with trade union colleagues, it would not normally go to TMB, and Christine Brereton agreed to bring that to this committee when finalised for Board oversight.

Action: Christine Brereton

14 Annual Organisational Audit (AOA):

This is a mandatory report produced annually by the Medical Director as responsible officer to be signed off at Trust Board level and put into the highlight report for approval, so the discussion doesn't take place twice. In the financial year 2020/2021 it shows clearly that every single doctor had their appraisal or robust reason why they did not get an appraisal. A total of 181 out of 416 doctors did not have an appraisal. The GMC put a hold on medical appraisals during COVID so they had the choice to proceed with a shortened appraisal or not to proceed at all. Another 13 have caught up and will be slotted in next year. This is under regulatory scrutiny from the GMC and NHSE/I and the trust is proceeding in the right direction. Linda Jackson thanked Kate Wood and asked if the two years are merged into one. Kate Wood confirmed that it covers two years' worth and that is what the GMC agreed. It was noted that medical appraisals are not included in the IPR because of the complexity. Christine Brereton added that medical appraisals are being put onto ESR now as that is the one version of the truth.
Kate Wood confirmed that the amber colour on page 12 indicates areas of additional focused activity. The Chair confirmed that the Committee is happy to recommend and approve the report to Trust Board.

15 Trust Board Highlight Report:

Chair to speak to Christine Brereton outside of the meeting to develop and submit this report

16 Any Other Urgent Business:

Christine Brereton reported that withdrawal of incentives for bank workers had not landed well with staff. A task and finish group has been set up to determine whether the trust pays bank rates or overtime rates. The incentives didn't make any difference so NLaG doesn't want to reinstate them. The difficulty is that York and HUTH have given incentives and that is the challenge.

The Chair is to ask Wendy Stokes to circulate the Annual Review of Effectiveness. It was confirmed that everybody who attends committee meetings regularly should give their feedback.

16.1 Board Assurance Framework (BAF) 2021-22
Strategic Objective 2 - to be a good employer:
The paper proposes the current likelihood goes from 4 to 3: the Chair felt that is justified and the committee should report to Trust Board if it feels it should be changed.

The paper also proposes that the risk rating goes from 20 to 15: the Chair had no objections and would want to support that. Kate Wood highlighted that the risk register and BAF are different. The BAF covers strategic objectives and the risk register covers every day risks. If the two merged the BAF will grow and the two things shouldn't be confused. This needs to be driven by Helen Harris and it is about strategic objectives not operational risks. Christine Brereton echoed what Kate said and if recommending a score change, she thinks that it needs a Board discussion and she would feel uncomfortable if this hadn't been discussed in depth at Exec Team and Board.

Michael Proctor had the view this committee is the Board in a different guise and it gives strong recommendations to Board after looking into the detail and issues. The Chair and Linda Jackson agreed with Michael Proctor about recommendations going to Board for final sign of. Kate Wood re-iterated that she thinks the discussion needs to happen at Board. She knows about the high level risk register and is not involved in other aspects of the BAF.

The Chair summarised that the committee would recommend to Board that the risk is reducing and if a discussion is to be had at Board that can be brought back to the next meeting, but for now leave as is and revisit it again.

17 Date, time and venue of next meeting:
Tuesday, 28 September 2021 at 2.00 pm held virtually via Microsoft Teams

The meeting closed at 16.42 pm

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)227

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Simon Parkes, Chair of ARG Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	Audit, Risk & Governance Committee Minutes from 3 June 2021
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	ARG Committee – 22 July 2021
EXECUTIVE SUMMARY	Minutes of the Audit, Risk & Governance Committee held on 3 June and approved at its meeting on 22 July 2021.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Oversight of entire BAF process, completion and achievement.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

MINUTES

MEETING: Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**

DATE: **3 June 2021** via MS Teams

PRESENT:	Andrew Smith	Chair of ARG Committee / Non-Executive Director
	Michael Whitworth	Non-Executive Director
	Gill Ponder	Non-Executive Director
IN ATTENDANCE:	Stuart Hall	Associate NED, NLAG / Vice Chair HUTH
	Lee Bond	Chief Financial Officer
	Terry Moran	Trust Chair
	Peter Reading	Chief Executive
	Helen Harris	Director of Corporate Governance
	Sally Stevenson	Assistant Director of Finance – Compliance & Counter Fraud
	Helen Kemp-Taylor	Managing Director / Head of Internal Audit (Audit Yorkshire)
	Tom Watson	Internal Audit Manager (Audit Yorkshire)
	Mark Surridge	External Audit – Director (Mazars)
	Mike Norman	External Audit – Senior Manager (Mazars)
	Rob Pickersgill	Deputy Lead Governor
	Nicola Parker	Assistant Director of Finance – Planning & Control
	Adrian Beddow	Associate Director of Communications
	Anne Barker	Finance Directorate Administration Manager / PA to CFO

Item 1 06/21 **Welcomes:**

Andrew Smith welcomed Terry Moran, Trust Chair, and Peter Reading, Chief Executive, to the meeting, which was to approve the accounts and other year-end related audit matters. Andrew Smith also welcomed Gill Ponder, a new NED, to the meeting.

Andrew Smith advised that a private meeting, prior to the ARG Committee meeting, had been held between the Non-Executive Directors and the Internal and External Auditors, and no issues had come out of it.

Item 2 06/21 **Apologies for Absence:**

There were no apologies of absence.

Item 3 06/21 **Declarations of Interests**

There were no declarations of interest made.

Item 4 06/21 **Minutes of the previous meeting held on 22 April 2021**

- The minutes of the public meeting held on 22 April 2021 were reviewed and agreed as an accurate record.
- The minutes of the private meeting held on 22 April 2021 were reviewed and agreed as an accurate record.
- The Highlight report from the meeting held on 22 April 2021 was noted.

Item 5 06/21 **Matters Arising / Review of Action Log**

This item had been deferred to the next full meeting in July 2021.

Item 6 06/21 **Public Disclosure Statements**

6.1 Audited Annual Accounts 2021/21

Nicola Parker presented the Audited Annual Accounts for 2020/21 which had been reviewed in detail in draft form at the ARG Committee meeting held on 22 April 2021.

Nicola Parker advised that only two changes to the draft accounts had needed to be made and highlighted as follows:

- Page 26 – Directors' remuneration split out and updated as worked through and items signed-off.
- Page 53, Note 43 – Split out agreement of balances. Guys and St Thomas' NHS Foundation Trust have a subsidiary company, ETL; the expenditure the Trust has with this organisation is now included.

The only other minor change yet to be made related to the date for signing off the documents, once confirmed by the Auditors.

Andrew Smith said this was an impressive result and thanked Nicola Parker for the update to the accounts.

Andrew Smith asked if there were any updates from the Auditors, of which there were none.

The audited annual accounts were duly approved by the Committee on behalf of the Trust Board, under delegated authority, prior to submission to NHSE/I.

6.2 Audit Completion Report / Management Letter of Representation 2020/21

The report presented summarised the External Auditor's (Mazars) audit conclusions for 2020/21.

Mark Surridge presented the report and started by saying that the Committee had just heard from Nicola Parker with the Trust's annual accounts and cannot underestimate the quality of financial reporting of the Trust which was very, very good. Mark Surridge confirmed that the changes made since the draft annual accounts were minimal, almost typographical, and the Trust were in a very good place. He gave credit to the Finance team as the Auditors cannot do their work without the support of the Finance team.

Mike Norman stated that he would take the paper as read, and highlighted that there was a summary shown at page 5. Mike Norman also referred to the Audit Strategy Memorandum issued in January 2021 which outlined identified significant audit risks, key audit matters and other areas of management judgement, and stated that these remain appropriate and it was anticipated that an unqualified opinion would be given.

Mike Norman advised the Committee that the key point to note was on the splitting of the opinion on the accounts and the separate reporting they were required to do on the VFM conclusion, in line with the national guidance issued in April 2021. Mike Norman informed the Committee that there was nothing of concern to highlight to them, adding that they will report to the National Audit Office (NAO) that the accounts are consistent with other reports.

Mike Norman also advised the Committee of the following points:

- The remaining work on expenditure around pay costs and the updated Remuneration report was now complete.
- Plant, Property and Equipment – the final report from the District Valuer was still awaited. In conversation with them, Mike Norman advised that there was nothing to highlight.
- Some final checks to be made on the Trust's Annual Report.
- The Auditors will follow usual closing procedures with final checks in relation to any remaining steps and their normal quality control process.
- There were no internal control recommendations made and no adjustments to bring to the Committee's attention.
- The Letter of Representation (Appendix A of the report) would be issued, and this was the normal letter.
- Although the Auditors Report would look different this year, it would be a clean audit report and there were no issues to bring to the attention of the Committee.

Mike Norman confirmed that an unqualified audit opinion was expected.

Andrew Smith asked the External Auditors if they were comfortable that nothing was expected to come out of the residual processes and cause a problem, particularly in relation to the PPE valuer's report. Mike Norman stated that he was confident from discussions he had had with the valuer that there was nothing to report, and therefore any problems were very unlikely.

Mark Surridge concurred with Mike Norman's view and informed the Committee that history told them that the work around this area by the Trust had been robust.

Lee Bond referred to the Management Letter of Representation and noted the reference to Trust PFI arrangements, and the fact that the Trust did not have any such PFI schemes. Lee Bond added that he assumed this was a standard letter and that particular section would be edited out. Mike Norman confirmed that this section would be taken out.

Rob Pickersgill referred to the scope of the VFM work and asked that, as this was new this year, could the scope be developed further next year, and would there be follow-up ensuring actions had been undertaken.

Mark Surridge agreed the scope of the work had changed this year following initial guidance in October/November 2020 and revised again only recently in April 2021., Mark Surridge explained that there were three strands to the work; firstly a long term review, secondly partnership and collaboration work and finally good governance, involving the Audit Committee function and risk management and how the Trust develops and addresses risk particularly under Financial Special Measures. Mark Surridge added that they could reflect on but not second guess the CQC outcome; however the Trust should have actions to address underlying issues, etc.
Robert Pickersgill commented that the scope was enormous.

Mark Surridge added that quality improvement was also a factor so therefore a much broader remit. Having the NAO guidance late made it more difficult to interpret hence the split between VFM and annual accounts. However, this way, where the organisation is attempting to address the quality issues, this can be highlighted and not be given an immediate inadequate rating.

Mark Surridge finished by confirming that the External Auditors work was driven in the direction of only looking at the real show stopper areas.

Andrew Smith commented that he was encouraged by the way Mark Surridge had contextualised things.

Andrew Smith commented that in recognition of the Auditors comments, the audited accounts were a real credit to the Finance team, and he wished this to be placed on record along with his thanks to the whole Finance team.

Gill Ponder noted the comments from the External Auditors on the smoothness of the annual accounts process and wished to add her thanks to the entire team.

6.3 Annual Governance Statement 2020/21 – final version

Helen Harris presented the final version of the Annual Governance Statement (AGS) for 2020/21. The initial draft was considered by the ARG Committee at its meeting on 22 April 2021 and suggested amendments, received at and after that meeting, had been incorporated into the final document presented today. Helen Harris gave a brief update on the amendments made on the relevant pages and confirmed that both Peter Reading and Terry Moran had reviewed and agreed the final version.

Peter Reading confirmed that he had requested one of the changes, namely the moving of the performance section, but it did not change in any material sense and added that he was very comfortable to put his name to it if agreed by the ARG Committee.

Terry Moran commented that he had previously raised a query regarding IG breaches on page 24, as he was concerned that the statement made was not sufficiently transparent that the matter related to a number of people involved in the breach and not just one breach. Helen Harris confirmed that section 7 had been updated to take account of Terry Moran's comments on this. Terry Moran confirmed that this now addressed his concerns.

Gill Ponder queried if they should also include a record of responding in a timely manner to Freedom of Information (FOI) requests. Peter Reading agreed that this was a good suggestion and he would be happy for a suitable sentence to be added to that effect, acknowledging that the volume of FOIs had grown in the last year.

Adrian Beddow commented that the Trust had a good record of responding to FOI requests within the required time period (20 days) up until Covid-19 hit, but during the last year this had proved more difficult for staff to respond in a timely manner and as a result there had been a number of breaches of the 20 day response time over the last 14 months i.e. 25 out of 600 FOI requests approximately.

It was agreed that the addition of a sentence to this effect should be included in the AGS in light of Gill Ponder's suggestion and Adrian Beddow's response.

Following the discussion, and subject to the suggested amendment the AGS was approved.

6.4 Head of Internal Audit Opinion 2020/21 – final version (HoIAO)

Helen Kemp-Taylor presented the final version of the HoIAO previously seen as a draft at the April 2021 ARG Committee meeting.

The purpose of the opinion is to contribute to assurances of control and forms part of the Trust's AGS. Helen Kemp-Taylor went on to say that it was necessary to consider the context of Internal Audit work over the last year with the significant challenges brought about by Covid-19 and a number of changes in the Executive structure in-year, as well as the focus having been on clinical audits, the team had done a sterling job to complete the work by the end of the year in order to provide a meaningful HoIAO. There had been a number of changes made to the audit plan during the year with seven reviews deferred to the 2021/22 audit plan, following agreement of the ARG Committee.

Helen Kemp-Taylor highlighted that twelve significant assurance opinions had been given with five limited assurance opinions and these were detailed within the report.

The follow-up of Internal Audit recommendations had also been progressed during the year resulting in twenty seven with a revised due date leaving six overdue (5%).

The overall opinion provides ***Significant Assurance****,* that there is a good system of internal control in place. Helen Kemp-Taylor advised that there were no core control weaknesses to bring to the Committee's attention, hence the level of assurance provided.

Questions were sought from the Committee.

Rob Pickersgill raised the significant assurance given for the BAF review and highlighted specifically the reference at the bottom of page 4 to a revised BAF"*to provide a clear and concise overview"* and asked if this was a slight conflict appearing and being done as recommended in the audit report, and whether the Trust Board could give assurance on its development.

Helen Kemp-Taylor explained that the Internal Audit opinion is provided on the design and operation of the BAF and design in terms of format so is absolutely significant assurance, as it fulfils what is required and its intended purpose. The Trust were currently working with a representative from NHSE/I to develop and make the BAF clearer and more useful to the Board's needs, so whilst it does meet what is required, its effectiveness could be improved. Tom Watson concurred with Helen's comments in this regard.

Helen Harris confirmed that the BAF was being developed further and highlighted to the Committee that the Trust Board had agreed the strategic objectives and risk scoring approach and risk appetite statement, and now a Trust Board business reporting framework had also been agreed. The BAF would be presented to Trust Board every four months and the Sub-committees on a quarterly basis.

Stuart Hall began by referring back to the audited accounts item and stated that he recognised the amount of effort from the Trust's Finance team in producing these, adding that the limited snagging items didn't impact on the sign off of the accounts. Stuart Hall then raised the issue of A&E performance (page 4) i.e. testing of forty attendees to the Emergency Care Centre (ECC), with inconsistencies found in twenty three cases between ECC casualty cards / ambulance reports or no ambulance report available. There were also a number of arrival time anomalies. There were nine out of twenty four cases where there had been delays in creating the admission record and/or clinical record until at least 30 minutes following ECC discharge. Stuart Hall was concerned how these circumstances had arisen and suggested it should be cross referred to another Committee to look into the detail further. Andrew Smith agreed and asked Gill Ponder to pick this up through Finance and Performance Committee, and Gill Ponder agreed that this would be done.

Action: Gill Ponder

6.5 Trust Annual Report 2020/21

Adrian Beddow presented the draft Trust Annual Report 2020/21 which was taken as read and explained that the report was work in progress with some work to do before the submission deadline. Adrian Beddow asked if the Committee had any comments.

The Committee had no comments to make and the draft Trust Annual Report was approved. Andrew Smith thanked Adrian Beddow for his efforts on the production of the Trust's Annual Report.

Item 7 06/21 Internal Audit (Audit Yorkshire)

7.1 Internal Audit Progress Report

Tom Watson presented the report which was taken as read and highlighted the salient points. There were six audit reports finalised since the last ARG Committee meeting with two further reports in draft which completed the programme of work for 2020/21. The results of the assessment to the Trust's Provider License self-assessment had been reported to the Trust Board Workshop held in May 2021 although no formal report provided.

Tom Watson highlighted that there had been a requested change to the audit plan in relation to the planned staff / stakeholder engagement review. The request was to defer the audit to 2021/22 due to a number of staff vacancies in the relevant team who would be involved in the audit. Approval was sought from the Committee for the deferral.

The number of actual audit days in 2020/21 was 214 against 229 planned days. The Summary of Performance against 2020/21 Plan (page 3) outlined the days against each area of audit work.

Following the brief update from Tom Watson, Andrew Smith asked the Committee if they were happy to defer the Staff / Stakeholder engagement audit as requested, which was agreed.

7.2 Annual Internal Audit Report 2020/21

Tom Watson explained that through the HoIAO and Internal Audit Progress Report there was nothing further to add in relation to the overall Annual Internal Audit Report, for 2020/21 but was happy to take any questions from the Committee. The Annual Report included the full list of changes agreed through the ARG Committee throughout the year.

The report was noted.

Andrew Smith thanked Helen Kemp-Taylor and Tom Watson for their support and hard work over the last year through what had been a challenging period.

Item 8 06/21 Documents for Review / Approval

8.1 Audit, Risk and Governance Committee Annual Report 2020/21

The Annual Report summarises the ARG Committee's key work during the past year. Andrew Smith stated that he could not take the credit for the report as it had been prepared on his behalf by Sally Stevenson and approved by Andrew Smith for submission to the Committee for approval.

Sally Stevenson asked if the assurance ratings section (page 5) should be updated to take account of those reviews finalised since the drafting of the Annual Report, which was agreed.

Andrew Smith thanked Sally Stevenson for her efforts in drafting the report.

Subject to the above amendment the ARG Committee Annual Report for 202/21 was approved for submission to the Trust Board and the Council of Governors.

Item 9 06/21 Any Other Business

9.1 Any Other Urgent Business

There were no other urgent issues raised.

Item 10 06/21 Matters for Escalation to the Trust Board

The following items were agreed to be highlighted to the Trust Board:

- Audited Annual Accounts 2020/21
- 2020/21 External Audit Completion Report and Management Letter of Representation
- Annual Governance Statement 2020/21Head of Internal Audit Opinion 2020/21
- Trust Annual Report 2020/21
- Audit, Risk and Governance Committee Annual Report 2020/21

Item 11 06/21 Matters to Highlight to other Trust Board Assurance Committees

A&E Data – to Finance and Performance Committee.

Lee Bond asked if Stuart Hall's query on the A&E data was about performance or data quality. Stuart Hall confirmed that it was from a data quality aspect and the inconsistencies, which at twenty three, were not insignificant, between manual and electronic systems

Peter Reading commented that it was right for this issue to go to the Finance and Performance Committee, adding that ambulance handovers are always a problem, and it was likely to be error rather than conspiracy but it was right and proper to ask for confirmation.

Item 12 06/21 **Review of ARG Committee Workplan**

The ARG Committee workplan was reviewed and noted that all changes previously discussed were included. The workplan was noted, with no comments.

Item 13 06/21 **Review of the Meeting**

Andrew Smith asked that if anyone had any comments on how the meeting had gone, they should feel free to feed them back to him or Sally Stevenson.

Andrew Smith drew the meeting to a close by commenting that the whole annual accounts process had gone very smoothly, recognising the very complimentary comments given by others in attendance in this regard during the meeting, and placed on record his thanks on behalf of the ARG Committee to the Finance team and also the auditors for the part they played in the year-end process.

The meeting closed at 2.55pm

Item 14 06/21 **Date and Time of the next meeting**

Thursday, 22 July 2021 – 9.30am-12.30pm – via Teams Meeting

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)228

DATE OF MEETING	5 October 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Neil Gammon, Independent Chair of HTF Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	Health Tree Foundation Trustees' Committee – Minutes from 13 May 2021
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	HTF Committee – 15 July 2021
EXECUTIVE SUMMARY	Minutes of the Health Tree Foundation Trustees' Committee held on 13 May and approved at its meeting on 15 July 2021.

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

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

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

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **13 May 2021 – Via Teams Meeting**

Present:	Neil Gammon	Non-Executive Director / Chair of HTF
	Peter Reading	Chief Executive
	Linda Jackson	Vice Chair, NLAG
	Michael Whitworth	Non-Executive Director
	Gill Ponder	Associate Non-Executive Director
	Lee Bond	Chief Financial Officer
	Ellie Monkhouse	Chief Nurse
	Dr Kate Wood	Medical Director
	Jug Johal	Director of Estates & Facilities
	Christine Brereton	Director of People
	Tony Burndred	Governor
	Paul Marchant	Chief Financial Accountant
	Victoria Winterton	Head of Smile Health
	Clare Woodard	HTF Charity Manager
	Adrian Beddow	Associate Director of Communications
In attendance:	Anne Barker	Finance Admin Manager (For the Minutes)
	Zoe Dutton	Operational Matron in Medicine (For items 6.2-6.8)
	Suzanne Nicholson	Planning Co-ordinator (For items 6.2-6.8)

Item 1 05/21 **Apologies for Absence**

Apologies for absence were received from: Mike Proctor, Ian Reekie (Tony Burndred attending) and Andy Barber

It was noted that Ellie Monkhouse and Dr Kate Wood would be late attending due to other meeting commitments.

Neil Gammon welcomed Gill Ponder, new Non-Executive Director, to the meeting.

Item 2 05/21 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declaration of Interests". None were raised.

Item 3 05/21 **Minutes of last meeting held on 8 March 2021**

The minutes of the meeting held on 8 March 2021 were reviewed for accuracy and completion of actions.

Accommodation for HTF Team - Jug Johal noted that the accommodation for the HTF team at SGH had been completed. The ongoing work at the main entrance at DPOW meant that the accommodation could not be finalised at the present time.

Funding Options for Heritage Preservation at SGH - Jug Johal advised that a solution had been found to retain the front archway, in a much more scaled down manner. It would be part of the entrance area and inserted into the new building. Conversations are being held between Mike Simpson and Clare Woodard on the heritage boards.

Various decisions and options for funding – Ellie Monkhouse and Dr Kate Wood to decide outside of the meeting. Dr Kate Wood responded direct to Clare Woodard with suggestions for the use of covid money.

All other actions had been completed and the minutes were agreed as an accurate record.

4.1 Neil Gammon's Appointment to Independent Chair

This discussion on this item would be led by Linda Jackson at the end of the meeting following Neil Gammon's departure.

Item 5 05/21 **Review of Action Log**

The action log was reviewed as follows:

11 (16 01 21) – Fusion Biopsy machine for Urology – Waiting for Digital Strategy Group to sign off. Further update at the July meeting.

7 (18 03 21) – Dedicated Estates Support for HTF – Successful recruitment of handyman for SGH site with Russ Wood (Woody) re-joining the team on a part time basis from the Estates team.

The part-time Sparkle Project Officer was proving difficult to recruit and agreement was sought for this post to be made a full time position to attract more interest. Discussions with the Estates Directorate had resulted in proposing a full time position for an initial period of 12 months to deal with the backlog. Dependent on sufficient reduction to the backlog the post would be reviewed after the initial 12 months; this could result in reducing the dedicated HTF time and the remainder of the hours supporting Trust projects within the Estates Directorate.

Linda Jackson supported the proposal given that 8 months had elapsed without any support. There were no other comments and it was agreed to proceed as outlined.

3 (16 01 21) – Clinical Scholarship Fund – If agreed a 5% contribution from each of the funding zones to set up the first year's Scholarship. The scholarship would be for specialised training and over and above the Trust core training. Christine Brereton advised that the differential between the scholarship and a requirement of the job would need to be clearly identified. Peter Reading said that funds are scarce and was concerned that if a course was funded and then the recipient left the Trust so more work was needed.

It was agreed that this item would be brought back to the Committee once it had been worked through in greater detail.

Action: Clare Woodard

1.30pm Zoe Dutton and Suzanne Nicholson joined the meeting for Items 6.1-6.8.

Item 7 05/21 **Updates from Health Tree Foundation**

7.1 HTF Update Report

Clare Woodard presented the report and highlighted areas to note including:

C1 Glover Ward – Use of legacies – Questions raised by nurses to Clare Woodard on the use of the ward during the Covid pandemic and whether the ward would be

returning to its intended use for Cardiology as stipulated in the terms of the legacy. Clare Woodard had assured the nurses that this would be raised at the Committee.

1.35pm Ellie Monkhouse joined the meeting

Peter Reading acknowledged that the nurses had raised an interesting issue given that a large amount of money was donated for a specific use and the Trust would have to have a good reason, legally, to change that use. Peter Reading agreed to take this action away and discuss with Shaun Stacey.

Action: Peter Reading

Future Strategic Funding Plan – Clare Woodard explained that some fund zones have healthy balances with little regular spend and suggested it would be useful to have medium and long term funding plans in place, aligned to the Trust's strategic goals. Neil Gammon suggested that as the direction of health care delivery moves into integrated care the Committee would need to think carefully about how much of that partnership working the HTF would wish to be involved in. He noted that HTF is acting as the ICS anchor and focal point for the collation of bids and subsequent distribution of Phase 3 NHS Charities Together monies.

Victoria Winterton highlighted previous discussions with a list of appeals brought back for discussion and decision. Neil Gammon agreed with this approach and proposed discussion at the September 2021 meeting of any suggestions made.

Action: Clare Woodard

Neil Gammon asked about the status of the three appeals currently underway.

Clare Woodard advised that fund raising and donations were being received for the Dementia Friendly wards across the Trust with the main focus on provision of the RITA machines; signage and décor. The Goole garden is an ongoing appeal with continued fund raising and grant application sought. The equipment for the MRI ambient experience was delivered in January 2021 at a cost of £46k. As the balance of the MRI appeal is currently £8k, the shortfall of £38k has been funded from other funds until the appeal target is reached.

Linda Jackson noted therefore that money was borrowed from other areas and would be replaced as more comes in for the appeal and asked if monitoring was being done on that, which was confirmed.

Clare Woodard also referred to the community champions' reports and highlighted that following the departure of one of the champions, the post had now been successfully recruited to with a commencement date of June 2021.

Following review and discussion the report was noted.

Item 6 05/21 Items for Discussion / Approval

Zoe Dutton and Suzanne Nicholson were welcomed to the meeting.

6.1 Highlight / Overview for Items 6.2-6.8

Clare Woodard introduced the items and explained that she had been invited to join the AAU/ED Strategy Delivery Group at the start of the project meetings and attended on a weekly basis; this was commended by the Committee.

There was a raft of wishes for the scheme which required prioritisation into those classed as charitable and those that were not. A list of wishes was agreed and these were to be presented to the Committee by Zoe Dutton and Suzanne Nicholson.

6.2 Mobile Charging Points

Zoe Dutton presented this report and explained that over the last year it had become clear that given the amount of time sometimes required to be spent in the Emergency Department patients/visitors' mobile phones ran out of charge. The provision of the charging points was something that a number of other Trusts had installed based in ED areas. The chargers are similar to lockers and are secure for charging mobile phones/iPads . and would be an excellent enhancement for patients and visitors to the Emergency Department. The cost of the charging points is £16.5k.

Peter Reading strongly supported this wish as a necessity and essential and Linda Jackson agreed was an enhancement for patients / visitors to ED Departments.

Neil Gammon wanted to be sure that the ongoing running costs would be covered by the Trust and not charitable funds, which was confirmed.

Following discussion this request was approved.

6.3 TV/Patient Information Boards

The paper highlighted the use of digital patient information notice boards within the EDs at both DPOW and SGH and would provide the opportunity to display a varied amount of information such as, public body messages, approved health messages for self-care, infection control, waiting time information as well as signposting alternative services available.

Ade Beddow suggested that most people in EDs would be looking at their mobile phones and suggested a loud speaker system to give out messages. Peter Reading and Linda Jackson did not think that people stuck in ED would want health messages but rather have the TV showing.

Ellie Monkhouse suggested a combination of both popular TV programming and messages to be able to give out information on what is going on across the organisation.

Gill Ponder suggested that if sitting in A&E people do want to know where they are in the queue and how long they could be waiting and did not think that people have a receptive mind to health messages in that situation.

Dr Kate Wood joined the meeting

Zoe Dutton explained that by having two screens it would allow to show different things at the same time, which was the reason for asking for two screens. She added that the public could be asked for feedback so could tailor the information accordingly.

The cost of the wish was £3.5k with the cost of annual licence fees of approximately £1k to be paid by the Trust.

Following discussion this request was approved.

6.4 Paediatric Waiting Area – Games Console

The request for a games console in the Paediatric Waiting area would serve as a welcome distraction whilst having to wait in the ED area. The units would offer access to DVDs / films as well as interactive games and could be moved to other paediatric areas to be used in distraction therapy. The cost of the games consoles is £7.4k.

Gill Ponder questioned the infection control element and Zoe Dutton explained that it was a purpose design allowing for full clean down after each use. It was also confirmed that there were content controls in place.

The Committee agreed the purchase of the Games Consoles.

6.5 LED Digital Ceiling Lights

Zoe Dutton introduced this wish and explained that it would be similar to those provided in the scanner rooms. There were three key areas of the department which would benefit by having digital skies in rooms where there are no windows; cubicles in paediatric areas allowing multi-sensory opportunities and distraction and staff rest areas. The staff rest area was included due to the benefits of staff wellbeing. It was noted that this area did not have windows and Jug Johal explained that this was in order to give the staff a bigger rest area when the initial plans were drawn up.

Dr Kate Wood had seen the MRI unit and was in support as it would be transformative in the paediatric area; Jug Johal fully supported the request.

Neil Gammon noted the suggestion of sponsorship / grant funding. Clare Woodard explained that given it was a significant amount of money (£48k) external support / grant funding would be explored. There could be potential sponsorship opportunities or HTF could look at a proportion from across the funds.

Neil Gammon asked the Committee if they were happy to approve a relatively large sum of money and secondly if content to look into sponsorship / grant funding but if not successful would they still want to go ahead with the wish; there were no objections to this proposal.

Linda Jackson queried if this could be an opportunity for fund raising and Clare Woodard suggested that in the first instance she would look at sponsorship / grant funding as she thought there were different appeals that could be undertaken within paediatrics. If unsuccessful through this route then would be happy for HTF to “take the hit”.

Action: Clare Woodard

Following discussion this request was approved.

6.6 Interactive Floor Panels

Zoe Dutton outlined the request for interactive floor panels in the paediatric areas which included interactive themes using keyboards e.g. Scrubs the Bear Squashing bugs in the jungle. She confirmed that the infection control element standards would be met. It would provide a safe environment in segregated areas and could also be used with dementia patients. Zoe Dutton explained that the staff are excited and keen to fund raise for this equipment. The cost of the interactive floor panels is £18.3k.

Dr Kate Wood was fully supportive of this request as she had seen them in action, but with some caution expressed as to the excitement that this could cause that would need managing. Zoe Dutton explained that there were different options and can be tailored to adapt to what is needed – or it could be switched off. It would also require staff to be able to monitor the situation and take appropriate action.

The Committee were happy to approve.

6.7 Patient Feedback Stations

The report outlined the request for two Viewpoint feedback devices which would include real time reporting. The purpose of the equipment is to make gaining feedback as user friendly as possible to improve services and patient experience. The cost of the units is £3.2k.

Ellie Monkhouse advised that there were strict technicalities with Family & Friends (F&F) feedback and more work is being done around that. Whilst Ellie Monkhouse did not discount this request the F&F is done nationally and would need to ensure that the two things could work together.

Gill Ponder observed that the results of using these devices would not identify why a particular score was given; there was no way of knowing if someone was using the device multiple times and there was no qualitative feedback.

It was agreed to obtain more information from the patient experience team to understand quite clearly the output of these machines and bring back for further discussion to the next meeting.

Action: Clare Woodard

6.8 Patient Self Check in Screens

The report outlined the request for two self-check-in, wall mounted kiosks at each site (four in totals) to allow patients to self-register; this would include software to link to Symphony and System One. The cost of the check-ins is £35.1k

Zoe Dutton explained further that it would mean an additional opportunity for patients to “self-drive” their care as they could input details and access services, choose a language and would be an alternative way of booking in and patient choice and would be linked to patient records.

Lee Bond questioned how this linked to the triage processes, noting that Hull have a similar system but it gets abused as people think they can be seen quicker by exaggerating their symptoms.

Zoe Dutton acknowledged this and explained that initially it would be for the basic self-check-in, noting that if a patient required ED they would go through the normal ED process. Having the machines in place would allow other functionality in the future.

Ellie Monkhouse suggested it would be incredibly useful for people who should not be in A&E, in that they could be signposted to another service and this would potentially reduce the admin burden and help better manage clinical assessment and queues. Jug Johal noted the language choice and signposting patients to different areas so agreed it would be a huge patient benefit.

Neil Gammon questioned IT/Digital grant funding opportunities and Clare Woodard confirmed that external funding was being considered. If this was agreed Neil Gammon asked if the Committee would still want to fund if external funding was not available. Clare Woodard explained that she would look to fund across zones. Linda Jackson was not comfortable with this suggestion.

Neil Gammon suggested, therefore that the HTF team work with Zoe Dutton and Shauna McMahon on the grant funding, which was agreed.

Neil Gammon highlighted the benefits of bringing in the HTF in the early stages and thanked Zoe Dutton and Suzanne Nicholson for attending and for the clarity of the papers which had stimulated a really good debate.

Lee Bond observed that after listening to the discussions each of the requests have various merits and some are being seen in EDs across the country. In terms of the Sparkle person it is clear that this is a benefit across the Estate but suggested some of the ethnicity elements, in his opinion, were core, as is the paediatric issues. He acknowledged the grey areas in what is charitable and what is not and whilst some of the requests today were around £2-3k, one at £8k, but overall is the best part of £100k. If not successful in getting additional funding in place over the next 6 months, because they had to be done in the building stage, asked if there was £150k in an ED fund otherwise it would need to be taken out of charitable funds. He suggested that the boundaries are getting blurred in what is core for EDs and the decisions for the Committee should be over and above. Neil Gammon agreed with the grey area and boundaries do get blurred.

Lee Bond added however, that if not HTF then it would come out of budgets. Peter Reading agreed with both of Lee Bond's points in that it was never black and white.

It was suggested that a prioritisation list was worked out. Jug Johal noted that that the ED schemes were almost £1m overspent and this list would have been classed as gold plating the ED and would have been redirected to HTF.

Ellie Monkhouse commented that this is a unique opportunity for the Trust in building a brand new A&E and is an opportunity to give high quality care and asked if we would we not want it to be the best experience and highest care that we can give.

Zoe Dutton explained that there are a cohort of staff and the local community who are so excited and queuing up to fund raise and was a fantastic opportunity to utilise the drive and excitement of teams who want the best A&E.

14.45pm Following the lengthy discussion Zoe Dutton and Suzanne Nicholson were thanked for attending and they left the meeting.

6.9 HTF Terms of Reference (TOR)

The TOR was presented for final agreement following review at the previous HTF meeting.

Lee Bond referred to the delegation limits, in particular between £5k-£25k and asked if Dr Kate Wood and Ellie Monkhouse agreed with this as he suggested they should be agreed by the Committee.

Neil Gammon commented that this would increase the length of the committee meetings. Clare Woodard explained that those in the upper levels would be brought to the Committee anyway as in the case of those heard today from Zoe Dutton and

Suzanne Nicholson.

Dr Kate Wood explained that the forms were developed following input from her and Ellie Monkhouse to ensure that all the due diligence is done before being submitted to them for approval. Clare Woodard noted that all those requests that had been agreed featured in the HTF update report.

Following the discussion the TOR were approved subject to final ratification by the Trust Board.

Post Meeting Note: HTF TOR approved by Trust Board on 1 June 2021 and final version forward to Document Control.

Item 9 05/21 **Finance Update**

Paul Marchant presented the finance report for the year 19/20 and highlighted total income of £1,058. Included within this figure is £520k of Covid related income. Total income is £283k better than the plan of £775k although £237k less than plan when Covid income is excluded.

Expenditure for the year 19/20 of £1,188k is £36k underspent against the plan of £1,224k.

Fund Revaluation – The CCLA investment fund was revalued at 31 March 2021, which resulted in a loss of £13k for the fourth quarter, but a total net gain for the year of £319k. The next fund revaluation will be carried out on 30th June 2021.

Paul Marchant highlighted that for every £1 spent only 3p is spent on governance and 14p on fundraising costs and 83p is spent on charitable activities.

It was anticipated that the auditors would be reviewing the accounts in August with the final accounts to be ready in October 2021.

Lee Bond thanked Paul Marchant for the helpful report and particularly liked the inclusion of KPIs. He was impressed having only 17p for every £1 spent on admin and governance.

Item 8 05/21 **Sparkle Update**

Clare Woodard had updated the Committee under the HTF highlight report.

Item 10 05/21 **Any Other Business**

Neil Gammon referred to the proposal of thanking staff for the hard work during the past year during Covid and referred specifically to the prize draw. Gill Ponder explained that at ULH everybody was given an additional day's leave and also a random prize draw with prizes of varying degrees from TV, spa breaks to chocolates and flowers and created a tremendous buzz amongst staff; the Exec Team went out and personally handed over the prizes. Gill Ponder was unsure of the total outlay and Neil Gammon asked Clare Woodard to look into this further and see what HTF could support and report back to Peter Reading.

Action: Clare Woodard

At the present time it was felt that until the financial aspects could be advised, the level of support from the Committee could not be agreed. Victoria Winterton advised that there was £20k left in the covid funds which was specifically for staff. Gill Ponder

highlighted that the larger gifts were donated from local businesses at ULH.

Linda Jackson was uncomfortable to agree this today and suggested either an extra-ordinary meeting or virtual agreement via email once the costs are known, which was agreed.

Item 11 05/21 **Matters for Escalation to the Trust Board**

The following items were agreed to be included within the Highlight Report to the Trust Board:

- The consideration of wishes for the new ED builds at SGH & DPOW
- Approval of Neil Gammon as Independent Chair of Trustees for two further years; to 31 March 2023.

At this point Neil Gammon left the meeting in order for the Committee to discuss the next item.

Item 4 05/21 **Matters Arising**

4.1 Neil Gammon's appointment to Independent Chair

Linda Jackson explained that Terry Moran had canvassed the Committee members for agreement to appoint Neil Gammon as Independent Chair for two years. There was no negative feedback and therefore ratification was sought from the Committee to appoint Neil Gammon until 31 March 2023.

The Committee agreed.

Item 12 05/21 **Date and Time of the next meeting**

Thursday, 15 July 2021 – 1.00pm-4.00pm – Via Teams Meeting

Attendance Record:

Name	May 2021	July 2021	Sept 2021	Nov 2021	January 2022	March 2022
Neil Gammon	✓					
Peter Reading	✓					
Terry Moran	-					
Linda Jackson	✓					
Gill Ponder	✓					
Mike Proctor	apols					
Lee Bond	✓					
Jug Johal	✓					
Kate Wood	✓					
Ellie Monkhouse	✓					
Christine Brereton	✓					
Paul Marchant	✓					
Andy Barber	apols					
Victoria Winterton	✓					
Clare Woodard	✓					
Adrian Beddow	✓					
Ian Reekie (Governor)	apols					
Total						

NLG(21)229

DATE OF MEETING	05/10/21
REPORT FOR	Trust Board of Directors Public
REPORT FROM	Adrian Beddow, Associate Director of Communications
CONTACT OFFICER	Charlie Grinhaff, Communications Manager
SUBJECT	Communications Update
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	
EXECUTIVE SUMMARY	This report covers Quarter 2 of 2021/22 and highlights key activity of the Communications team in relation to internal and external communications activity.

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

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

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

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Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

October 2021

Kindness • Courage • Respect

October update covering Q2 July to September 2020/21

Key developments and projects

This quarter has been an exceptionally busy period and we are heading into October which is traditionally a very busy time for the team with big campaigns like the staff survey and flu vaccines and numerous awareness days, weeks and months to promote. *Please note this report has been produced using data up until Friday 24 September*

The team continue to give communications support to the Trust priorities, including:
Pandemic response: Winter pressures are a top topic for media enquiries
Quality priorities - End of life - This is gathering pace with the strategy now launched, and plans being finalised to pilot the new Bluebell model and Family Voices
Quality Improvement: We continue to work with the QI team to highlight projects and success stories
Strategic service development and improvement: The Associate Director of Communications continues to spend at least two days a week on the HAS programme of work
Estates, equipment and capital investment: We continue to support the £130million capital programme, including the opening of the new car park deck

Projects:
Flu campaign
Staff survey
Annual report
Annual Members meeting
Get it WRITE first time – themed week from the Trust Learning Group
COVID-19 booster vaccinations
Website rebuild

Internal Communications

Ask Peter: We are continuing to see more than 100 coming in every month, with 315 between July and 24 September.
This is just one less than the previous year, when we saw record numbers asked.
Hot topics include: staffing, incentives, estates and facilities and uniforms.
One question which remains unanswered is the VAT salary sacrifice rebate one.

Senior Leadership Briefing: topics covered recently include feedback from the15 steps challenge, flu campaign, Quality improvement across the Trust

Meet the Chief is restarting as another forum for staff to raise concerns with the Chief Executive

Monday Message
Recent topics include:
How we're tackling our waiting lists
Encouraging staff to take the flu vaccination
Explaining workforce challenges and updating on recruitment success
CQC inspection preparation
Humber Acute Services
End of life update

315
Ask Peter responses between July and September

3,414
Staff use our closed Facebook group

Staff Facebook group: this is generating many compliments for staff which is a useful resource to help the team celebrate staff on our other channels. There were more than 1,000 posts in this period.

The post with the highest engagement was a heartfelt thank you to the ICU team for caring for a staff member's family member.

External Communications - media

In September we noticed an increase in the number of patient complaints to the media, with 3 in the space of 1 week (4 for the month) compared to 0 in August and 2 in July. This has prompted us to categorise enquiries by theme to look for trends. Over Q2 the majority of media enquiries related to COVID-19 (25), 16 came in on the back of a news release, 15 were on hospital pressures and the rest resulted from an FOI response or came under the categories of legal matters, staffing or other.

We issued 20 news releases in Q2 and there were 318 media articles published about the Trust. 295 of these were positive or neutral in tone. The most covered news release was on the cricket match in aid of the ED appeal.

National media coverage
The Trust has appeared in the national media a number of times in this period. The highest profile one being the trial of the former doctor (although it should be noted the events happened in his private clinic). Negative stories including a patient complaint about the timeliness of her Sepsis diagnosis, the experience of a deaf patient and queues forming outside A&E all hit the national press. On a more positive note, our efforts to transform outpatients achieved positive national attention - digital appointment letters and an interview with Shauna McMahon featured in trade press.

Media interviews carried out:
Graheme Williams on zero waste and recycling
HTF NHS birthday and ED appeal
Look North filmed a rediroom and spoke to Graham Jacques
Shaun Stacey re hospital pressures

Social Media and Website

Top 5 social media stories in Q2

- Charity football match raises £20k for ICU (reached 11,000 people and attracted 444 likes and reactions)
- ED appeal
- Update to visiting at Grimsby hospital
- Blue badge holders can park for free
- ED appeal - interactive paeds floor

Top tweet was on hospital pressures:

Top Tweet earned 3,069 impressions

Thread: Our hospitals (Scunthorpe, Grimsby and Goole) are experiencing very high levels of demand and are extremely busy in the A&Es, with patients on the wards and due to increasing numbers of COVID-19 positive inpatients. (1/4) pic.twitter.com/6eHxkxbsM0

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144,000
Reach on our corporate Facebook page

170,000
Tweet impressions

399,000
Page views on our website

Most popular website pages

- Staff portal page
- Staff guidance
- Grimsby hospital homepage

Top media releases on the website

- Grab a jab – just under 10,000 views
- Visiting restrictions eased
- Temporary visiting restrictions at Grimsby