Northern Lincolnshire and Goole NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 4 October 2022, Newton Suite, Forest Pines, Ermine Street, Broughton, DN20 0AQ
Time – 9.00 am – 12.30 pm
(Lunch – 12.30 pm – 1.00 pm)
For the purpose of transacting the business set out below

		Note / Approve	Time	Ref
1.	**Introduction**			
1.1	**Chair's Opening Remarks** Sean Lyons, Chair	Note	09:00 hrs	Verbal
1.2	**Apologies for Absence** Sean Lyons, Chair	Note		Verbal
1.3	**Patients' Story and Reflection** Jo Loughborough, Senior Nurse – Patient Experience	Note		Verbal
2.	**Business Items**			
2.1	**Declarations of Interest** Sean Lyons, Chair	Note	09:15 hrs	Verbal
2.2	**To approve the minutes of the Public meeting held on Tuesday, 2 August 2022** Sean Lyons, Chair	Approve		NLG(22)163 Attached
2.3	**Urgent Matters Arising** Sean Lyons, Chair	Note		Verbal
2.4	**Trust Board Action Log – Public** Sean Lyons, Chair	Note		NLG(22)164 Attached
2.5	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note	09:25 hrs	NLG(22)165 Attached
2.6	**Integrated Performance Report (IPR)**	Note		NLG(22)166 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Key Issues – Quality & Safety** Dr Kate Wood, Medical Director & Ellie Monkhouse, Chief Nurse	Note	09:35 hrs	NLG(22)166 Attached
3.2	**Quality & Safety Committee Highlight Report and Board Challenge** Fiona Osborne, Non-Executive Director & Chair of the Quality & Safety Committee	Note	09:45 hrs	NLG(22)167 Attached
3.3	**Infection Control Annual Report** Linda Barker, Head of Infection, Prevention & Control	Note	09:50 hrs	NLG(22)168 Attached

3.4	**Maternity / Ockenden Update** Jane Warner, Associate Chief Nurse Midwifery	Note	10:00 hrs	NLG(22)169 Attached
3.5	**Key Issues – Performance** Shaun Stacey, Chief Operating Officer	Note	10:10 hrs	NLG(22)166 Attached
3.6	**Finance & Performance Committee Highlight Report and Board Challenge – Performance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	10:20 hrs	NLG(22)170 Attached
4.	**Strategic Objective 2 – To Be a Good Employer**			
4.1	**Key Issues – Workforce** Christine Brereton, Director of People	Note	10:25 hrs	NLG(22)166 Attached
4.2	**Workforce Committee Highlight Report and Board Challenge** Fiona Osborne, Non-Executive Director	Note	10:35 hrs	NLG(22)171 Attached
4.3	**Guardian of Safe Working Hours Annual Report** Dr Liz Evans, Guardian of Safe Working Hours	Note	10:40 hrs	NLG(22)172 Attached
BREAK – 10:50 hrs – 11:00 hrs				
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Key Issues – Finance – Month 05** Lee Bond, Chief Financial Officer	Note	11:00 hrs	NLG(22)173 Attached
5.2	**Executive Report – Estates & Facilities** Jug Johal, Director of Estates & Facilities	Note	11:10 hrs	NLG(22)174 Attached
5.3	**Fire Alarm Replacement – Scunthorpe General Hospital** Jug Johal, Director of Estates & Facilities	Note	11:20 hrs	NLG(22)175 Attached
5.4	**Business Planning Timetable** Lee Bond, Chief Financial Officer	Note	11:25 hrs	Verbal
5.5	**Major Capital / Overarching Capital** Lee Bond, Chief Financial Officer & Ivan McConnell	Note	11:30 hrs	NLG(22)176 Attached
5.6	**Finance & Performance Committee Highlight Report & Board Challenge – Finance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:40 hrs	NLG(22)177 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Key Issues – Strategic & Transformation** Ivan McConnell, Director of Strategic Development	Note	11:45 hrs	NLG(22)178 Attached
6.2	**Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge** Gill Ponder, Non-Executive Director	Note	11:55 hrs	NLG(22)179 Attached
6.3	**Strategic Development Committee Highlight Report & Board Challenge** Linda Jackson, Non-Executive Director & Chair of the Strategic Development Committee	Note	12:00 hrs	NLG(22)181 Attached
7.	**Strategic Objective 5 – To Provide Good Leadership**			
7.1	None			
8.	**Governance**			
8.1	**Audit, Risk & Governance Committee Highlight Report & Board Challenge** Simon Parkes, Non-Executive Director and Chair of the Audit, Risk & Governance Committee	Note	12:05 hrs	NLG(22)182 Attached

8.2	**Emergency Preparedness Resilience & Response Annual Report** Shaun Stacey, Chief Operating Officer	Note	12:10 hrs	NLG(22)183 Attached
9.	**Approval (Other)**			
	None			
10.	**Items for Information / To Note (please refer to Appendix A)** Sean Lyons, Chair	Note	12:20 hrs	
11.	**Any Other Urgent Business** Sean Lyons, Chair	Note		Verbal
12.	**Questions from the Public**	Note		Verbal
13.	**Date and Time of Next meeting** **Board Development** Tuesday, 1 November 2022, 9.00 am **Public & Private Meeting** Tuesday, 6 December 2022, 9.00 am	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.
- **Members should contact the Chair** as soon as an actual or potential conflict is identified. **Definition of interests –** A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold." Source: NHSE – Managing Conflicts of Interest in the NHS.

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

APPENDIX A

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

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

10.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
10.1	**Finance & Performance Committee Minutes** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(22)184 Attached
	Quality & Safety Committee	
10.2	**Quality & Safety Committee Minutes – July & August 2022** Fiona Osborne, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(22)185 Attached
10.3	**Nursing Assurance Report** Ellie Monkhouse, Chief Nurse	NLG(22)186 Attached
10.4	**15 Steps Annual Report** Ellie Monkhouse, Chief Nurse	NLG(22)187 Attached
	Workforce Committee	
10.5	**Workforce Committee Minutes – July 2022** Fiona Osborne, Non-Executive Director	NLG(22)188 Attached
	Audit, Risk & Governance Committee	
10.6	**Audit, Risk & Governance Committee Minutes – June 2022** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(22)189 Attached
	Health Tree Foundation Trustees' Committee	
10.7	**Health Tree Foundation Trustees' Committee Minutes – July 2022** Neil Gammon, Chair of the Health Tree Foundation Trustees' Committee	NLG(22)190 Attached
	Other	
10.8	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(22)191 Attached

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 2 August 2022 at 9.00 am, Forest Pines, Ermine Street, Broughton, DN20 0AQ

For the purpose of transacting the business set out below:

Present:

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

In Attendance:

Adrian Beddow	Associate Director of Communications
Tony Bundred	Public Governor
Chris Evans	Associate Director of Information Systems
Neil Gammon	Independent Chair of the Health Tree Foundation Trustees' Committee
Charlie Grinhaff	Communications Manager
Stuart Hall	Associate Non-Executive Director
Helen Harris	Director of Corporate Governance
Jenny Hinchliffe	Deputy Chief Nurse
Ivan McConnell	Director of Strategic Development
Fiona Osborne	Associate Non-Executive Director
Bill Parkinson	Associate Director of Safety & Statutory Compliance
Ian Reekie	Lead Governor
Mr Kishore Sasapu	Deputy Medical Director (representing Dr Kate Wood)
Maneesh Singh	Associate Non-Executive Director
Hannah Stephenson	Hempsons Solicitors
Simon Tighe	Deputy Director of Estates & Facilities
Jane Warner	Associate Chief Nurse Midwifery
Sara Wood	Quality Matron (for item 1.3 only)
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Director of Corporate Governance (note taker)

1. Introduction

1.1 Chair's Opening Remarks

Linda Jackson welcomed everyone to the meeting and declared it open at 9.55am. Due to a road traffic accident not all members of the board were in attendance which meant the Board meeting was not quorate due to a significant road traffic accident that closed both sides of the M180. A decision was made for the meeting to start with agreement that any items requiring approval would be moved later in the meeting when quoracy was correct. Linda Jackson, Vice Chair would Chair the meeting until the point when Sean Lyons, Chair arrived.

1.2 Apologies for Absence

Apologies for absence were received from Dr Kate Wood, represented by Mr Kishore Sasapu, Jug Johal, represented by Simon Tighe, Shauna McMahon, represented by Chris Evans, Ade Beddow, represented by Charlie Grinhaff and Simon Parkes. Apologies for attending the meeting late were given by Sean Lyons, Christine Brereton, Michael Whitworth and Mike Proctor due to delays in respect of the road traffic accident.

1.3 Patients' Story and Reflection

Sara Wood shared the story and explained this had been in respect of one of the themes that had been highlighted due nutrition and hydration. The board received an outline of a particular case in respect of a patient that had problems with swallowing due to poor mouth care. After some additional support the issue was resolved for the patient. Sadly the patient had passed away soon after due to other health issues but the family had been so grateful for the support given as it had meant they could speak to the patient before they had died.

The story was also to be included in the Nursing and Patient Safety days to support learning and this particular story had had a powerful impact. Following on from this, further training would be introduced to staff on mouth care, unfortunately, the pandemic had impacted the training previously.

Dr Peter Reading felt all staff working on wards with vulnerable patients should be made aware of the importance of mouth care and queried whether more support was required going forward to increase awareness. Sara Wood advised the story had helped to highlight the importance as it had shown the human element of why mouthcare was so important. Support had also been given by divisions for staff to receive training.

Ellie Monkhouse thanked Sara Wood for sharing the story and highlighted how it demonstrated how far staff had come in learning and sharing information especially through forums. Linda Jackson felt it was an excellent story to share wider to aid learning and asked if thanks could be shared with the Speech Therapists, as the board were proud due to the intervention of the team to enable the patient to speak to the family.

2. Business Items

2.1 Declarations of Interest

No declarations of interests were received.

At this point the agenda was taken out of order to accommodate quoracy requirements.

2.4 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.

2.6 Chief Executive's Briefing – NLG(22)118

Dr Peter Reading highlighted key points from the report and drew the boards attention to the Culture Transformation Event that was due to be launched and encouraged members to attend one of the events planned.

2.7 Integrated Performance Report (IPR) – NLG(22)119

Linda Jackson advised the IPR was for noting and would be used to support the Executive Reporting for Quality & Safety, Workforce, Performance and Non-Executive Highlight Reports.

3. Strategic Objective 1 – To Give Great Care

3.1 Key Issues – Quality & Safety - NLG(22)119

Ellie Monkhouse advised performance was being sustained in terms of the nursing metrics in particular. One highlight was that despite the achievement of all infection control objectives the previous year, Clostridium Difficile (C.Diff) would be difficult to achieve over the next year. This was due to the over-use of antibiotics during the pandemic and would be a national issue.

Mr Kishore Sasapu referred to the Summary Hospital Level Mortality Indicator (SHMI) and advised this continued to improve, it was felt the improvements had not been in respect of coding alone. Improvements would still need to continue in respect of the Out of Hospital SHMI at North East Lincolnshire.

It was noted cancer remained a challenge in respect of treatment and the management of the patient tracking list (PTL) was being carried out in multiple meetings. There was more confidence nowadays due to there being greater visibility on the patient pathway which had meant intervention could be supported when required.

3.2 Quality & Safety Committee Highlight Report and Board Challenge – NLG(22)120

Fiona Osborne highlighted key issues from the report. One point to highlight was that the committee had been keen to move away from monitoring the process management for patients to ensure safety and focussing more on outcomes and on the patient experience.

Lee Bond noted the committee had been advised on the completion of a Serious Incident (SI) investigation on a particular case and queried whether the committee received all SI Reports. Fiona Osborne advised the committee received a consolidated report of all SIs but due to confidentiality this was limited in terms of details until the investigations were completed. The committee did review the report in terms of incidents and themes to identify any re-occurrence in the same areas. As there had been more than one in maternity this had been reviewed and the committee had been assured there were no endemic issues. Mr Kishore Sasapu advised all SIs were reviewed through the SI Panel Meeting. On completion of investigations the SIs were then reviewed by the SI Incident Review Group.

Helen Harris referred to the highlight report in respect of the confirm or challenge of the Board Assurance Framework (BAF) and advised a conversation had taken place with Mike Proctor in respect of this. It had been agreed the same process would remain in place with the Executive Director reviewing the BAF to present this to the committee and that Non-Executive involvement was focussed at the sub-committee meetings.

3.3 Ockenden Progress Update – NLG(22)121

At this point Mike Proctor joined the meeting which now met quoracy requirements.

Jane Warner provided a brief background on previous reports received and highlighted the progress with current actions as detailed within the report shared. It was advised some of the funding provided to put actions in place had been used to support mandatory training and increase consultant numbers. A baseline assessment had been undertaken on the final report and the Trust had not been asked to provide any evidence in respect of this, however, it was expected this would be required once the East Kent Report was published.

Linda Jackson referred to the many actions from the Ockenden Report One and Two and queried how they would be focussed on to ensure achievement. Jane Warner agreed this would be a challenge but the team were clearly sighted on the 92 actions required. It was hoped the initial actions in Ockenden Report One and Two would be signed off shortly to ensure focus could be on the new actions. The latest report was clearly separated into areas of responsibility and some of those were to be nationally and regionally driven. Linda Jackson referred to the table of actions and highlighted that the main red areas related to workforce, planning and safe staffing so queried what key actions would be in place to address them. Jane Warner advised the team were ensuring areas were staffed to establishment requirements and the birthrate plus report was undertaken. This had been completed and the final report was now due to be shared at the board. Ellie

Monkhouse had also undertaken a separate establishment review which would be undertaken twice yearly.

Gill Ponder highlighted the Trust previously off-set some overspends against underspends for maternity staffing, however, going forward if those roles were appointed to this could create a financial issue across the Trust. Lee Bond confirmed this would be a risk and would need to be addressed in terms of when this was expected. Jane Warner advised other Trusts were in a similar position due to issues with recruitment. Work continued with students to make Northern Lincolnshire & Goole NHS Foundation trust (NLAG) an attractive place to work. Sessions were being held between the Head of Midwifery and students to make them more accessible. In September this year 14 Student Midwives were expected to join NLAG and Jenny Hinchliffe continued to look at options for international recruitment. Lee Bond queried whether the 14 midwives due to start in September would have a period of time before pin numbers were received. Jane Warner confirmed this would be the case but the time would be used for the completion of mandatory training and support. The Trust had also appointed a pastoral support midwife as this had worked well at other Trusts. Lee Bond questioned whether recruitment at one site was more successful than the other. It was confirmed the Grimsby site was usually more successful with recruitment, it was felt this was due to the logistics of the location of the Scunthorpe and due to other opportunities in that area.

Mr Kishore Sasapu referred to the governance related actions and queried whether there was a reason for so many being rated as red. Jane Warner advised this had been due to an honest “where we are now” baseline assessment. It was felt this would change to an amber rating once work commenced.

Ellie Monkhouse wanted to highlight the challenge of the work and recognise it should not be underestimated as it would impact on workforce and the Trust financially. It was beneficial that NLAG continued to have NHS England / Improvement (NHSE/I) scrutiny as this included attendance at the Maternity Transformation Board. Some quality improvement support was being sought to support the work required. Other processes were being reviewed to enable NLAG to sustain two services.

Linda Jackson thanked Jane Warner and the team for the hard work undertaken to date. It was noted that the recruitment of 14 midwives was a positive move forward.

3.4 Complaints Annual Report – NLG(22)122

Ellie Monkhouse advised the improved performance of complaints had been maintained, however, some further improvement could still be made. Linda Jackson noted the significant improvement in the excellent report shared. Stuart Hall referred to the average response time to complainants being 51 days and queried if this was acceptable. Ellie Monkhouse advised this was acceptable as the response time was set at 60 days. It was noted complaint responses were monitored and those that went over 60 days would undergo a root cause analysis (RCA) to review the process.

3.5 Nursing, Midwifery & AHP Strategy Annual Report – NLG(22)123

Ellie Monkhouse shared the report and advised this was a good news story as it highlighted the work undertaken across the organisation during the pandemic.

Gill Ponder noted it was a fantastic report that was well presented.

Linda Jackson agreed and advised the Care Quality Commission (CQC) had previously requested this information be shared.

3.6 Key Issues – Performance – NLG(22)119

Shaun Stacey advised a substantial deep dive had been undertaken at the previous Finance & Performance Committee (F&PC) into elective care. The challenge around the emergency front door continued and evidence to support this had been highlighted. Although there were some improvements with ambulance handover, this remained a challenge and a concern at a nationwide level. The new model of Same Day Emergency Care (SDEC) continued to work well, however, this additional support ceased at 10.00 pm when the unit closed. This then impacted on A&E which continued to be busy until around 2.00 am as shown in the IPR. The additional support required for the winter period would need to be reviewed and would continue to be discussed at F&PC.

Dr Peter Reading explained that during the CQC inspection concerns had been raised around the opening times of SDEC, in view of this it was expected the report may detail the facility hours should be extended. Although there was a hope to put this in place, the funds were currently not available. It was noted that system pressures across the Integrated Care System (ICS) were recognised by the Integrated Care Board (ICB) and the Chief Executive, Stephen Eames was due to attend a meeting the following week which would include various representatives from the region.

Dr Peter Reading advised an external visit was arranged for the 12 August 2022 at the Scunthorpe site and in attendance would be Sir David Sloman, Chief Operating Officer at NHSE/I, this would include a tour of Accident & Emergency. Other invitations would be given to social care and ambulance staff partners across the system. This would provide an opportunity to share positive stories along with concerns in the area on ambulance handover times, discharge and social care.

Stuart Hall referred to the outpatients key risks in respect of patient initiative follow ups which appeared to be an issue on the South and North Bank. A query was raised as to how this could be addressed, as it was not standard practice. Shaun Stacey advised the process for this was well designed, however, this was not always in respect of what Getting it Right First Time (GIRFT) recommended, but what Colleges' recommended. Mr Kishore Sasapu advised some specialties fitted well in respect of this, although not all specialties were able to allow this. Following further discussion Linda Jackson asked if the Quality & Safety Committee (Q&SC) could review whether this mapped across appropriately into relevant areas. Mike Proctor felt there was a need to recognise patients were sometimes experts in personal conditions, in particular long term so this was process was overdue.

ACTION: Mike Proctor / Fiona Osborne

3.7 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(22)124

Fiona Osborne referred to the report. in respect of the Emergency Recovery Fund (ERF) funding the committee asked for the team presenting the item to review a potentially revised plan or to look at how the funding would be applied. Lee Bond referred to the funding and confirmed this would not now be withdrawn for the first two quarters of the year. By month seven it was hoped the projected activity would be achieved. Work continued to ensure the Trust was in a better position for the third quarter.

5. Strategic Objective 3 – To Live Within our Means

5.1 Key Issues - Finance – Month 03 - NLG(22)129

Lee Bond referred to the report and apologised as there were some references to month one in the report, however, the information related to month three. There was to be a further set of financial challenges that would be mandated by the centre in respect of bank and agency spend. Each ICS had been given a target but the individual Trust target had not yet been received, this would be confirmed over coming weeks. One issue would be the re-tender for the Urgent Care service if this was highlighted in the CQC Inspection Report; this would be addressed at that point.

Linda Jackson queried when the re-tender was due, Lee Bond confirmed this would be due shortly. The first contract had been awarded on a pilot basis. Fiona Osborne referred to the new guidance on spend as to whether there had been any response from the Trust preferred suppliers as to whether anything would change. Lee Bond advised not so far.

In respect of electives Mr Kishore Sasapu advised the previous process would have been to discharge emergencies and add the patient to the non-elective waiting list. However, the best practice now in place was to treat the patient whilst admitted as an emergency, although this did not always come in line with the unit price. Lee Bond advised of not being aware of the Trust clinical practices, activity increase on the non-elective side did create further pressures for the operational team in terms of pay. Shaun Stacey wanted to highlight there had not been a change in clinical practice, the process was to now treat the patient at the time rather than return as a routine, but this would create higher costs. Further impacts also included the costs of products increasing.

Dr Peter Reading queried that in a period of high inflation and pay awards how concerned should the Trust be on the impact of this to the organisation. Lee Bond advised there would be increases in external services going forward and the Trust would have to manage this. The pay issue was a concern as it was not felt the Unions would agree to the current one offered. If a higher pay award was offered, there may be further concern.

At this point Michael Whitworth joined the meeting.

5.2 Finance & Performance Committee Highlight Report and Board Challenge – Finance - NLG(22)130

Fiona Osborne referred to the report and drew the boards attention to particular key points identified.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Key Issues – Strategic & Transformation – NLG(22)131

Ivan McConnell referred to the report and drew the boards attention to particular highlights.

Dr Peter Reading noted that from an external point of view going into the consultation, this November had to be top priority for NLAG which could not be put at risk. The Humber Acute Services Review (HASR) was the fifth attempt by NLAG to resolve strategic shortcomings due to clinical geography. The work undertaken by the team had been incredibly thorough and it was essential this was not put at risk. Lee Bond queried what would be the outcome if the Trust were advised there was no capital. Ivan McConnell advised the Trust needed to work closely with the ICS as there would not be capital available for all models.

Ellie Monkhouse queried what the plan was in respect of how long NLAG could sustain what was being delivered in line with the management of finance, capital and issues with the estate. Ivan McConnell explained the only option would be a temporary service change, however, this would need to be consulted on as it would be substantive. Mr Kishore Sasapu wanted to note consultants would be engaged in the process but on the understanding that there would be some financial support for this to be put in place. There was concern that some services would be lost in the process particularly for the South Bank in elective services. Dr Peter Reading advised that as the move went into the consultation process for Urgent & Emergency Care, Maternity and Paediatrics work completed had allowed for some understanding on a range of options that would be available. In respect of elective care, there were options available. It had been noted at a recent Joint Board meeting with HUTH, that it was crucial that there was a balance between the North and South Bank on services to be available, with this also recognised at ICS level.

6.2 Health Tree Foundation Trustees' Committee (HTFTC) Highlight Report & Board Challenge – July 2022 – NLG(22)132

Neil Gammon referred to the report and highlighted key points. It was noted any board members that identified an opportunity to apply for funding to the Health Tree Foundation should put this forward for consideration. The Charity Manager would highlight this to the Senior Leadership group this week as an increase in investment spending was requirement.

6.3 Executive Report – Digital Strategy – NLG(22)133

Chris Evans referred to the report and highlighted key points.

Lee Bond wanted to highlight that one of the options to subsidise the staff pay rise would be to use funds from the digital budget which could impact on some of the deadlines being delayed for digital. This would in turn impact on the organisation in the long term.

Dr Peter Reading noted there were issues around whether NLAG joined up digital systems with HUTH or whether this was undertaken on an ICS basis, further discussions would take place in respect of this.

Fiona Osborne wanted to recognise the amount of work undertaken in the previous year and the huge progress that had been made. If budgets were to be reviewed in respect of the pay rise it would need to be recognised that the Trust should ensure this did not affect quality and change management needed to be seen as important. Mr Kishore Sasapu raised an issue in respect of access to some systems and images not being available, although HUTH clinicians were able to see WebV. A query was raised as to whether this would be resolved. Chris Evans advised work had been completed around this to ensure the access issue was resolved.

Ellie Monkhouse was concerned about the digital funding being used to support the financial budget as part of the digital transformation linked into patient safety enhancements. It was felt other ways should be reviewed to fund such issues. Dr Peter Reading noted the points raised by Ellie Monkhouse and Fiona Osborne but the decisions being made would be at Secretary of State level and would not be a Trust decision. It was agreed there would need to be transparency in respect of what the impact would be on some of the schemesas some schemes may be reprioritised. It was agreed Chris Evans would discuss this with Shauna McMahon to ensure awareness.

8. Governance

8.1 Audit, Risk & Governance Committee (AR&GC) Highlight Report & Board Challenge – June 2022 - NLG(22)134

Gill Ponder referred to the report and highlighted key themes.

8.2 Board Assurance Framework (BAF) – Quarter 1 - NLG(22)135

Helen Harris advised the BAF had been reviewed by Executive owners and each of the sub-committees had reviewed actions and risk ratings. It was noted two queries had been raised at a recent Audit, Risk and Governance Committee (AR&GC) meeting in respect of Strategic Objective Three. Lee Bond and Ivan McConnell had been asked to advise on the current risk ratings. Lee Bond advised this had not been updated for the new financial year and felt this should be improved. Ivan McConnell agreed there had been some uncertainty in respect of capital and this had been reflected in the rating so would be reviewed. Helen Harris wanted to highlight recommendations from the recent internal audit report would be addressed over the next quarter and be included in the next board report.

8.3 Trust Management Board (TMB) Terms of Reference – NLG(22)138

Linda Jackson advised the item was for noting as it had been approved via Chair's actions by Sean Lyons.

9. Approval (Other)

9.1 Fire Annual Report – NLG(22)136

Bill Parkinson referred to highlights within the report. One point in particular related to the Scunthorpe General Hospital (SGH) Fire Alarm system as there had been an increase in system faults after the completion of this report. The risk rating was currently at 20, this was being reviewed with the possibility of this increasing to 25.

Dr Peter Reading thanked Bill Parkinson for work undertaken in respect of recent false alarms. There was an awareness of the growing urgency to replace the system. It was noted there had been a significant drop in false alarms at the Grimsby site following the installation of the new system.

At this point Sean Lyons joined the meeting.

The Fire Annual Report was approved.

Post Meeting Note - The Trust Board virtually approved the Fire Alarm System upgrade for Scunthorpe General Hospital in September 2022 a paper to note this would be shared at the October 2022 Trust Board meeting.

Sean Lyons took over as Chair of the meeting at this point.

9.2 LSMS Annual Report & Workplan and Security Annual Report – NLG(22)137

Bill Parkinson wanted to note there had been a rise in incidents and aggressive behaviour due to the increase in patients during the pandemic. Due to a good working relationship with the local police this had been supported. The Closed Circuit Television (CCTV) system had been updated which had identified individuals who had undertaken criminal offences on site.

Shaun Stacey highlighted the guidance around handling patients had changed and would mean a more clinical approach. Work was being undertaken on how to address this to ensure it met national guidance. This would need to be referenced in a future report.

The LSMS Annual Report & Workplan and Security Annual Report was approved.

2.2 To approve the minutes of the Public Meeting held on Tuesday, 7 June 2022 – NLG(22)115

The minutes of the meeting held on the 7 June 2022 were accepted as a true and accurate record and would be duly signed by the Chair.

2.3 To approve the minutes of the Trust Board Self-Certification Event held on Monday, 30 May 2022 – NLG(22)116

The minutes of the meeting held on the 30 May 2022 were accepted as a true and accurate record and would be duly signed by the Chair.

At this point Ade Beddow joined the meeting.

2.5 Trust Board Action Log – Public by exception NLG(22)117

Sean Lyons invited Board members to raise any further updates by exception in relation to the Trust Board Action Log.

Following discussion a number of actions were updated and closed on the action log.

In respect of item 3.6 discussion took place and it was agreed the standard report would include detail to show how many patients had been in the department for more than 12 hours without a decision to admit or discharge. The F&PC would also undertake a deep dive at bi-monthly meetings into urgent and emergency care on a rotational basis, this would then be shared with the board. As Chair of the F&PC Gill Ponder agreed with this action.

In respect of item 4.1 it was agreed an update would be provide outside of the meeting.

In respect of item 10 it was agreed an update on this would be sought outside of the meeting from Christine Brereton.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Key Issues - Workforce – NLG(22)119

This item was noted due to the apologies of Christine Brereton being delayed due to the road traffic accident.

4.2 Workforce Committee Highlight Report and Board Challenge – NLG(22)125

Michael Whitworth thanked Fiona Osborne for chairing the meeting and referred to the report highlighting key points.

4.3 Workforce Race Equality Standards Annual Report (WRES) – NLG(22)127
4.4 Workforce Disability Equality Standard Annual Report (WDES) – NLG(22)128

Dr Peter Reading provided an update on both reports in Christine Brereton's absence. It was noted both reports had been shared at the Workforce Committee and Trust Management Board (TMB). There were some areas of improvements in both reports along with some deterioration. Some networks had been put in place and leaders were to be identified to ensure improvements were made in driving this forward. Christine Brereton had commissioned Nico Batinica, Associate Director of Workforce Systems and Recruitment and David Sprawka, Head of

Recruitment & Employment Services, to undertake a review of process recruitment.

The Workforce Race Equality Standards Annual Report (WRES) and Workforce Disability Equality Standard Annual Report were approved.

7. Strategic Objective 5 – To Provide Good Leadership.

7.1 There were no items to discuss under this section.

10. Items for Information

The following items were shared at the June 2022 meeting:

- F&PC Minutes – April and May 2022
- Q&SC Minutes – May and June 2022
- National Inpatient Survey
- Workforce Committee Minutes – May 2022
- Medical Appraisal & Revalidation Annual Report (AOA)
- Freedom to Speak up Guardian Quarter 1 Report
- Guardian of Safe Working Hours Quarter 1 Report
- AR&GC Minutes – April 2022
- Audit Committee Annual Report 2021/22
- HTFTC Minutes – May 2022
- Communication Round-Up
- Documents Signed Under Seal

11. Any Other Urgent Business

There were no items of any other business raised.

Sean Lyons wanted to note the efforts of staff and pass on formal thanks in respect of the recent CQC inspection as this had been outstanding. The contributions had helped to display the Trust were in a good place. It was hoped the report would be received in draft form in September.

As this was to be the last meeting Mike Proctor and Michael Whitworth would attend due to leaving the Trust, Sean Lyons formally thanked both NEDs. Both had made a considerable contribution to Trust business and this was gratefully received. Fiona Osborne would be taking over from Mike Proctor in September and a recruitment process was underway for Michael Whitworth's replacement.

12. Questions from the Public

Sean Lyons asked for questions from the public. No questions were received.

13. Date and Time of the next meeting

Formal Trust Board Meeting

Tuesday 4 October 2022, Time: 9.00 am

The Private Trust Board meeting was due to follow at 13:15 hours.

Board Development

Tuesday, 1 November 2022, Time: 9.00 am

Sean Lyons closed the meeting at 12:51 hours.

Cumulative Record of Board Director's Attendance (2022/23

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

NLG(22)164

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2022/2023

Kindness · Courage · Respect

ACTION LOG & TRACKER

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Board Public Meeting
2022/23

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
2.7	07.06.2022	CEO Briefing		Update to be provided on how collaboratives would fit within NLAGs Assurance Frameworks.	Sean Lyons & Dr Peter Reading	04.10.2022	Update to be provided at the October Trust Board meeting.			
3.2	07.06.2022	Quality & Safety Committee Highlight Report & Board Challenge		Update to be provided from the Q&SC regarding board visits.	Mike Proctor, Dr Kate Wood, Ellie Monkhouse	02.08.2022	Update to be provided at the August Trust Board meeting. It was agreed this item was to be discussed at the August Q&SC meeting, a further update would then be provided to the board.			
4.1	07.06.2022	Key Issues - Workforce		Christine Brereton to look at opportunites with Universities in terms of recruiting family members of overseas students. Joint discussion to take place with Simon Nearney.	Christine Brereton	02.08.2022	Update to be provided at the August Trust Board meeting. **Post Meeting Note** - Christine Brereton advised this issue had been referred to the Humber Workforce Group.			
10	07.06.2022	Items for Information		Christine Brereton to advise of factual accuracies in specific ARG Minutes	Christine Brereton	04.10.2022	Update to be provided at the October Trust Board meeting.			
3.6	02.08.2022	Key Issues - Performance		Quality & Safety Committee to review what areas patient initiative follow ups mapped	Quality & Safety Committee	04.10.2022	Update to be provided at the October Trust Board meeting.			

Key:

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

Trust Board Public Meeting

2022/23

Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
2.5	07/12/2021	Mortuary & Board Store Assurance - Trust Board response to NHS England / Improvement		It was agreed the Audit, Risk & Governance Committee would be responsibility for the oversight of actions being undertaken.	Simon Parkes	Feb-22	An update was to be provided at the February 2022 meeting. It was confirmed at the February 2022 meeting this would be added to the AR&GC workplan.		AR&GC workplan	
3.5	07/12/2021	Executive Report - Performance		It was agreed more focus would be included within the report going forward to highlight actions for specific areas.	Shaun Stacey	Feb-22	An updated report would be provided at the February 2022 meeting. An updated report was shared at the February 2022 meeting.		Minutes - February 2022 Board Meeting	
4.1	07/12/2021	Executive Report - Workforce		Update to be provided on the current position in respect of mandatory Covid vaccines for staff within the Executive Report - Workforce.	Christine Brereton	Feb-22	An update was to be provided at the February 2022 meeting. An update was provided at the February 2022 meeting.		Minutes - February 2022 Board Meeting	
8.2	07/12/2021	Board Assurance Framework (BAF)		A meeting to review the requirement of sub-categories within Strategic Objective 2 was to be held.	Helen Harris / Ellie Monkhouse / Christine Brereton	Feb-22	An update was to be provided at the February 2022 meeting. Item closed, update provided at April 2022 meeting.			
3.2	01/02/2022	Quality & Safety Committee Highlight Report & NED Challenge		Update to be provided on Governor Engagement in respect of the Quality Priorities approval process.	Helen Harris / Dr Kate Wood / Mike Proctor	Apr-22	An update was to be provided at the April 2022 meeting. Item closed, update provided at April 2022 meeting.			
3.5	07.06.2022	Volunteer Strategy		Volunteer Strategy to be updated following proof reading	Ellie Monkhouse	02.08.2022	Update to be provided at the August Trust Board meeting. Amendments had been made to the report.			
3.6	07.06.2022	Key Issues - Performance		Update to be provided on whether the IPR could include exact timings patients had waited over a 12 hr breach.	Shauna McMahon	02.08.2022	Update to be provided at the August Trust Board meeting. At decision was made as to what would be included in the report going forward along with a deep dive at the F&PC meeting.			
3.7	07.06.2022	Finance & Performance Committee Highlight Report & Board Challenge		Deep Dive on ventilation and air conditioning to be shared with Ellie Monkhouse.	Gill Ponder	02.08.2022	Update to be provided at the August Trust Board meeting. This action could be closed as the report had been shared.			
6.2	07.06.2022	HTFTC Highlight Report & Board Challenge		Communication to be sent to staff on the process for accessing Health Tree funds.	Ade Beddow	02.08.2022	Update to be provided at the August Trust Board meeting. The Charity Manager was attending meetings to update colleagues on the progress. An update was also to be provided at the SLC on the current process.			
8.1	07.06.2022	ARG Highlight Report & Board Challenge		BAF Session to be added to the Trust Board Development Session timetable	Dr Peter Reading / Helen Harris	02.08.2022	Update to be provided at the August Trust Board meeting. It was advised the board development programme was being updated to reflect accommodating this session.			

Key:

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

NLG(22)165

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

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

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
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1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

1. Service Pressures and Staff Resilience

In common with the whole of the UK, NLaG's hospital and community services continue to operate under extraordinarily high pressure. Board members are asked to note the equally extraordinary fortitude and resilience of our staff in continuing to provide our full suite of services at the highest possible standards in spite of these circumstances.

2. CQC Report

It had been expected that the Trust would by now have received the draft report of the CQC inspection conducted in June and July, for the Trust to review with respect to factual accuracy. However, due to circumstances beyond the CQC's control, the issuing of the draft report to us has been delayed by a month, we now expect the final report to be published in November or December 2022.

3. National Inpatient Survey – 2021

The most recent National Inpatient Survey conducted by the CQC in November 2021, shows the Trust to be the most improved (compared to the previous year's survey) among the 73 trusts used as comparators to NLaG.

4. Opening of New Emergency Department at DPOW

The £17.9 million new Emergency Department at DPOW is scheduled to receive its first patients on Wednesday, 6 October. The new building, covering twice the area of the current department , genuinely deserves the epithet 'state of the art', and our ED staff at DPOW are very excited about moving in.

The Trust is very grateful to the Health Tree Foundation, and all those who have supported its ED appeal, and to the DPOW League of Friends, for their generous support in making the patient environment, and particularly the children's environment, as comfortable and welcoming as possible.

5. Humber Acute Services Review – Public Consultation

After careful consideration of a variety of issues and on the advice of NLaG and HUTH (Hull University Teaching Hospitals), the Humber and North Yorkshire Integrated Care Board (HNY ICB) has decided not to launch formal public consultation on the Humber Acute Services Review (HASR) in November 2022, as originally proposed, but instead to delay it until after next year's Council elections, ie probably until June 2023.

6. Staff Pay Award and Possible Industrial Action

All staff (except Executive Directors, for whom national guidance has only just been received) received their cost of living pay award for 2022-23 (including back pay) in their September pay.

7. Capital award for theatre upgrades

NLaG has had formal confirmation that it has been awarded £6.3 million national elective recovery capital to upgrade three operating theatres (Theatres 7 and 8 at DPOW, and Theatre A at SGH) to the highest modern standards (including laminar air flow).

8. Health Service Journal Awards – finalists

With local partners, the Trust has reached the finals of two Health Service Journal (HSJ) Awards – for the vaccination hub in Scunthorpe and for improvements in patient discharge arrangements. The awards ceremonies are next month.

9. Nursing, Midwifery and Allied Health Professionals Conference

The Trust held an extremely successful Nursing, Midwifery and Allied Health Professionals Conference in Scunthorpe on 28 September, with 250 attendees including guests from local partners and the NHS England Regional team.

Peter Reading
Chief Executive

NLG(22) 166

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 4th October 2022
Director Lead	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Medical Director Christine Brereton, Director of People
Contact Officer/Author	Shauna McMahon, Chief Information Officer
Title of the Report	**Integrated Performance Report (IPR)**
Purpose of the Report and Executive Summary (to include recommendations)	**1. Introduction** The IPR aims to provide the Board with a detailed assessment of the performance against the agreed indicators and measures and describes the specific actions that are under way to deliver the required standards. **2. Access and Flow** The executive summary of the Access and Flow section is provided over on page 4. **3. Quality and Safety** The executive summary of the Quality and Safety section is provided over on page 5and 6. **4. Workforce** The executive summary of the Workforce section is provided over on page 7. **5. Appendix** a) Appendix A National Benchmarked Centiles b) Appendix B Extended Scorecards as presented to each respective Sub-Committee **6. The Trust Board is requested to:** a) Receive the IPR for assurance. b) Note the performance against the agreed indicators and measures. c) Note the report describes the specific actions which are underway to deliver the required standards.
Background Information and/or Supporting Document(s) (if applicable)	Access and Flow – IPR (August Data) Quality and Safety – IPR (July / August Data) Workforce – IPR (July / August Data)
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ☐ Other: Click here to enter text.

Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable

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Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Improving quality care and access.	
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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ACCESS & FLOW – Shaun Stacey		
Highlights: (share 3 positive areas of progress/achievement) • Percentage of patients discharged same day as admission (excluding daycase) • Inpatient Elective average length of stay • Inpatient Non-Elective average length of stay Lowlights: (share 3 areas of challenge/struggle) • Diagnostic Procedures Waiting Times – 6 week breach rate (DM01) • Outpatient Overdue Follow Up (Non RTT) • Ambulance Handover Delays 60+ Minutes		
Key Issue to Address this period:	**What improvement Action was implemented?**	**Expected Outcome & What opportunities can we leverage?**
Diagnostic Procedures Waiting Times – 6 week breach rate (DM01)	Plan for delivery of mobile CT/MRI vans	Mobile CT/MRI vans will increase capacity of available diagnostic tests
Outpatient Overdue Follow Up (Non RTT)	Information reports in development to identify patients who persistently DNA/Cancel their appointment	Applying the NLaG access policy to patients with multiple DNA's should see the Outpatient waiting list decrease
Ambulance Handover Delays 60+ Minutes	Work continues on the new build for both sites to increase footprint (DPoWH due to open in October 2022)	New ED at DPoW with larger footprint should aid the ambulance handovers and reduce the number of delays

IPR EXECUTIVE SUMMARY **Date: September 2022**

QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

Highlights: (share 6 positive areas of progress/achievement)

- VTE Assessments meeting target and divisions monitoring their delivery of this
- The Trusts' rolling 12-month SHMI (March 2022) continues to improve with the lowest on record for the Trust at 103
- Bacteraemia cases are stable and as expected. Clostridium difficile cases are stable, the case threshold will be challenging to achieve.
- There number of pressure ulcer incidents reported in July 2022 has decreased with a significant decrease reported by the Surgical division.

Lowlights: (share 6 areas of challenge/struggle)

- The Trust's rolling 12 month out of hospital SHMI remains high and exceeded the upper process limit in April 2022 at 137.8 compared to the Trust's target 110.
- Screening for Sepsis (using the formal tool), and the completion of the Sepsis Six pathway (where a red flag is triggered) continues to have low compliance rates for both adults and children.
- The number of patients admitted to IAAU with an actual weight recorded on EPMA or WEB V continues to be low compliance overall, although 18% were recorded in July compared to only 7.5% in June.
- There is no detail around the reduction in complaint response rates
- There has been a decrease in timescale of compliant responses with all divisions being aware and mitigating steps are in place.
- The number of mix sex breeches has increased in July- this was reviewed by S&CC and was due to lack of capacity in step down beds.
- The total number of falls reported in July has increased. The low fill rate, heatwave and high activity across the sites may have been potential contributing factors.

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?

Out of Hospital SHMI Sepsis Screening Measuring patient weights	NE Lincs Place have presented findings from review by NHSE – actions to be developed and monitored via MIG New screening tool to be launched Highlighted via divisions Reminder alert placed on EPMA	Expected further work on early identification of end of life and work to ensure comorbidities accurately recorded on out of hospital deaths Improvement in compliance as new tool better fits with clinical judgement Continue to work to identify barriers to measuring and recording weight

1. WORKFORCE – Christine Brereton

Highlights:

- The Core Mandatory Training position overall currently stands at 91%, Compliance continues to be above the Trust target of 90%
- 113 unregisters nurses

Lowlights:

- Hotspot areas of low compliance for Statutory /Mandatory training in medical workforce
- Turnover continues to be above target. The latest turnover data point 12.3%
- Unregistered Nursing vacancy positions continues to increase to 18.5% against a target of 8% (the sharp increase in the vacancy factor is due to the increased establishment from April 22)

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?

Unregistered Nursing Vacancies The key issue to address is the spike in Unregistered vacancies. A number of recruitment events for unregistered nursing are scheduled for September 2022, with an aim to recruit circa 120 new HCA staff, to date there has been 73 recruited with two further recruitment events scheduled to take place by the end of December. **Role Specific Training –** Accommodation and capacity of resource to deliver role specific training will be addressed through a paper to TMB with options for the two predominate concerns of resuscitation and moving and handling training. Additional concern release of staff to undertake the training due to current operational pressures. **Sickness Absence** – the key issue to be addressed within this period is to support the reduction of Sickness Absence and improve managers understanding and capability in relation to the sickness absence policy and process.	**Unregistered Nursing Vacancies** Recruitment Plans have been created detailing forecasts and have been circulated to operational groups and will be monitored through divisional PRIMS and Workforce Committee **Role Specific Training –** Paper with full risks and proposals scheduled to go to TMB. **Sickness Absence** - Relaunched the sickness absence line manager training with the launch of the new sickness absence policy. HR team supporting managers to produce sickness audits to ensure the policy is being applied correctly. Exploring options for modifying training.	**Unregistered Nursing Vacancy -** An improved vacancy position is anticipated to reduce turnover rates and support staff retention alongside Nursing career frameworks and introduction of nursing apprenticeships will see reliance on international nurse sourcing reduce longer term. **Role Specific Training –** Estate will be available/collaborate with HUTH on shared facilities and training resource. This will lead to greater classroom size and trainer resource. Increase access to training for operational staff. **Sickness Absence** - The expected outcome from the relaunch of the sickness absence line manger training ensuring managers, have the ability to manage sickness absence at the earliest opportunity. The expected outcome of this is to reduce short sickness periods and long term sickness absence processes.

Process limits will be affected when there has been or proc the data, for exam pact.

Image Key

This might be shown as:-

- The data points are consistently on one side of the mean.
- A statistically significant change in the data triggers consistent special cause variation on the same side of the mean.

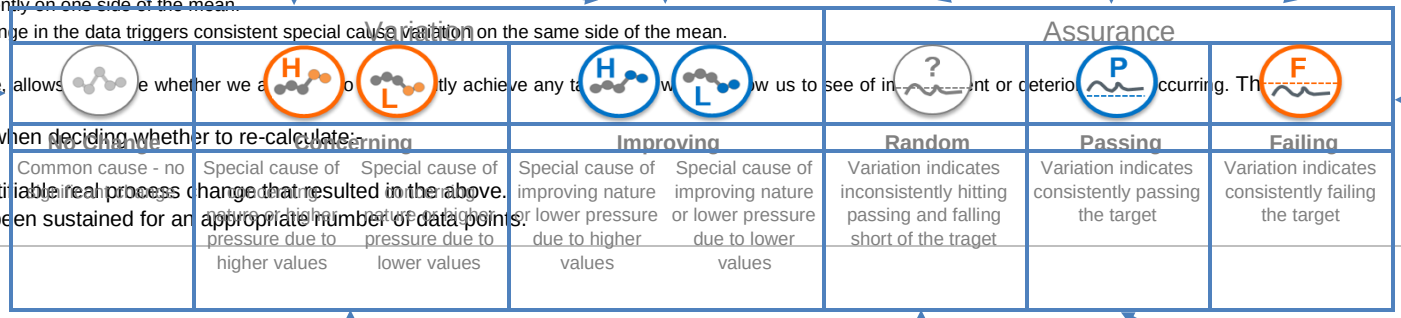
Are we Improving, declining or staying the same

Blue = significant improvement or low pressure

Can we reliably hit target

Grey = no signifcant change

Orange = change required to hit target



apply when deciding whether to re-calculate:-

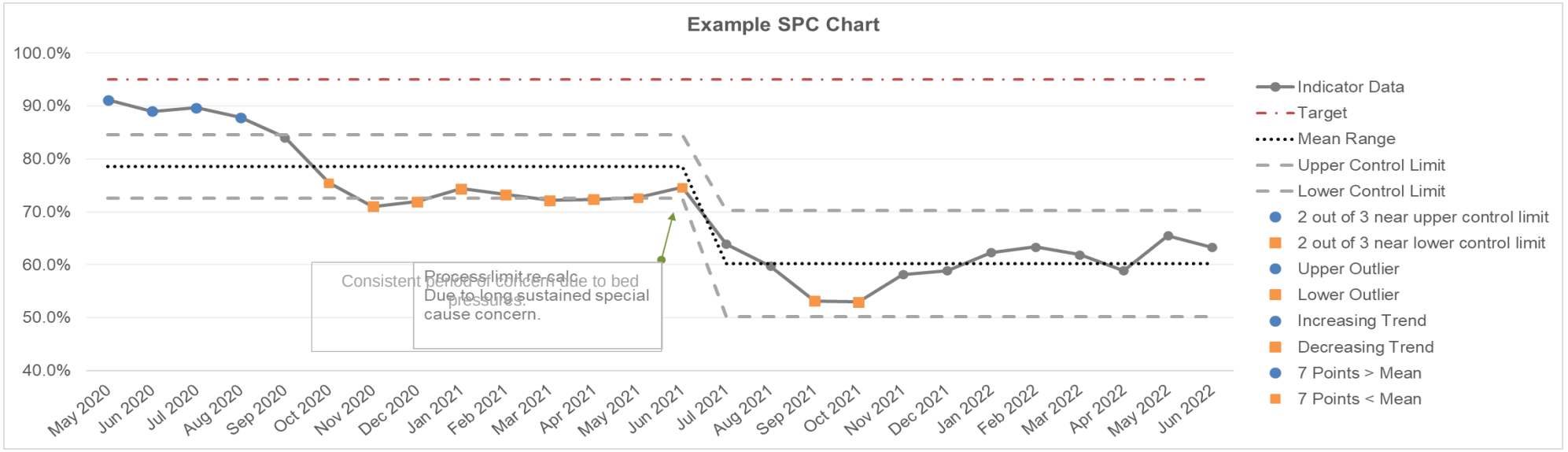
- There should be an identifiable real process change that resulted in the above.
- The change must have been sustained for an appropriate number of data points.

Orange = significant concern or high pressure

Hit and miss target

Blue = will reliably hit target

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



Orange Squares = significant concern or high pressure | Blue Circles = significant improvement or low pressure | Green Arrow = Process Limits Re-calculation point

Notes on Process Limits Re-Calculation

Radar

Note: Only indicators with a target are relevant for this page as it is based on the target assurance element of the indicator.
* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR

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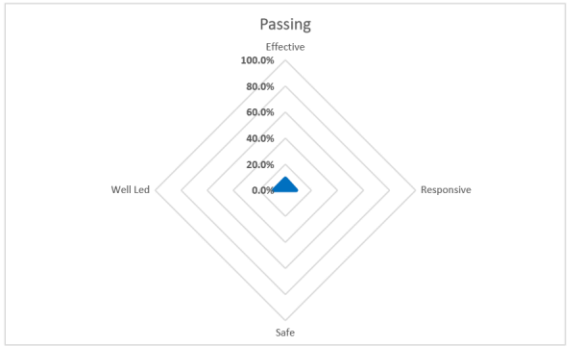
Consistently Passing

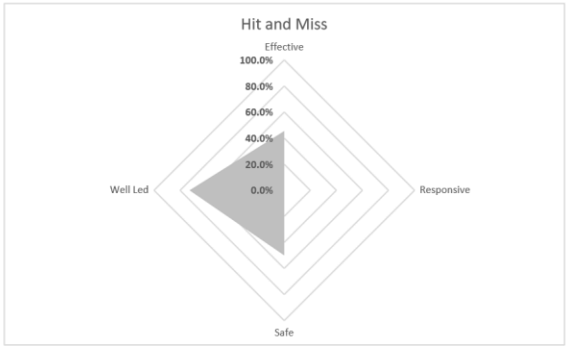
Total: 3



% Outpatient Non Face To Face Attendances
Core Mandatory Training Compliance Rate
Total Inpatient Waiting List Size

Hit and Miss

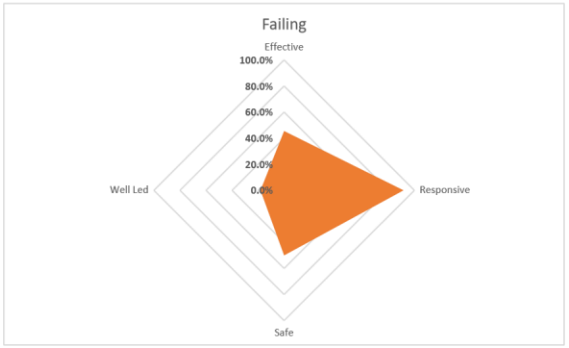
Total: 14



% Discharge Letters Completed Within 24 Hours of Discharge
Bed Occupancy Rate (G&A)
Duty of Candour Rate
Medical Staff PADR Rate
PADR Rate
Role Specific Mandatory Training Compliance Rate
Turnover Rate
% of Extended Stay Patients 21+ days
Inpatient Elective Average Length Of Stay
Inpatient Non Elective Average Length Of Stay
Unregistered Nurse Vacancy Rate
Registered Nurse Vacancy Rate
Medical Vacancy Rate
Trustwide Vacancy Rate

Consistently Failing

Total: 19



% Inpatient Discharges Before 12:00 (Golden Discharges)
% Patients Discharged On The Same Day As Admission (excluding daycase)
Ambulance Handover Delays - Number 60+ Minutes
Cancer Request To Test In 14 Days*
Cancer Waiting Times - 104+ Days Backlog*
Cancer Waiting Times - 62 Day GP Referral*
Combined AfC and Medical Staff PADR Rate
Emergency Department Waiting Times (% 4 Hour Performance)
Number of Incomplete RTT pathways 52 weeks*
Number of Overdue Follow Up Appointments (Non RTT)
Outpatient Did Not Attend (DNA) Rate
Percentage Under 18 Weeks Incomplete RTT Pathways*
Venous Thromboembolism (VTE) Risk Assessment Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
Complaints Responded to on time
Sickness Rate
Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission
Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*
Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge

			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement	H		% Discharge Letters Completed Within 24 Hours of Discharge Inpatient Non Elective Average Length Of Stay Duty of Candour Rate Medical Staff PADR Rate	% Patients Discharged On The Same Day As Admission (excluding daycase) Outpatient Did Not Attend (DNA) Rate Complaints Responded to on time Number of Incomplete RTT pathways 52 weeks* Venous Thromboembolism (VTE) Risk Assessment Rate
		L			
	Common Cause		Core Mandatory Training Compliance Rate	Bed Occupancy Rate (G&A) Inpatient Elective Average Length Of Stay Medical Vacancy Rate	% Inpatient Discharges Before 12:00 (Golden Discharges) Ambulance Handover Delays - Number 60+ Minutes Cancer Request To Test In 14 Days* Cancer Waiting Times - 104+ Days Backlog* Emergency Department Waiting Times (% 4 Hour Performance) Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)* Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38* Sickness Rate
	Special Cause Concern	H	% Outpatient Non Face To Face Attendances Total Inpatient Waiting List Size	% of Extended Stay Patients 21+ days Turnover Rate PADR Rate Role Specific Mandatory Training Compliance Rate Unregistered Nurse Vacancy Rate Registered Nurse Vacancy Rate Trustwide Vacancy Rate	Number of Overdue Follow Up Appointments (Non RTT) Cancer Waiting Times - 62 Day GP Referral* Percentage Under 18 Weeks Incomplete RTT Pathways* Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge Combined AfC and Medical Staff PADR Rate
		L			

Scorecard - Access and Flow

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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Planned	% Under 18 Weeks Incomplete RTT Pathways*	Aug 2022	66.2%	92.0%	Alert	L	F
	Number of Incomplete RTT pathways 52 weeks*	Aug 2022	364	0	Alert	L	F
	Total Inpatient Waiting List Size	Aug 2022	10,673	11,563	Alert	H	P
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Aug 2022	32.8%	1.0%	Alert		F
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Aug 2022	33,762	9,000	Alert	H	F
	Outpatient Did Not Attend (DNA) Rate	Aug 2022	7.1%	5.00%	Alert	L	F
	% Outpatient Non Face To Face Attendances	Aug 2022	26.6%	25.00%	Highlight	L	P
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Aug 2022	39.6%	85.0%	Alert	L	F
	Cancer Waiting Times - 104+ Days Backlog*	Aug 2022	40	0	Alert		F
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Aug 2022	12.5%	75.0%	Alert		F
	Cancer - Request To Test In 14 Days*	Aug 2022	82.8%	100.0%	Alert		F
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Aug 2022	59.1%	95.0%	Alert		F
	Number Of Emergency Department Attendances	Aug 2022	12,347	No Target	Alert	H	n/a
	Ambulance Handover Delays - Number 60+ Minutes	Aug 2022	738	0	Alert		F
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Aug 2022	563	0	Alert	H	F
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Aug 2022	390	0	Alert	H	F
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Aug 2022	40.3%	40.0%	Alert	H	F
	% of Extended Stay Patients 21+ days	Aug 2022	13.2%	12.0%	Alert	H	?
	Inpatient Elective Average Length Of Stay	Aug 2022	2.2	2.5			?
	Inpatient Non Elective Average Length Of Stay	Aug 2022	3.9	3.9		L	?
	Number of Medical Patients Occupying Non-Medical Wards	Aug 2022	183	No Target			n/a
	% Discharge Letters Completed Within 24 Hours of Discharge	Aug 2022	89.9%	90.0%		H	?
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Aug 2022	16.5%	30.0%	Alert		F
	Bed Occupancy Rate (G&A)	Aug 2022	93.2%	92.0%			?
COVID	Number of COVID patients in ICU beds (Weekly)	Aug 2022	0	No Target		L	n/a
	Number of COVID patients in other beds (Weekly)	Aug 2022	15	No Target		L	n/a

	% COVID staff absences (Weekly)	Aug 2022	7.9%	No Target		L	n/a

Scorecard - Quality and Safety

Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable) *The figures for July 2022 are unvalidated

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Jul 2022	0.00	see analysis			n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Jul 2022	0.30	see analysis			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Jul 2022	0.10	see analysis			n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Jul 2022	0.05	see analysis			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Jul 2022	0.55	see analysis			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Jun 2022	102.9	As expected			As expected
	Summary Hospital level Mortality Indicator (SHMI)	Mar 2022	102.7	As expected		L	As expected
Safe Care	Patient Safety Alerts actioned by specified deadlines	Jul 2022	100%	100%			n/a
	Number of Serious Incidents raised in month	Jun 2022	7	No target			n/a
	Occurrence of 'Never Events' *(Number)*	Jun 2022	0	0		n/a	n/a
	Duty of Candour Rate	Jun 2022	100%	100%		H	?
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Jul 2022	6.2	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Jul 2022	3.1	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Jul 2022	95.8%	95.0%	**Alert**	H	F
	Care Hours Per Patient Day (CHPPD)	Jul 2022	7.9	No target	**Alert**	L	n/a
	Mixed Sex Accommodation Breaches	Jul 2022	22	0		n/a	n/a
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	May 2022	8.0	No target			n/a
	Complaints Responded to on time	May 2022	77.0%	85.0%	**Highlight**	H	F
	Friends and Family Test (FFT)						
	Number of Positive Inpatient Scores	Jul 2022	736 out of 788	No target		n/a	n/a
	Number of Positive A&E Scores*	Jul 2022	207 out of 347	No target		n/a	n/a
	Number of Positive Community Scores	Jul 2022	77 out of 85	No target		n/a	n/a
	Number of Positive Outpatient Scores	Jul 2022	47 out of 54	No target		n/a	n/a

	Number of Positive Maternity Antenatal Scores	Jul 2022	28 out of 32	No target		n/a	n/a
	Number of Positive Maternity Birth Scores	Jul 2022	120 out of 124	No target		n/a	n/a
	Number of Positive Maternity Post-Natal Scores	Jul 2022	2 out of 2	No target		n/a	n/a
	Number of Positive Maternity Ward Scores	Jul 2022	46 out of 54	No target		n/a	n/a

Scorecard - Workforce

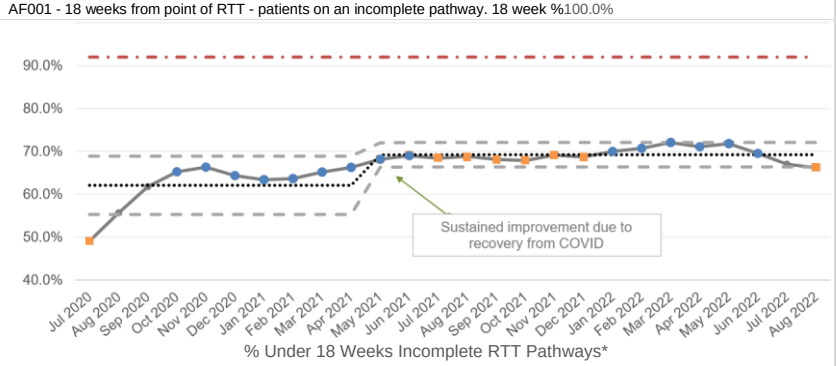
Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first *Indicators marked with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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate	Jul 2022	18.5%	8.0%	**Alert**	H	?
	Registered Nurse Vacancy Rate	Jul 2022	14.6%	8.0%	**Alert**	H	?
	Medical Vacancy Rate	Jul 2022	16.1%	15.0%			?
	Trustwide Vacancy Rate	Jul 2022	13.0%	8.0%	**Alert**	H	?
Staffing Levels	Turnover Rate	Aug 2022	12.4%	10.0%	**Alert**	H	?
	Sickness Rate	Jul 2022	6.6%	4.1%	**Alert**		F
Staff Development	PADR Rate	Aug 2022	79.0%	85.0%	**Alert**	L	?
	Medical Staff PADR Rate	Aug 2022	84.0%	85.0%		H	?
	Combined AfC and Medical Staff PADR Rate	Aug 2022	79.4%	85.0%	**Alert**	L	F
	Core Mandatory Training Compliance Rate	Aug 2022	91.0%	90.0%			P
	Role Specific Mandatory Training Compliance Rate	Aug 2022	77.0%	80.0%	**Alert**	L	?

Access and Flow - Planned

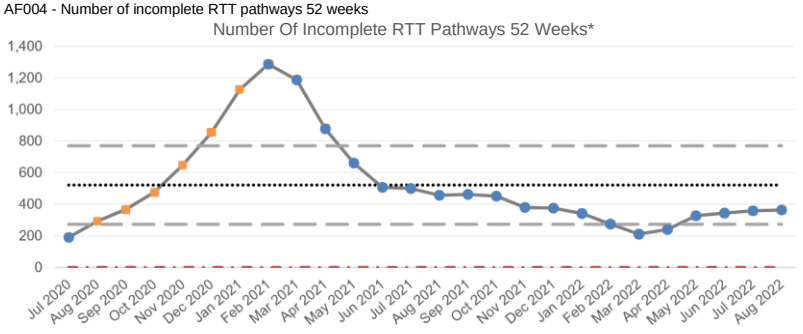
* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR

AF001 - 18 weeks from point of RTT - patients on an incomplete pathway. 18 week %100.0%



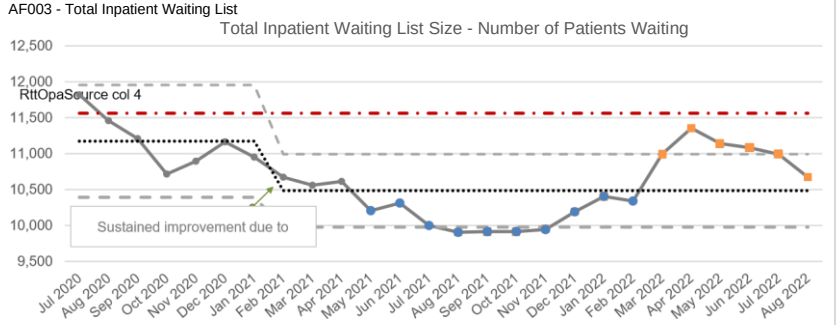
Aug 2022
66.2%
Target **92.0%**
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Consistently falling short of the target

AF004 - Number of incomplete RTT pathways 52 weeks



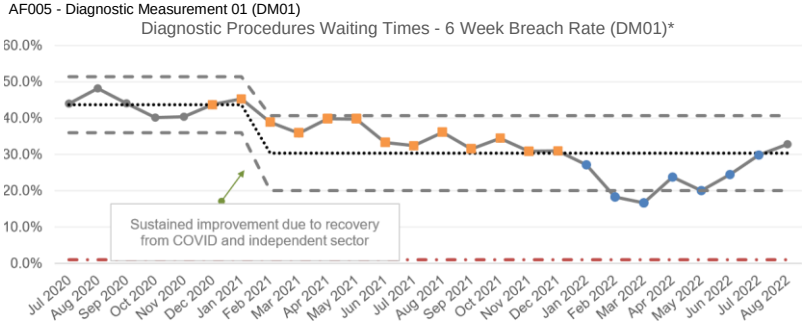
Aug 2022
364
Target **0**
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently falling short of the target

AF003 - Total Inpatient Waiting List



Aug 2022
10,673
Target **11,563**
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently passing the target

AF005 - Diagnostic Measurement 01 (DM01)



Aug 2022
32.8%
Target **1.0%**
Variance
Common cause - no significant change
Assurance
Consistently falling short of the target

Data Analysis:

Under 18 weeks incomplete*: Although recent data has been largely stable the most recent datapoint fell outside the process limits. This is not yet a trend and may recover next month. Current data indicates that the target will not be met without action, planned actions outlined below.

Incomplete 52 weeks*: The number of 52 week waits has decreased over the past 18 months, and shows improvement following the spike in 2020. Current data indicates that the target will not be met without action, planned actions outlined below.

Inpatient waiting list: Note: Process limit re-calculation from Feb 21. The number of patients on the waiting list over the past 6 months has increased and is now showing special casue concern. The indicator can reliably be expected to meet the target.

Diagnostics 6 Week Wait (DM01)*: Note: Process limit re-calculation from Feb 21. The increase seen over this summer is not yet statistically significant. The data remains within the expected values. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

- Acceptance of Mutual Aid - 52+ week wait
- Theatre capacity affected by short notice sickness, issues with theatre estates and an influx of acute activity causing elective activity to be converted.
- Increased 52 week waits
- Consultant workforce vacancies in Cardiology, Gstroenterology & Dermatology.
- Echo DM01 waiting times have increased - insufficient capacity in core - secured IS provider
- Ongoing performance management of the IS Provider contracts
- Gynaecology Nursing capacity to support delivery of planned care due to reduced staffing numbers across the service
- Breast Consultant and Middle Grade capacity due to substantive vacancies
- Increased medical staff sickness in August 2022 due to COVID-19
- Ongoing downtime in DPOW CT due to roof leaks
- Unable to mutually agree diagnostic appointments due to inadequate admin workforce

Key Risks:

- Potential further COVID waves and staff sickness
- Carry over of annual leave - clinician availability and summer peak.
- Unable to mitigate the activity gaps of tenders not being realised
- Ongoing management of high levels of acute activity impacting elective work
- Theatre nurse staffing vacancy, retention and high sickness rates
- Mutual aid of HUTH patients that require cardiology/respiratory diagnostics
- Planned downtime of CT3 to move into new ED build

Actions:

- Continue to utilise St Hugh's for new patients for Ophthal, ENT and Orthopaedics (ongoing)
- Utilisation of vacancy underspend on ODPs to uplift theatre sessions with external provider for insourcing team (September 2022)
- Plans for October and November being drawn to run full specialty weeks for elective theatres (September 2022)• Additional sessions by NLaG clinicians (ongoing)
- Work with various external providers to provide additional clinic capacity (ongoing)
- Production of process maps for booking of patients to ensure optimum list utilisation (August 2022)
- Review of Demand and Capacity across all specialties to quantify current context and identify any imbalances (September 2022)
- Improved capacity oversight of all leave/sickness across the senior management and senior clinical team (August 2022)
- Review of booking rules for CT & MRI to ensure max efficiency (September 2022)
- Paper submitted to execs for increase in admin workforce to match demand (September 2022)
- Plan for delivery of mobile CT/MRI vans (October 2022)

Mitigations:

- A robust structure is in place to regularly review waiting lists and focus on long waiting and high risk patients.
- Locum staff in place where able to secure
- Weekly assurance that on the planning numbers we continue to see a reduction in longer waiters and movement towards constitutional standards• Clinical risk stratifiation

Access and Flow - Outpatients

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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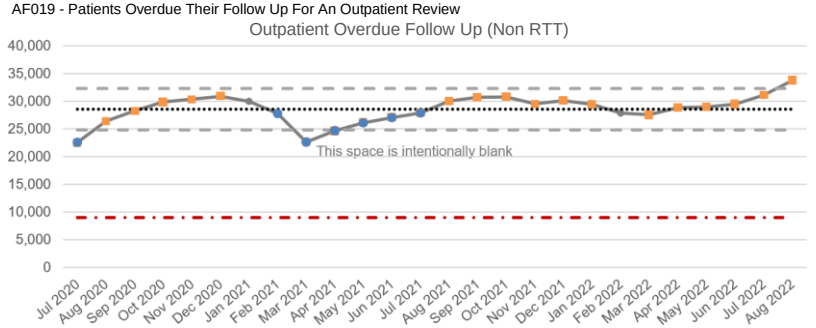
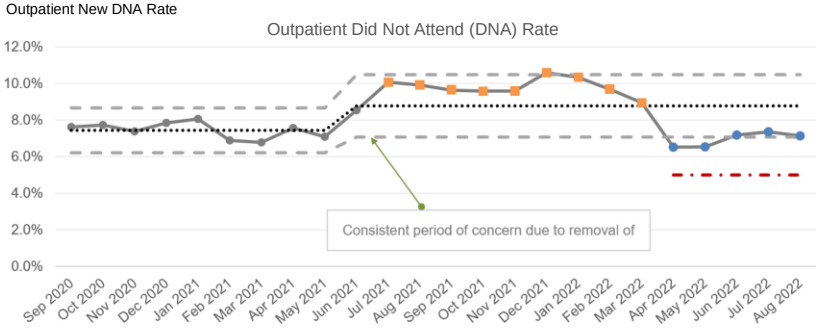
AF019 - Patients Overdue Their Follow Up For An Outpatient Review



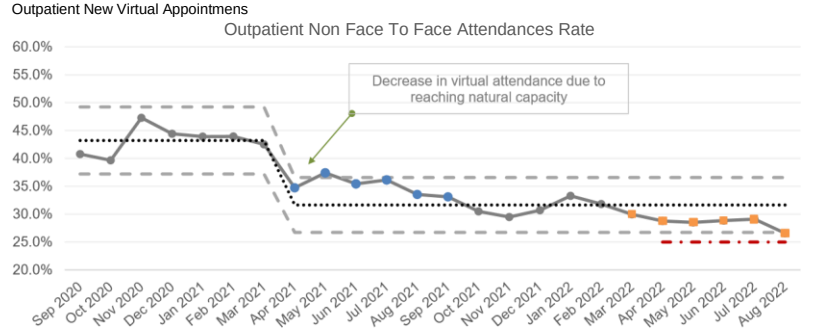
Aug 2022	Target	Variance	Assurance
33,762	**9,000**	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target

Outpatient New DNA Rate



Aug 2022	Target	Variance	Assurance
7.1%	**5.0%**	Special cause of improving nature or lower pressure due to lower values	Consistently falling short of the target

Outpatient New Virtual Appointmens



Aug 2022	Target	Variance	Assurance
26.6%	**25.0%**	Special cause of concerning nature or higher pressure due to lower values	Consistently passing the target

~~Data Analysis:~~

Outpatient Overdue follow up: Performance has largely recorded concern for the past year. Over this period the indicator has consistently failed the target of 9,000 by some margin. Current data indicates that the target will not be met without action, planned actions outlined below.

Outpatient DNA rate: Process limit recalculation from June 21. Following a period of concern the indicator has recorded improvement for the past 5 months. The target of 5% starts from April 2022. Current data indicates that the target will not be met without action, planned actions outlined below.

Non Face to Face Outpatient: Note: Process limit re-calculation from Apr 21. The figure has consistently fallen below the mean for six or more consecutive months triggering special cause concern. However, performance is reliably achieving the ICS target. Local target is 32% by end March 2023.

Challenges:

- Balance between providing overdue follow ups and reducing follow ups by 25%
- Funding arrangements for the CHN model post 22-23 financial year remains challenging
- The overdue follow up list has increased significantly in month 5
- A&G requests and responses times are significantly behind the target rates

Key Risks:

- Clinical buy-in to embed PIFU as standard clinical practice
- Inability to secure a long-term finance model for CHN when pump prime funding expired from March 2023
- The quality of Advice and guidance needs to improve significantly
- There is significant risk that the follow up backlog continues to increase unless there is significant focus on changing traditional models of working and embrace PIFU and A&G as a new way of working

Actions:

- Targeted work with specialties to increase the number of patients on a PIFU pathway in line with expected Trajectory (March 2023)
- Further collaborative work with Primary Care Networks: Clinics being held by GPWSI in Rheumatology (ongoing)
- Heart Failure at home being trialled as part of PKB in Cardiology (ongoing)
- Specialty Level trajectories for achieving a reduction in the backlog of overdue follow ups, increasing PIFU numbers and improved response times to A&G (ongoing)
- Clinicians engaged with following the access policy with regards to DNAs (ongoing)
- Information reports in development to identify patients who persistently DNA/Cancel their appointment (October 2022)
- Phase 2 for the digital letters project commenced go-live with non-leaflet Inpatient Letters and is on a rolling programme including SMS text messaging(ongoing)
- Clinical Lead commenced in post on 1st Sept, working to focus on PIFU, A&G quality and changes in clinical practice for traditional models of OP followup. Clinical champions appointed in Medicine and Surgery to be confirmed in Family Services (ongoing)

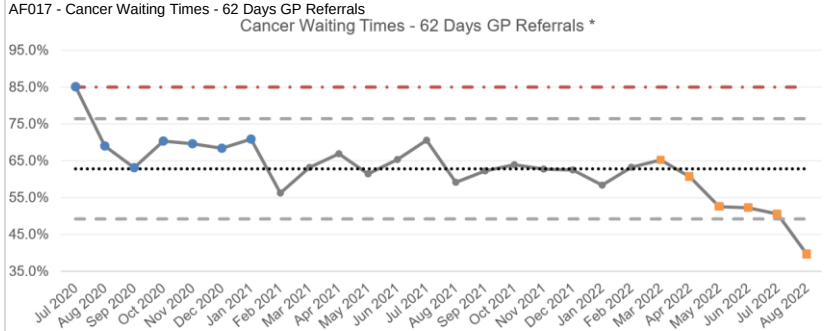
Mitigations:

- Weekly assurance meetings on the activity planning numbers
- Risk Stratification of outpatient waiting lists
- Mutually agree the majority of out-patient appointments, to minimise DNA rates
- Director of Place at North LIncs is co-orindating a group to develop a BS to secure funding to support the CHN Model from March 2022 onwards
- Working with colleagues in Cancer Alliance to identify patients suitable for PIFU• Focus on clinical leadership to secure clinical buy-in

Access and Flow - Cancer

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

AF017 - Cancer Waiting Times - 62 Days GP Referrals



Aug 2022
39.6%

Target
85.0%

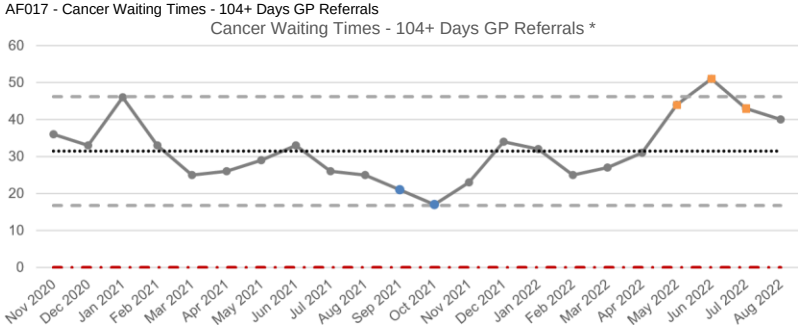
Variance

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

Assurance

Consistently falling short of the target

AF017 - Cancer Waiting Times - 104+ Days GP Referrals



Aug 2022
40

Target
0

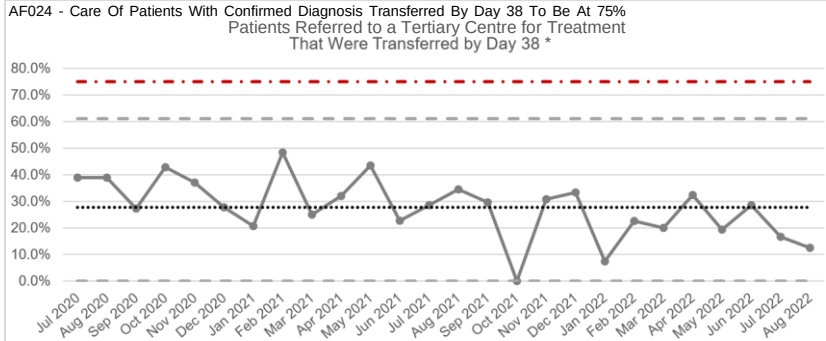
Variance

Common cause - no significant change

Assurance

Consistently falling short of the target

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



Aug 2022
12.5%

Target
75.0%

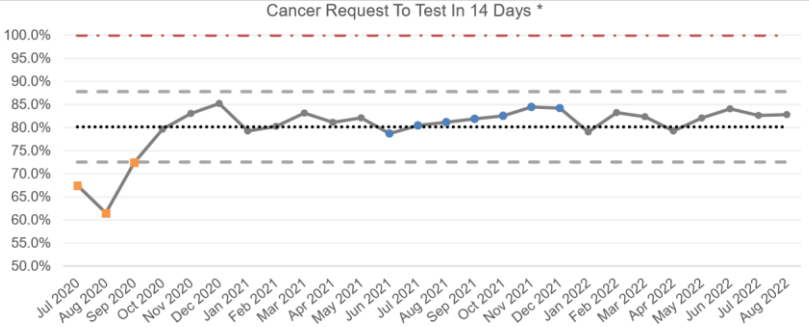
Variance

Common cause - no significant change

Assurance

Consistently falling short of the target

Cancer Request To Test In 14 Days *



Aug 2022
82.8%

Target
100.0%

Variance

Common cause - no significant change

Assurance

Consistently falling short of the target

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

Data Analysis:

62 days GP referral*: Performance has deteriorated over the past 6 months and now falls outside the expected range. This target has not been achieved over the last 2 years. Current data indicates that the target will not be met without action, planned actions outlined below.
104+ days GP referrals*: With the exception of June 2022 performance has remained within the process limits. The indicator is consistently falling short, and current data indicates that the target will not be met without action, planned actions outlined below.
Transferred by day 38*: Wide variation is due to very low numbers. Performance has not changed significantly over the past 2 years, and the target has not been achieved during this time. Current data indicates that the target will not be met without action, planned actions outlined below.
Request to test 14 days*: Performance is stable and as expected based on the data. The target of 100% has not been achieved for more than 2 years. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

- Management of complex unfit patients requiring significant work-up are causing delays
- Most tumour sites are unable to achieve 62 day standard due to multiple factors, including diagnostic and pathoogy turnaround times
- Colorectal and UGI is a challenge but the teams are working to improve referrals in to ensure the right patients receive the diagnostics required• Notable increase in Urological Cancer referrals over last 3 months
- Medicine UGI and Lung tumour site pathways for 28 day performance continue to be challenged
- Gynaecology Nursing capacity to support delivery of planned care due to reduced staffing numbers across the service
- Breast Consultant and Middle Grade capacity due to substantive vacancies• Increased medical staff sickness in August 2022 due to COVID-19

Key Risks:

- For UGI and Head & Neck surgery is carried out in Hull which is currently causing significant delay
- Lack of Oncology Capacity for 1st appointments - now booking 4 weeks from point of referral• Covid positive patients
- One Clinician at SGH running STT UGI service - manageable as small numbers but during leave and sickness leaves service vulnerable
- HUTH have relocated Urology oncologist to Breast, which is causing a significant risk to waiting times. Patient choice
- Urology cancer consultant taking extended period of leave from September 2022.
- There are a number of issues related to visiting consultant services (e.g urology, oncology), tertiary based staging scans (EUS, PET CT) which affect the ability to transfer (IPT) for treatment by Day 38
- Request to test (14 days) - in order to meet 28 day Faster Diagnosis Standard, this needs to be reduced to 7 calendar days.
- Meeting the 38 day IPT standard is impacted through delays occurring with tertiary diagnostics/staging TAT and visitng consultant/oncology services

Actions:

- RDC pathway in place (ongoing)
- Additional Consultant Led Endoscopy Clinics to enable decision making at time of procedure (September 2022)
- Urology service review completed with additional one stop clinics being introduced (September 2022)
- Additional consultants business case approved in Urology (September 2022)
- 62 day performance is being reviewed and managed weekly - along with the 28 day performance (ongoing)
- Single Lung MDT with HUTH & NLaG (October 2022)
- Cancer Improvement Plans developed in Medicine for Lung and UGI cancer (ongoing)
- Timely removal of patients from cancer tracking once non-malignancy confirmed (ongoing)
- Production of process maps for booking of patients to ensure optimum list utilisation (August 2022)
- Review of Demand and Capacity across all specialties to quantify current context and identify any imbalances (September 2022)
- Improved capacity oversight of all leave/sickness across the senior management and senior clinical team (August 2022)

Mitigations:

- Increase RDC capacity to work alongside STT to streamline service in Colorectal
- Funding approved to recruit to Band 3 and Band 2 admin support• RDC to be opened up to non site specific pathway from 1st May 2022
- Urology agency consultant currently in post.
- The pathway analyser tool that has been developed within NLAG (using the IST tool) and the in depth analysis of pathways will enable teams to identify where improvements in NLAG can be achieved
- The joint transformation pathway work with HUTH will help with the transfer of patients between NLAG/ HUTH and to identify areas where the pathway

NHS
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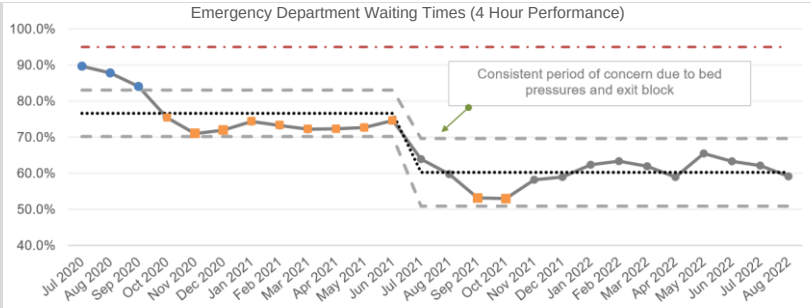
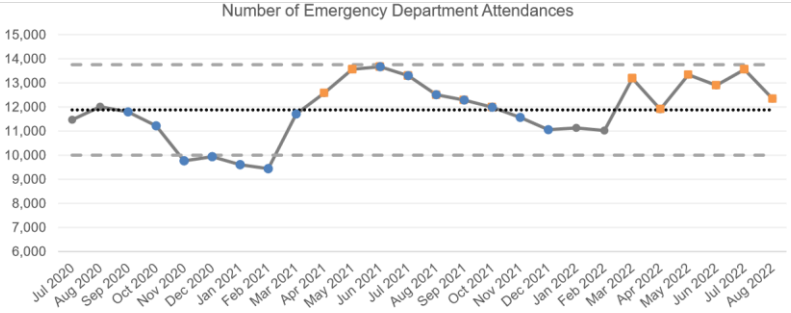
NHS Foundation Trust

Access and Flow - Urgent Care 1



Aug 2022	Target	Variance	Assurance
59.1%	**95.0%**	Common cause - no significant change	Consistently falling short of the target



AF006 - A&E 4 Hour Performance

Aug 2022	Target	Variance	Assurance
12,347	**No Target**	Special cause of concerning nature or higher pressure due to higher values	There is no target therefore target assurance is not relevant

AF009 - Ambulance Handover Delays 60+ Minutes

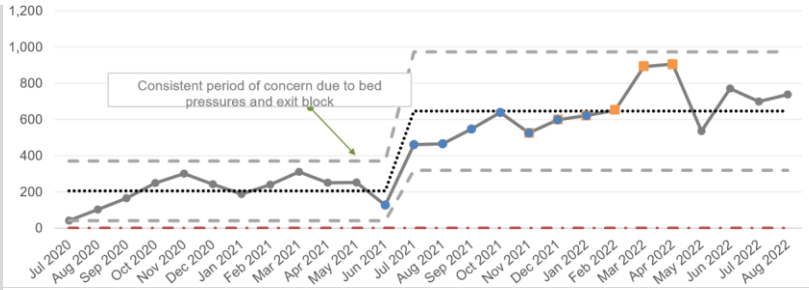
Ambulance Handover Delays 60+ Minutes

Aug 2022	Target	Variance	Assurance
738	**0**	Common cause - no significant change	

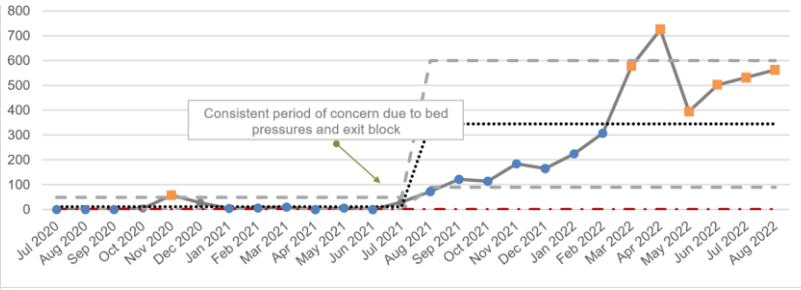
Bed Occupancy

Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission

Aug 2022	Target	Variance	Assurance
563	**0**	Special cause of concerning nature or higher pressure due to higher values	



Consistently falling short of the target



Consistently falling short of the target

Data Analysis:

ED 4 hour waiting: There has been a significant deterioration in performance over the past two years resulting in a re-calculation of the process limits from July 21. Current data indicates that the target will not be met without action, planned actions outlined below.
ED Attendances: The number of attendances remains within the expected range. However, has moved closer to the upper range of the data over the past several months due to an increased number of attendances.
Ambulance handover 60+ minutes: Process limits re-calculated from July 21. Performance remains elevated but within the expected range of the data since the re-calculation. Current data indicates that the target will not be met without action, planned actions outlined below.
DTA 12 hours: Process limit re-calculation from Aug 21. This indicator continues to record very high levels, and figures remain close to the upper process limit. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

- Pressure within the community in relation to demand for ambulance attendances
- High level of acuity with pressures within Resus
- Increased attendances

Key Risks:

- Staffing gaps in both medical and nursing
- High levels of agency and locum staff
- Inability to achieve Ambulance Handover targets due to patient flow within the hospital
- Inability to meet patient waiting times in ED
- Staff burnout
- Demand on resus area

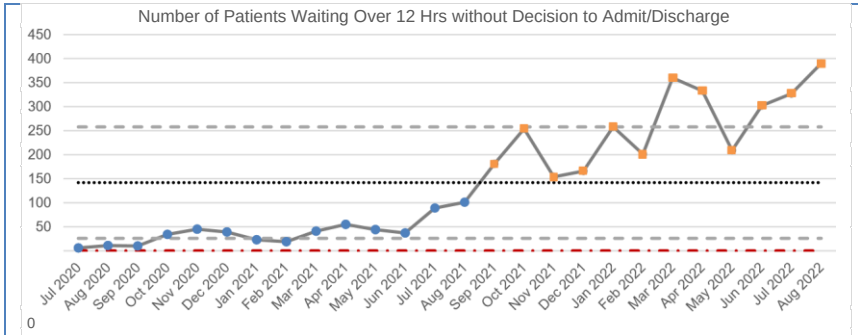
Actions:

- Daily review of medical and nursing staffing to ensure appropriate skill mix (ongoing)
- Work continues on the new build for both sites to increase footprint (DPoWH due to open in October 2022)
- Work continues on improvement to pathways (ongoing)
- Two hourly Board Rounds taking place (ongoing)
- Review of all Urgent Care Services across Northern Lincolnshire has commenced to look at reducing pressure across the system by ensuring that patients are seen at the right place, by the right person, first time (ongoing)
- Delivery of the improvements within the Ambulance Handover Plan (ongoing)
- Bid submitted for funding for Virtual Ward Development & OPAT across Northern Lincolnshire (ongoing)
- Discharge Programme in place including development of Home Care (October 2022)

Mitigations:

- Patients are triaged on the ambulances if there is a delay to ambulance handover to ensure patient safety
- New structure in place within ED with senior decision makers now identified on a daily basis for EPIC, Resus/Majors, Initial Assessment and Ambulance Triage
- Tier system is in place to ensure that escalation is taking place where appropriate to support patient flow to ensure a swift resolution to issues
- Fast track paediatric process in place
- Increased staffing in ED
- Alternatives to trolleys – beds, recliner chairs. Choice of meals for patients during prolonged ED stays
- Screen installed in SDEC and SAU to enable "straight to" ambulance handover pathways to be implemented to support ED avoidance
- Joint working group established with acute medicine & community & therapies• 2 hour community Response

Access and Flow - Urgent Care 2



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Aug 2022
390

Target
0

Variance

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

Assurance

Consistently falling short of the target

Aug 2022

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Aug 2022

Target

Variance

Assurance

Aug 2022

		Target			Target
		Variance			Variance
		Assurance			Assurance

Data Analysis:

Discharged same day as admission: Performance has recorded concern for the past 12 months with 5 of the 6 most recent months being outside the process limits. Current data indicates that the target will not be met without action, planned actions outlined below

Challenges:

•N umber of D2A's continue to rise - impacting on the ability to move patients from ED to IAAU •I ssues with the capacity in SDEC to enable Patient Flow within the department
•E scalation process for closure of SDEC
•U se of UCS rooms overnight to bed patients down resulting in a lack of rooms to see patients the following day

Key Risks:

•R ise in ambulance Handover Times due to lack of space within the department caused by bed waits
•L ack of rooms to be able to see new patients that arrive within the department
•P atient to staff ratios due to the numbers of patients within the department •S taff burnout
•N umber of red flag patients in the Waiting Room
•F ailure to meet triage targets

Actions:

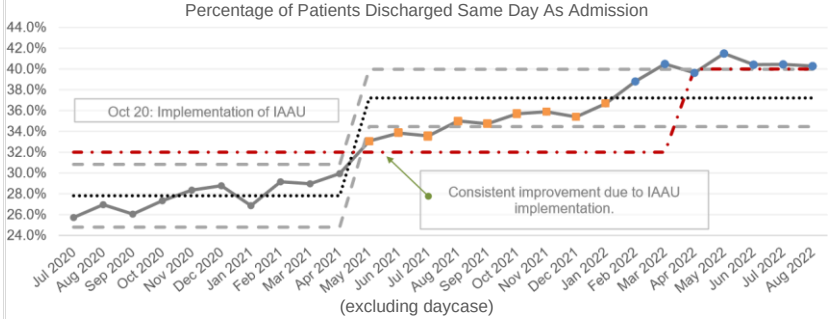
•P rocess is being implemented within September to live validate all patients that are within the department more than 12 hours (ongoing)
•C ontinued review of the patient numbers within the department to ensure that there are not alternative pathways that the patients could be moved to should their acquity improve (ongoing)

Mitigations:

•C are standards are in place to ensure that the patients are being reviewed regularly
•T wo hourly Board Rounds are taking place and patients are being reviewed where necessary
•C ritical Meds Sheets are implemented where required to ensure patients are receiving the medication they require whilst waiting to be admitted

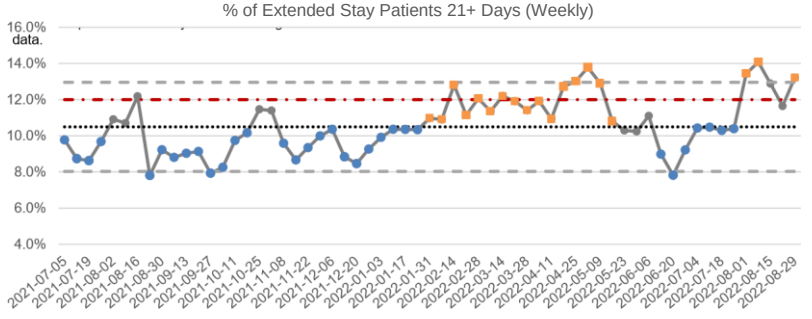
Access and Flow - Flow 1

same day discharge

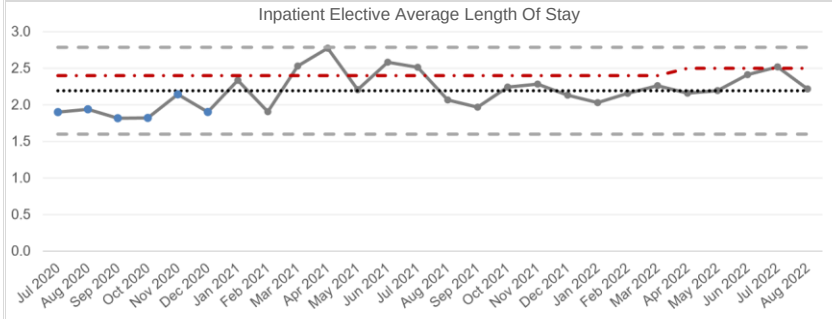


Aug 2022 **40.3%**
Target **40.0%**
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Consistently falling short of the target

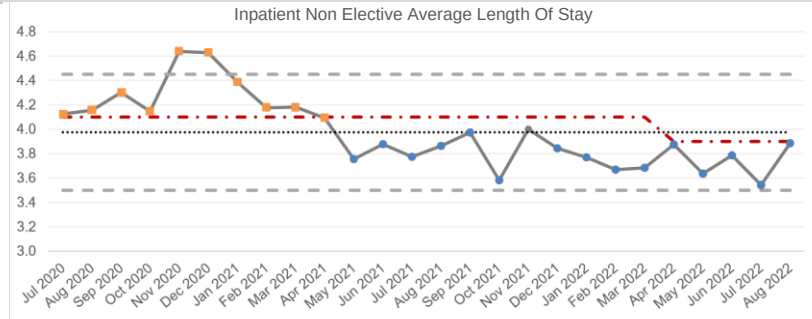
inpatient extended 21+



Aug 2022 **13.22%**
Target **12.0%**
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and falling short of the target



Aug 2022 **2.2**
Target **2.5**
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and falling short of the target



Aug 2022 **3.9**
Target **3.9**
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and falling short of the target

Data Analysis:
Discharged same day as admission: Note: Process limit re-calculation from May 21, and local target increased from 32% to 40% from April 22. Performance continues to show improvement with the most recent data points outside the expected range, showing the highest performance since 2020. **% Extended stay 21+ days:** The indicator has recorded significant variation over the past 12 months. The indicator can be expected to achieve and fail the target at random.
Elective length of stay: Note: the target has been increased from 2.4 days to 2.5 days with effect from April 22. The performance of this indicator continues to fall within the expected range. The target can be expected to achieve and fail at random.
Non elective length of stay: Note: The target has been decreased from 4.1 to 3.9 from April 22. This indicator has been showing an improvement coinciding with an increase in patients discharged on the same day as admission. The indicator can be expected to achieve and fail the target at random.

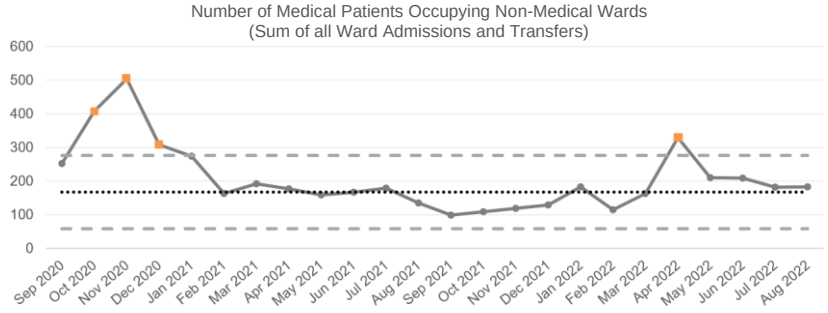
~~Challenges:~~
- Staffing constraints (sickness, vacancies, use of agency and bank staff)
- Covid & IPC constraints
- Exit block due to social care constraints (staffing, interim bed availability, lack of packages of care availability)
- Environment and ability to create (and staff) escalation beds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

~~Key Risks:~~
- Space and capacity issues within SDEC/IAAU
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways• Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission and long patient waits in ED• High acuity levels and patients means more patients require further support on discharge

~~Actions:~~
- Work with Community Services/NEL & NL CCGs to improve patient pathways and alternative community pathways (ongoing)
- Bid submitted for funding for Virtual Ward Development & OPAT across Northern Lincolnshire (Oct 2022)• Discharge Programme in place (Oct 2022)
- Joint working group established with acute medicine & community & therapies to refine and further establish urgent care pathways (ongoing)
- Speech & Language Therapy moving to 6 day working to further support flow (ongoing)
- Respiratory on call developments finalised moving to 7 day service from on call service model (ongoing)
- Joint audit carried out between NLAG and EMAS to improve direct access to SDEC. Action plan developed; completion August 2022• Daily board rounds on wards (ongoing)
- LLOS reviews in place for medicine twice per week led by the senior tri (ongoing)

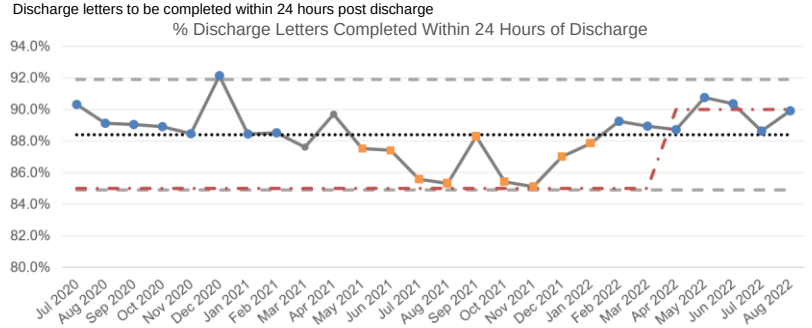
~~Mitigations:~~
- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clearaction plan for delayed discharge and escalation plan
- Themes are collated during the week from escalations and fed back to a fortnightly discharge improvement meeting which feeds our improvement plan
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire• 2 hour community Response

Access and Flow - Flow 2

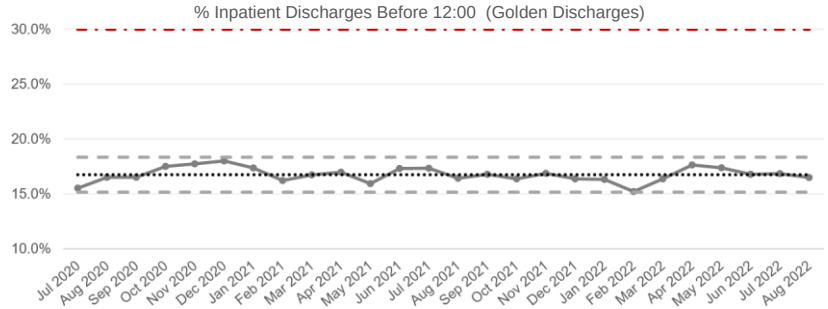


Aug 2022	Target	Variance	Assurance
183	**No Target**	Common cause - no significant change	There is no target, therefore target assurance is not relevant

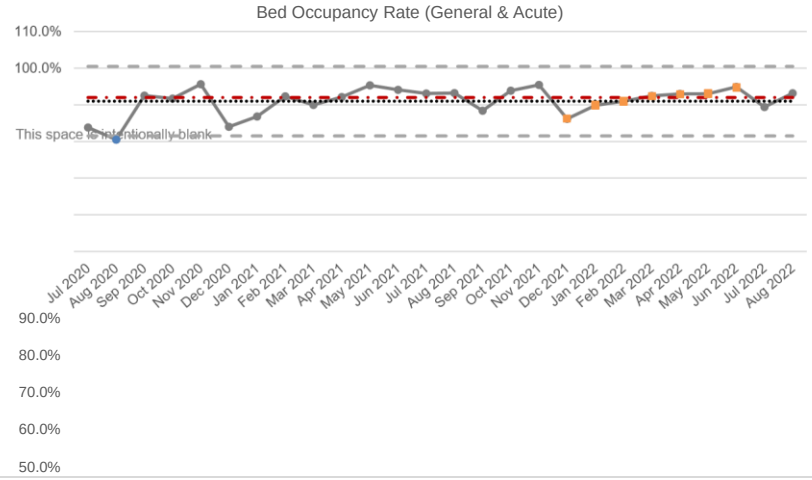
Discharge letters to be completed within 24 hours post discharge



Aug 2022	Target	Variance	Assurance
89.9%	**90.0%**	Special cause of improving nature or lower pressure due to higher values	Inconsistently hitting passing and falling short of the target



Aug 2022	Target	Variance	Assurance
16.5%	**30.0%**	Common cause - no significant change	Consistently falling short of the target



Aug 2022	Target	Variance	Assurance
93.2%	**92.0%**	Common cause - no significant change	Inconsistently hitting passing and falling short of the target

~~Data Analysis:~~
Medical Outliers: For the past 20 months performance has predominantly been as expected and within the expected range. The analysis of this indicator is very sensitive to ward re-categorisations including any temporary agreed usage of wards out of usual scope. **Inpatient discharge letters:** Note: the local target of 85% has been increased to 90% April 22. The data is falling within the expected range and has recorded improvement for the past 7 months. The indicator can be expected to achieve and fail the target at random. **Inpatient discharges before 12:00:** Performance is currently stable and as expected. In terms of assurance, current data indicates that the target will not be met without action, planned actions outlined below. **G&A Bed Occupancy:** Performance remains stable within the expected range for the data. The target can be expected to achieve and fail at random.

Challenges:

- Staffing constraints (sickness, vacancies, use of agency and bank staff)
- Covid & IPC constraints
- Exit block due to social care constraints (staffing, interim bed availability, lack of packages of care availability)
- Environment and ability to create (and staff) escalation beds
- Time of discharges need to be earlier in day
- Although discharge to Assess as a process is fully embedded within the trust there is a need to concentrate improvement work on the whole discharge

pathway, work is taking place to understand the current position and build a system wide improvement plan with our partners

Key Risks:

- Space and capacity issues within SDEC/IAAU
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways• Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission and long patient waits in ED• High acuity levels and patients means more patients require further support on discharge

Actions:

- Work with Community Services/NEL & NL CCGs to improve patient pathways and alternative community pathways (ongoing)
- Bid submitted for funding for Virtual Ward Development & OPAT across Northern Lincolnshire (Oct 2022)• Discharge Programme in place (Oct 2022)
- Joint working group established with acute medicine & community & therapies to refine and further establish urgent care pathways (ongoing)
- Speech & Language Therapy moving to 6 day working to further support flow (ongoing)
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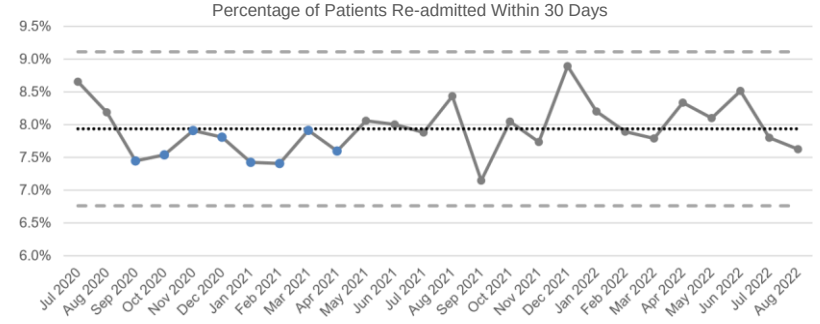
- Joint audit carried out between NLAG and EMAS to improve direct access to SDEC. Action plan developed; completion August 2022• Daily board rounds on wards (ongoing)
- LLOS reviews in place for medicine twice per week led by the senior tri (ongoing)

Mitigations:

- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clear action plan for delayed discharge and escalation plan
- Themes are collated during the week from escalations and fed back to a fortnightly discharge improvement meeting which feeds our improvement plan
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire• 2 hour community Response

Flow 3: (F&P Sub-Committee)



Aug 2022
7.6%

Target
No Target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

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% of Extended Stay Patients 7+ Days

Aug 2022
47.1%

Target
No Target

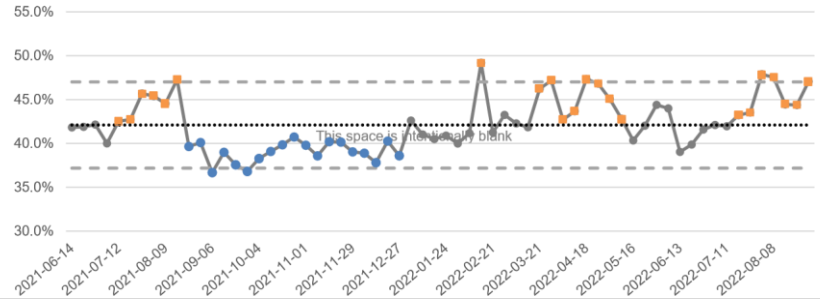
Variance

% of Extended Stay Patients 14+ Days

Aug 2022
25.6%

Target
No Target

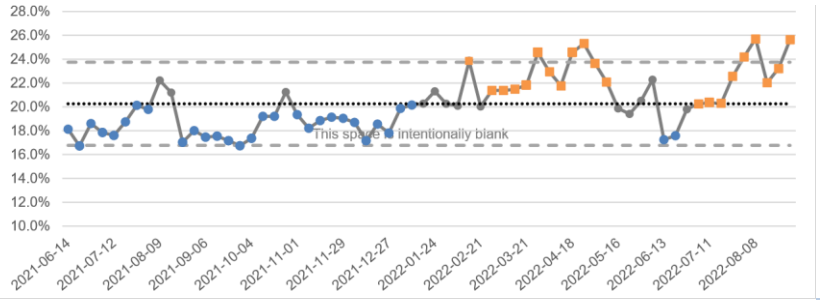
Variance



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

Assurance

There is no target, therefore target assurance is not relevant



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

Assurance

There is no target, therefore target assurance is not relevant

~~Data Analysis:~~

Emergency Re-admissions 30 days: Performance is currently stable and within the expected range. For context, the national benchmark figure for the 12 months to May 22 is 7.11%. NLAG's figure for May 22 was 8.10%.
Extended stay 7+ days: Although performance remains largely within the expected range it is recording concern and the 7+ day extended stay has increased compared with autumn 2021. See Flow page 1 for the 21+ day position.
Extended stay 14+ days: Although performance remains largely within the expected range it is recording concern and the 14+ day extended stay has increased compared with 2021. See Flow page 1 for the 21+ day position.

Challenges:

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

Key Risks:

- Space and capacity issues within SDEC/IAAU
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways• Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission and long patient waits in ED• High acuity levels and patients means more patients require further support on discharge

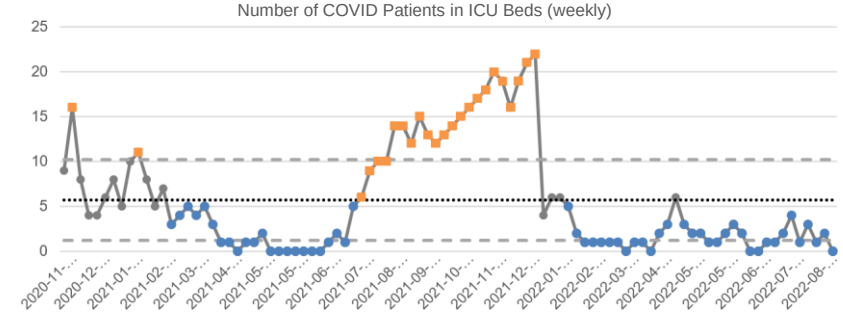
Actions:

- Work with Community Services/NEL & NL CCGs to improve patient pathways and alternative community pathways (ongoing)
- Bid submitted for funding for Virtual Ward Development & OPAT across Northern Lincolnshire (Oct 2022)• Discharge Programme in place (Oct 2022)
- Joint working group established with acute medicine & community & therapies to refine and further establish urgent care pathways (ongoing)
- Speech & Language Therapy moving to 6 day working to further support flow (ongoing)
- Respiratory on call developments finalised moving to 7 day service from on call service model (ongoing)
- Joint audit carried out between NLAG and EMAS to improve direct access to SDEC. Action plan developed; completion August 2022• Daily board rounds on wards (ongoing)
- LLOS reviews in place for medicine twice per week led by the senior tri (ongoing)

Mitigations:

- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clearaction plan for delayed discharge and escalation plan
- Themes are collated during the week from escalations and fed back to a fortnightly discharge improvement meeting which feeds our improvement plan
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire• 2 hour community Response

AF042 - COVID Patients In ICU Beds



Aug 2022
0

Target
No Target

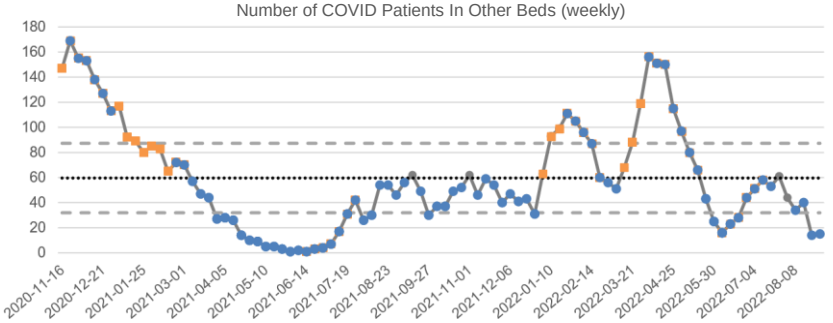
Variance

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

Assurance

There is no target, therefore target assurance is not relevant

AF043 - COVID Patients In Other Beds



Aug 2022
15

Target
No Target

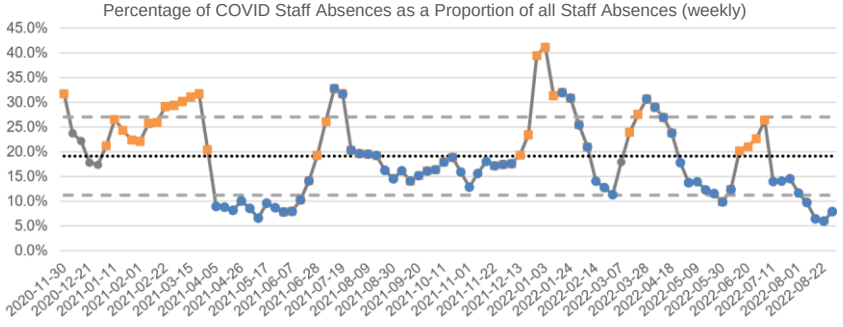
Variance

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

Assurance

There is no target, therefore target assurance is not relevant

AF044 - COVID Staff Absences



Aug 2022
7.9%

Target
No Target

Variance

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

Assurance

There is no target, therefore target assurance is not relevant

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Data Analysis:

COVID Patients In ICU beds: The number of covid patients in ICU beds has consistently recorded less than 5 for most of 2022 and remains predominantly at the lower bounds of the process limits for this indicator.
COVID Patients In Other Beds: The number of COVID patients in other beds has recorded statistically significant improvement since April 2022.
COVID Staff Absences: The rate has been volatile since during 2022 with repeated changes between concerning and improving performance. However, for the past two months the indicator has recorded improvement.

Challenges:

Key Risks:

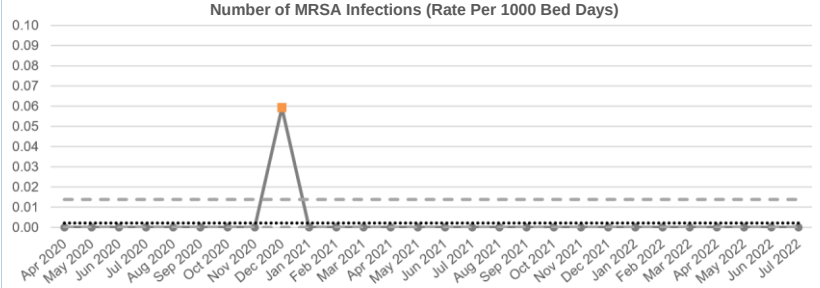
Actions:

Mitigations:

Quality and Safety - Infection Control 1

** Year to date figure and target is included in the data analysis section below*

Number of MRSA Infections (Rate Per 1000 Bed Days)



Jul 2022
0.00

*Target **see analysis below**

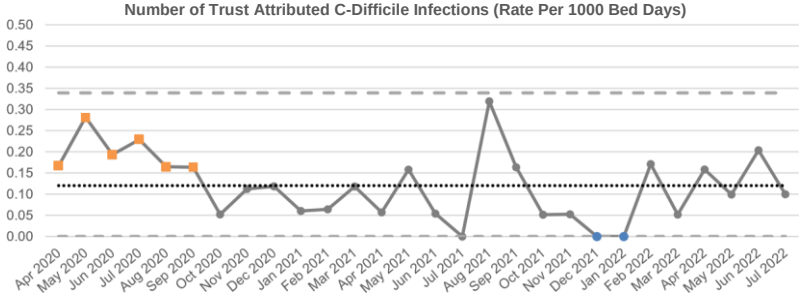
Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

Number of Trust Attributed C-Difficile Infections (Rate Per 1000 Bed Days)



Jul 2022
0.10

*Target
see analysis below

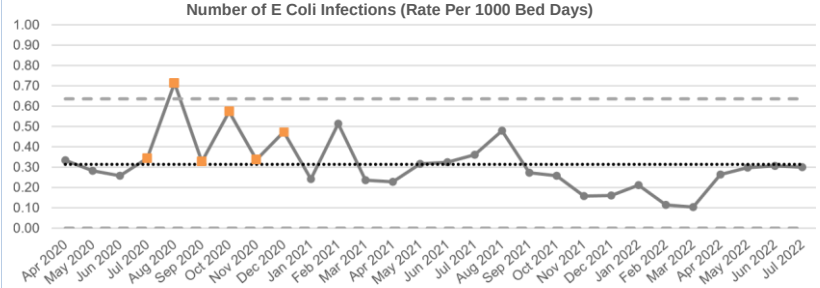
Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

Number of E Coli Infections (Rate Per 1000 Bed Days)



Jul 2022
0.30

*Target **see analysis below**

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

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Data Analysis:

MRSA: Performance is stable and within the expected range of the data. The YTD figure is 0 against an annual target of 0.
C Diff: Performance is stable and within the expected range of the data. The YTD figure is 11 against an annual target of 21.
E Coli: Performance is stable and within the expected range of the data. The YTD figure is 23 against an annual target of 65.

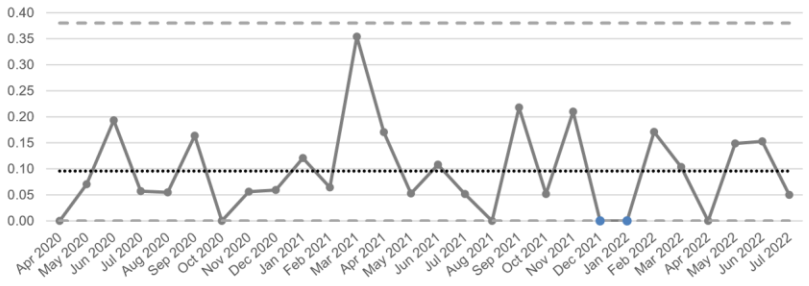
Commentary:
Bacteraemia cases are stable and as expected. Clostridium difficile cases are stable, the case thrshold will be challenging to achieve, PIR outcomes so far show cases to be unpreventable with justified antibiotics being main predisposing factor.

Quality and Safety - Infection Control 2

** Year to date figure and target is included in the data analysis section below*

Northern Lincolnshire and Goole NHS Foundation Trust

Number of MSSA Infections (Rate Per 1000 Bed Days)



Jul 2022
0.05
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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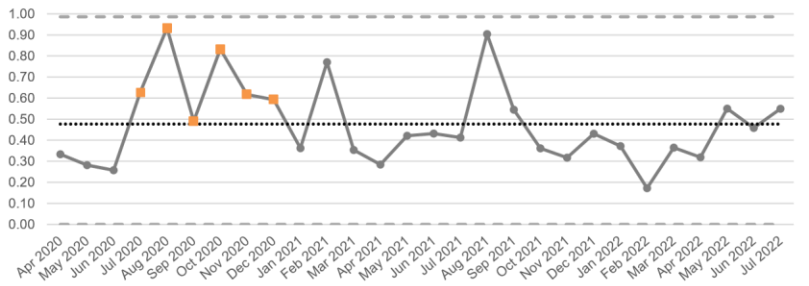
Number of Gram Negative Infections (Rate Per 1000 Bed Days)



Jul 2022
0.55
Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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Data Analysis:

MSSA: Performance is stable and within the expected range of the data. The YTD figure is 7, there is no annual target.

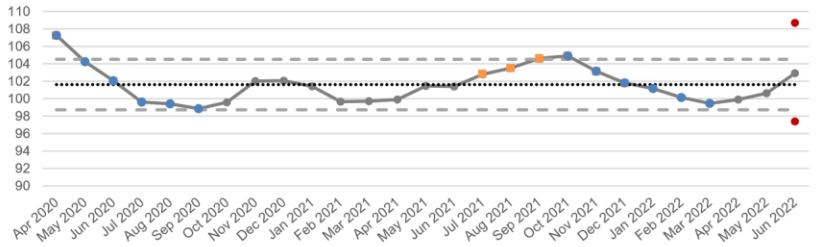
Gram Neg: Performance is stable and within the expected range of the data. The YTD figure is 37 against an annual target of 97.

Commentary:

Bacteraemis cases are stable and as expected.

Quality and Safety - Mortality

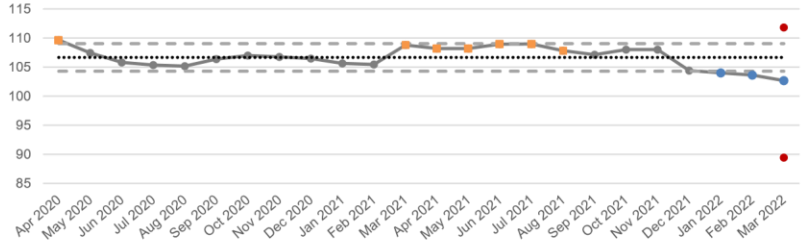
Hospital Standardised Mortality Ratio (HSMR)
Rolling 12 month position
Note: The red dots indicate the expected range



Jun 2022
102.9
Target
As expected
Variance
Common cause - no significant change
Assurance
Within 'as expected' range

This space is intentionally blank

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



Mar 2022
102.7
Target
As expected
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Within 'as expected' range

This space is intentionally blank

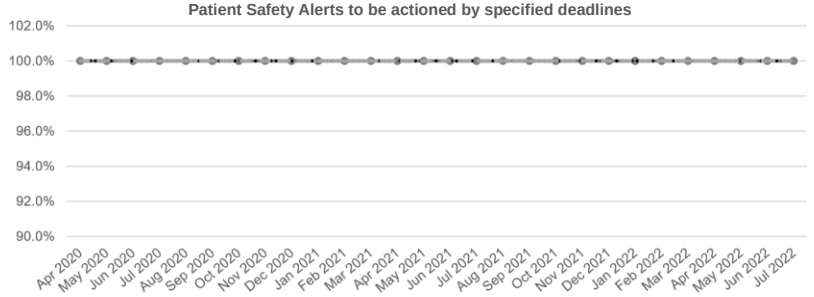
Data Analysis:
HSMR: Performance is within the expected range of the data. The data represents a rolling 12 month position.
SHMI: Performance has improved in recent months. The data represents a rolling 12 month position.

Commentary:

Quality and Safety - Safe Care 1

Northern Lincolnshire and Goole NHS Foundation Trust

Patient Safety Alerts to be actioned by specified deadlines



Jul 2022
100.0%

Target
No target

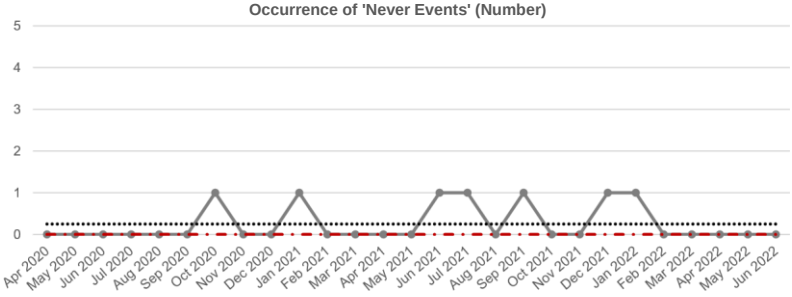
Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant

Occurrence of 'Never Events' (Number)



Jun 2022
0

Target
0

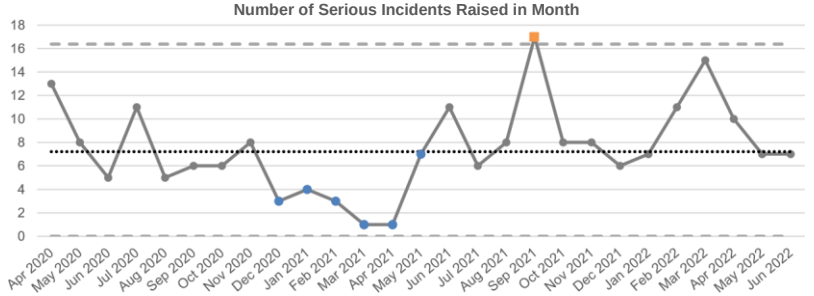
Variance

The data are not appropriate for an SPC chart, therefore varaince is not relevant

Assurance

The data are not appropriate for an SPC chart, therefore assurance is not relevant

Number of Serious Incidents Raised in Month



Jun 2022
7

Target
No target

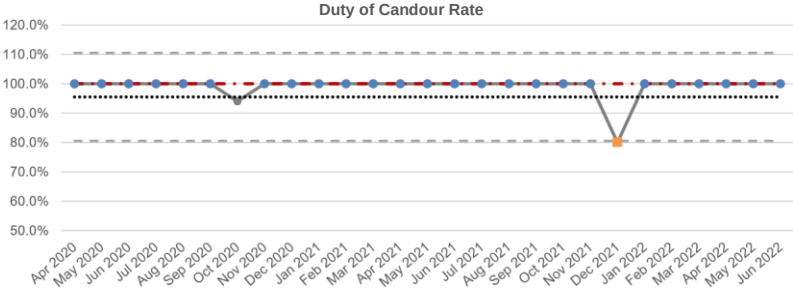
Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant

Duty of Candour Rate



Jun 2022
100.0%

Target
100.0%

Variance

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

Assurance

Inconsistently hitting passing and failing the target

Data Analysis:

Patient Safety Alerts: Performance continues at 100%.

Never Events: Due to the infrequency of never events an SPC is not appropriate. Never events data are a subset of the serious incidents data. There were 0 never events recorded in June 2022. **Serious Incidents:** Note this data is updated retrospectively to reflect any de-escalated incidents. The data is within the expected range of variation.

Duty of Candour: With the exception of October 2020 and December 2021 performance has achieved the target consistently for over two years.

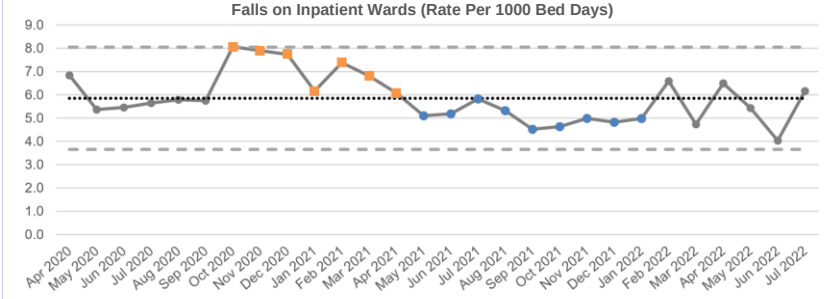
Commentary:
Never Events:
There have been no Never Events declared since January 2022.

Duty of Candour: Duty of Candour for serious incidents is 100%. A very slight gap remains in relation to ensuring duty of candour is completed for all instances of moderate level harm within 10 working days. This presents the risk of non-compliance against regulations, which may result in a financial penalty. The position is much improved. There was only 1 instance in the past 12 months where a duty of candour for a serious incident was not completed in 10 days.

Risk: Position in relation to Duty of candour for incidents other than serious incidents are reported to divisions on a weekly basis showing the number of which are still outstanding and those that are overdue. The risk is significantly reduced.

Actions: Work is ongoing with Divisions to obtain assurance that all moderate (and above) harm instances have duty of candour completed (monitored through SI panel with significant improvement noted). Duty of Candour Reports are availiable on Ulysses and are being monitored at divisional level as well as at SI Panel.

Quality and Safety - Safe Care 2



Jul 2022
6.2

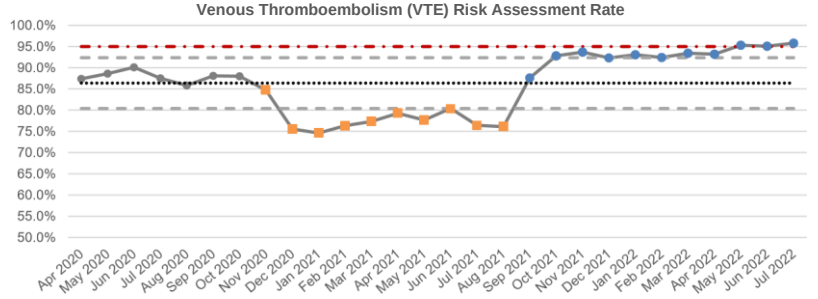
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant



Jul 2022
95.8%

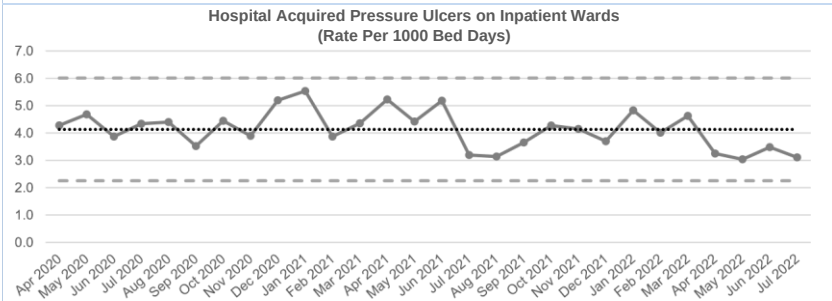
Target
95.0%

Variance

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

Assurance

Consistently failing the target



Jul 2022
3.1

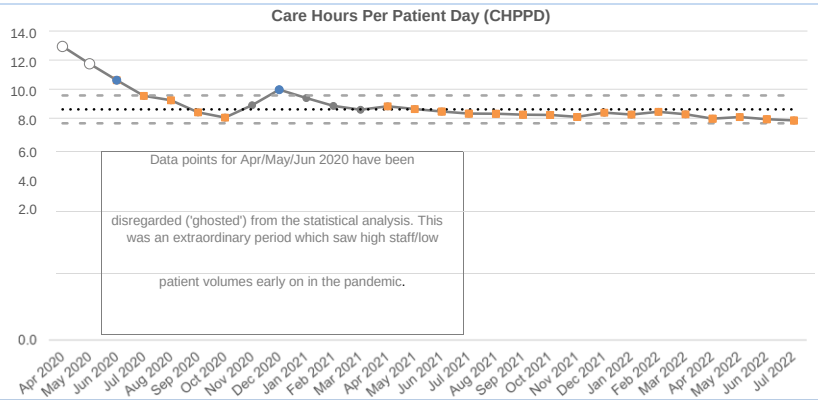
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant



Jul 2022
7.9

Target
No target

Variance

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

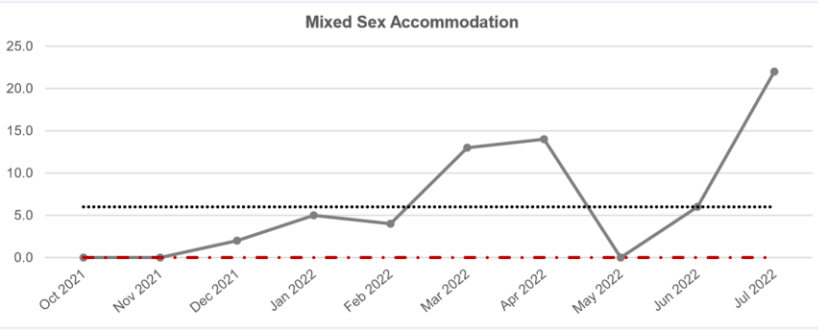
Assurance

There is no target therefore target assurance is not relevant

Data Analysis:

Falls on Inpatient Wards: Performance in the last six months has been stable and within the expected range.
VTE Risk Assessment: Performance has shown a significant improvement over the past eleven months. The figure for July has achieved the target, however, it is not possible, at this stage, to give assurance that it will consistently achieve the target in future months. More data is needed. **Hospital Acquired Pressure Ulcers:** Performance is consistently within the expected range.
Care Hours Per Patient Day: Performance has been below the average value for the data for more than one year and is close to the lower process limit, but remains within the expected range.

Commentary: Falls continue to be monitored by Divisions and safety falls huddles continue for any falls with harm. For Pressure Ulcers there are no concerning themes or trends reported. There has been no signifcant changes in CHPPD since the increase which was seen in the first wave of Covid when bed numbers were reduced to support management of the pandemic and increased patient acuity. It remains difficult to benchmark using this data due to changes in ward demographic and acuity over the past 2 years.	



Jul 2022
22
Target
0
Variance
There is currently insufficient data, therefore variance is not relevant
Assurance
There is currently insufficient data, therefore assurance is not relevant

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This space is intentionally blank

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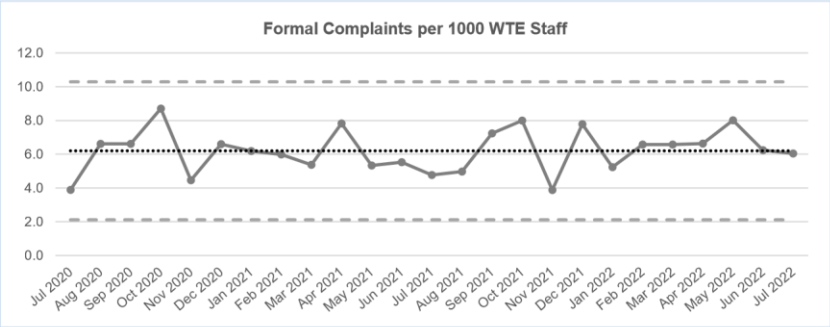
Data Analysis:
Mixed sex accommodation: There were 22 MSA breaches reported for July. There is insufficient data for SPC presentation.

Commentary:
For Mixed Sex breeches the theme for these was that the Trust had declared OPEL 4 on all occasions and there was a lack of capacity in step down beds.

Quality and Safety - Patient Experience 1



May 2022
8

Target
No target

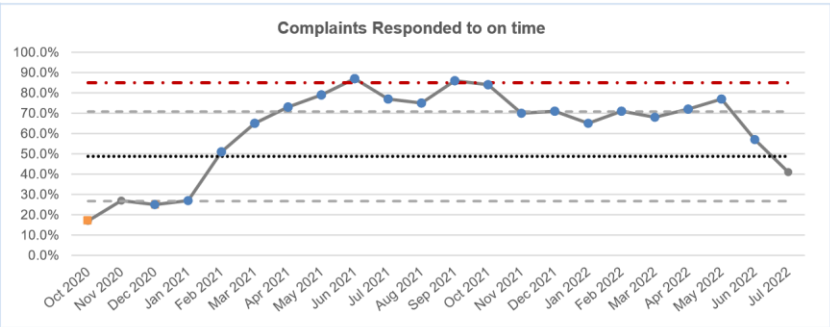
Variance

Common cause - no significant change

Assurance

There is no target therefore assurance is not relevant

This space is intentionally blank



May 2022
77.0%

Target
85.0%

Variance

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

Assurance

Consistently failing the target

This space is intentionally blank

Data Analysis:
Formal Complaints: The data continues within the expected range.
Complaints Responded to on time: The data continues within the expected range and is randomly hitting and missing the target.

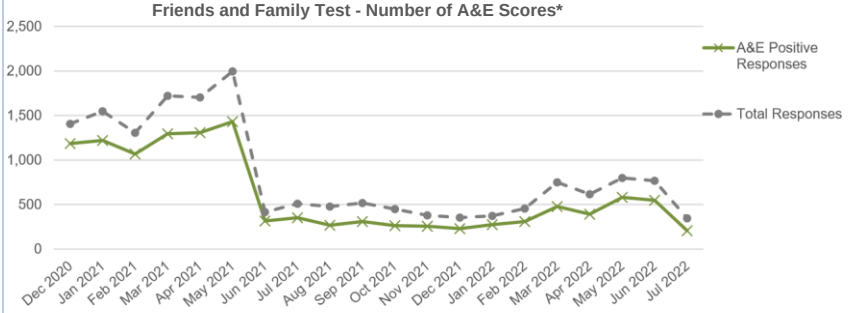
Commentary:
Progress
> Noted decreased in timescale compliance - actions requested of divisions to review processes
> Thematic Roundtable meeting held
> Action Planning session planned to develop responsive plan to emerging compliance issues
> Learning shared divisionally
> Divisions asked to monitor allocation of lead investigators and planned annual leave when allocating, due to impacts in process
> Key complaint management tools shared with HUTH complaint team and onsite learning visit planned

Risks
> Sustainability of KPI closed complaints in timescale if actions not undertaken
> Increased central team and clinical time required to manage complex complaint cases - impacting on compliance
> Instability of central team direct management structure

Mitigations
> Weekly Support and Challenge meetings
> Weekly/Fortnightly Tri meetings with Pals and Complaint manager to be started
> Weekly complaint report to be implemented
> In-depth monthly divisional reporting shared
> Action plan in place

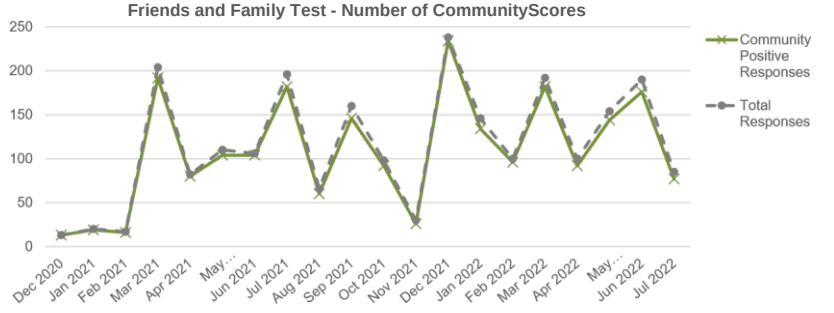
Quality and Safety - Patient Experience 2

Friends and Family Test - Number of A&E Scores*



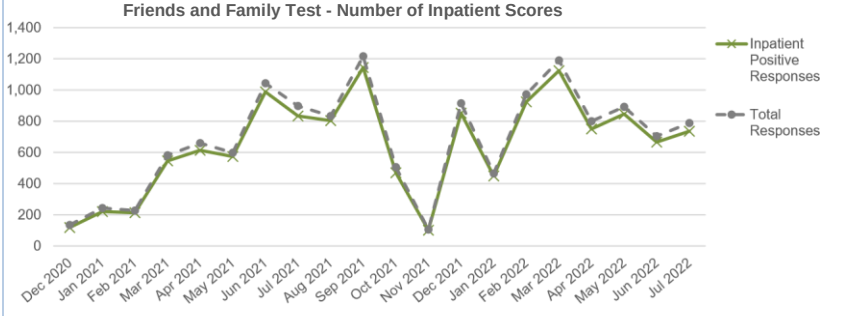
Jul 2022
207 out of 347
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

Friends and Family Test - Number of CommunityScores



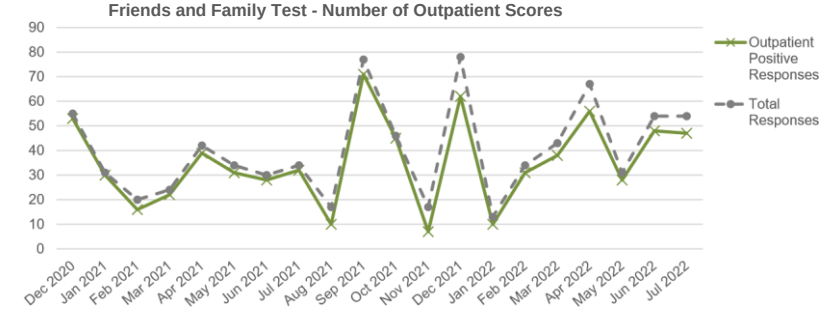
Jul 2022
77 out of 85
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

Friends and Family Test - Number of Inpatient Scores



Jul 2022
736 out of 788
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

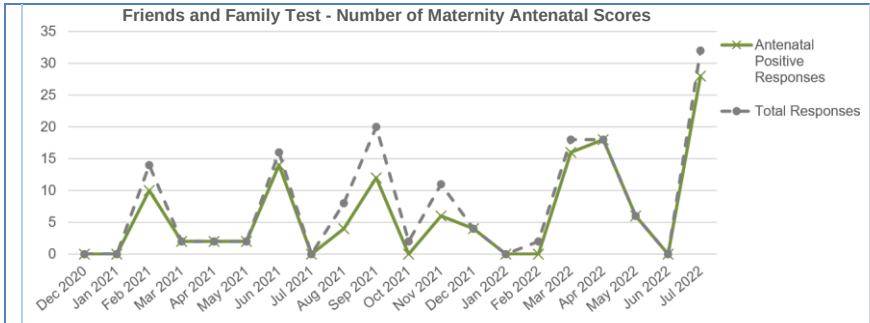
Friends and Family Test - Number of Outpatient Scores



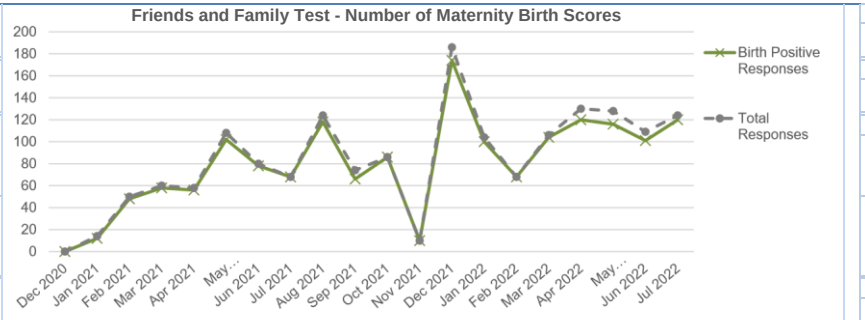
Jul 2022
47 out of 54
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

~~Data Analysis:~~
A&E FFT: There were 347 responses received in total for July 2022, and 207 were positive (59.7%). *The figures for July 2022 are unvalidated.
Community FFT: There were 85 responses received in total for July 2022, and 77 were positive (90.6%)
Inpatient FFT: There were 788 responses received in total for July 2022, and 736 were positive (93.4%)
Outpatient FFT: There were 54 responses received in total for July 2022, and 47 were positive (87.0%)

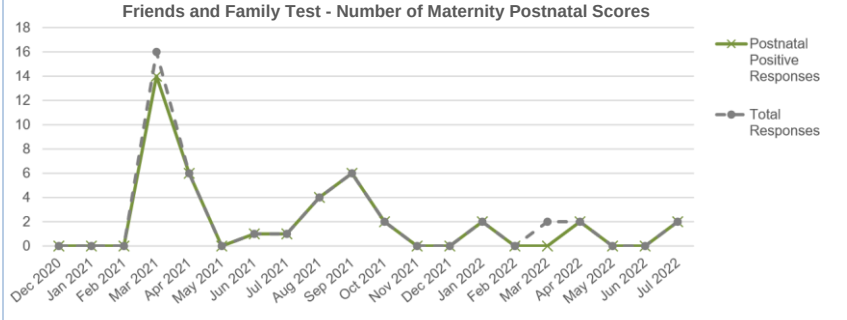
Commentary: Progress > Onsite visit by IWGC > Methodology review of ECC, Community and OPD > Action plan finalised Risks > Staff engagement > Lack of response rates reflective of activity means data use is limited > Restricted methodologies in some areas - impacting on accessibility Mitigations > Quarterly Divisional Review Meetings for oversight > Weekly meetings IWGC > Triangulation meeting commenced - Roundtable Meeting > Patient Experience Manager to be released from supporting complaints by end September to support fully	



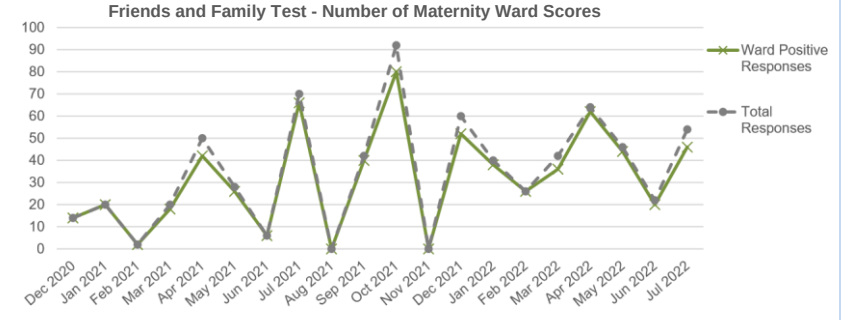
Jul 2022
28 out of 32
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jul 2022
120 out of 124
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



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



Jul 2022
46 out of 54
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

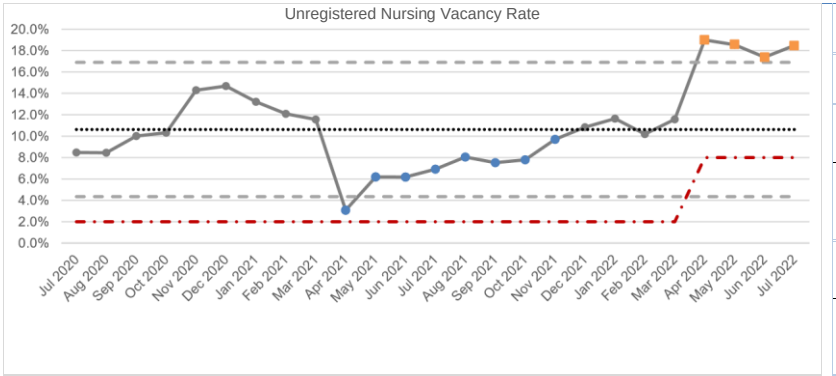
~~Data Analysis:~~
Maternity Antenatal FFT: There were 32 responses received for July 2022, and 28 were positive (87.5%)
Maternity Birth FFT: There were 124 responses received in total for July 2022, and 120 were positive (96.8%) **Maternity Postnatal FFT:** There were 2 responses received for July 2022, and both were positive.
Maternity Ward FFT: There were 54 responses received in total for June 2022, and 46 were positive (85.2%)

Commentary:
Progress
> Divisional team aware of focus areas
> Methodology being reviewed and platform improved
> Action plan finalised

Risks
> Staff engagement
> Lack of response rates reflective of activity means data use is limited
> Restrictive methodologies is some areas impacting on accessibility

Mitigations
> Quarterly divisional patient experience review meetings
> Weekly meetings with IWGC
> Triangulation of data - Roundtable Meeting in place
> Patient Experience Manager to be released from complaints, to support fully from end of September

Workforce - Vacancies



Jul 2022
18.5%

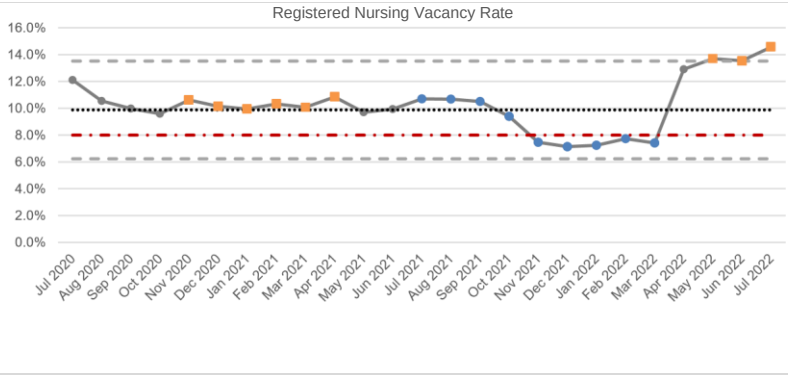
Target
8.0%

Variance

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

Assurance

Inconsistently hitting passing and failing the target



Jul 2022
14.6%

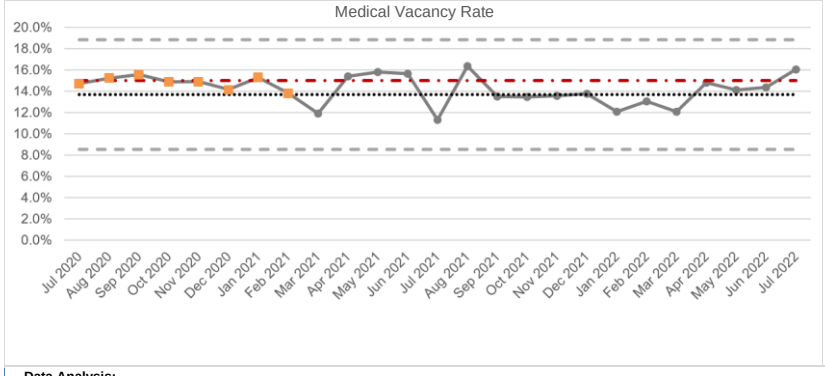
Target
8.0%

Variance

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

Assurance

Inconsistently hitting passing and failing the target



Jul 2022
16.1%

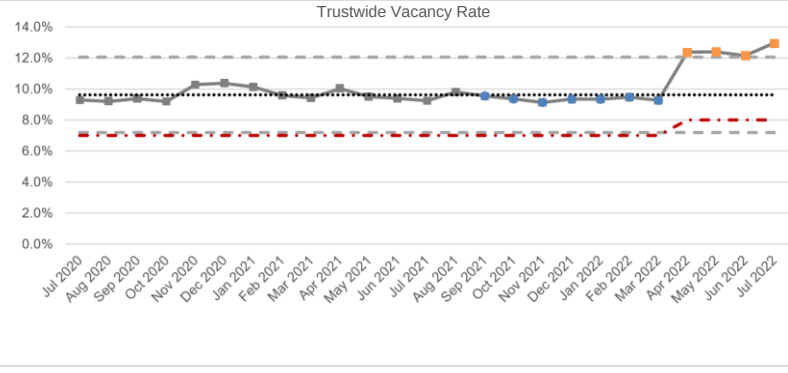
Target
15.0%

Variance

Common cause - no significant change

Assurance

Inconsistently hitting passing and failing the target



Jul 2022
13.0%

Target
8.0%

Variance

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

Assurance

Inconsistently hitting passing and failing the target

Data Analysis:
Unregistered Nursing Vacancies: After a significant reduction last spring, the rate has gradually been increasing and has now risen outside of the expected range.
Registered Nursing Vacancies: After a period of improvement, performance has started to deteriorate in the last four months and is now recording concern.
Medical Vacancy Rate: Performance has been stable and as expected for over a year. The target can be expected to be achieved and failed at random.
Trustwide Vacancy Rate: Performance has fallen outside the expected range over the past four months after consistently falling within the expected range. Current data indicates that the target will not be met without action.

Commentary:
Issues/Risks: Retention of HCAs. Unfamiliarity with the role and expectations of what the role entails influencing decisions to leave, current high vacancy rate.

Mitigations: A project group led by the Chief Nurse's office to oversee activity and consider mitigating actions. A pool of appointed HCAs has been appointed with circa 40 candidates currently in the pool. Four recruitment events are taking place in September with a view to appointing circa 130 HCAs to start between October and December 2022. HCA induction capacity has been increased to allow rapid onboarding of new HCAs from the September recruitment events. A Rapid Project Improvement Workshop is underway, supported by QI and NHSi/e to review the whole Unregistered Nursing process from sourcing to induction and retention. Stakeholder engagement has taken place, with a 30/60/90 day action plan currently underway considering various elements including establishment control, approval of references, attraction and information.

Actions: Continue mass recruitment events. Complete RPIW process actions.

Issues/Risks: Availability of accomodation can delay recruitment processes. CPD Team capacity to support international nurses. Significant increase in cost of flights adding pressure to international nurses.

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

Mitigations: A project group led by the Chief Nurses office to oversee all activities. Newly qualified nurse (NQN) recruitment for 21/22 was successful, and attendance at university events to further strengthen NQN engagement. International nurses - ongoing recruitment of international nurses with cohorts planned for start.. A funding bid has been successful for further funding to support recruitment, with funds awarded to support the arrival of 90 international nurses between January and December 2022. This figure has been reduced from 120 linked to NHSi/e funding, however plans still in place to make up the remainder in the financial year before March 23 Awaiting outcome of business case to increase CPD team capacity to facilitate meeting target for international nurses. Nursing workforce plan aiming to facilitate start of 120 international nurses, 80 NQNs, 70 local, and to reduce turnover. Nursing career frameworks and introduction of nursing apprenticeships will see reliance on international nurse sourcing reduce longer term.

Commentary Vacancies Cont/d:
Issues/Risks: Availability of accomodation can delay recruitment processes. Pausing of MTI candidates due t

Actions: Ongoing recruitment activity across specialties. Resolving MTI issues

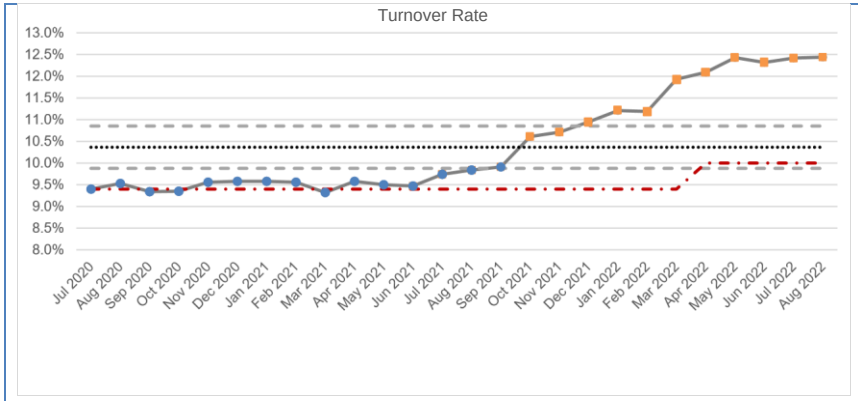
Mitigations: Recruitment team continuing to engage with candidates.. A pipeline of 57 medical staff has bee landlords has been established to support accomodation needs where the Trust is unable to accommo accommodation team to free up onsite accommodation. Accommodation team have given notice to long term starters and a change of policy relating to length of stay. Recruitment team are meeting the accommoda accommodation needs. Junior Doctors intake between August and October has a fill rate of circa 82%, with ba with the Royal College to address the issues raised, including reviewing induction and support to MTI candidat

Issues/Risks: Travel difficulties are delaying starts for some new employees..Availability of accomodation can delay recruitment processes Actions:

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

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

Workforce - Staffing Levels



Aug 2022	Target	Variance	Assurance
12.4%	**10.0%**	Special cause of concerning nature or higher pressure due to higher values	Inconsistently hitting passing and failing the target

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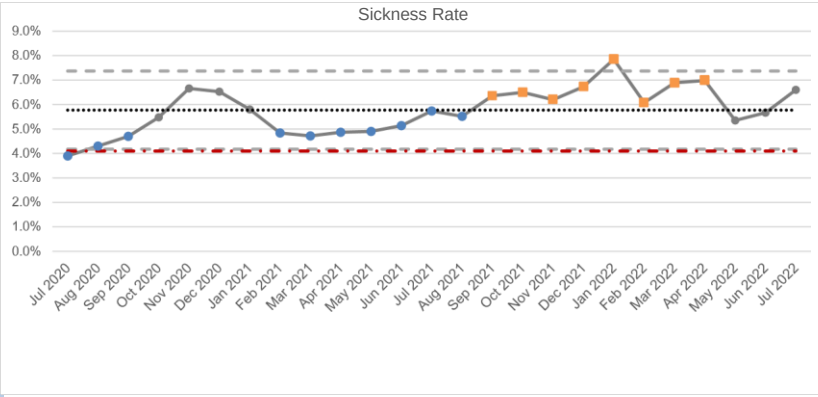

Jul 2022	Target	Variance	Assurance
6.6%	**4.1%**	Common cause - no significant change	Consistently failing the target

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Data Analysis:
Turnover Rate: After having stayed fairly stable during the peak of pandemic, the turnover rate has been steadily increasing since the end of summer 2021 and has recorded concerning performance for the past eleven months.
Sickness Rate: This indicator has recorded a general increase in sickness rates since last summer but usually falls within the expected range for the data. Current data indicates that the target will not be met without action.

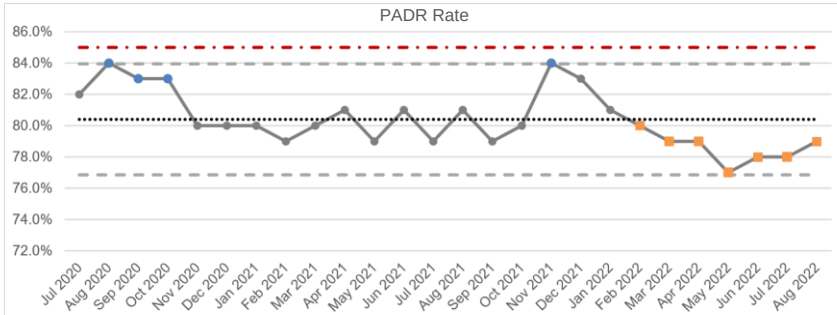
Commentary:

The data over the last 4 Months (May-August) shows the data for turnover has begun to level out. From the data (to low uptake of exit questionnaires) , from the data we do have indicates that career development, culture, behaviour may be reasons. Retention will be a key focus of our culture transformation programme.

The Culture Transformation launch event took place on 4th August, own the working group workstreams is focused on recruitment and retention will undertake this work. Alongside this the Trust has set out a Nursing career framework utilising the apprenticeship levey to develop a Nursing workforce of the future

The Trust have recently revised the Sickness Management policy and have rolled out training amongst managers to enable quicker return to work process where an individual is well enough to do so, and also have more meaningful conversations with staff to ensure that all is being done to keep staff well at work. We know respiratory illnesses are currently prevalent within the community which is maintaining higher levels of sickness but the Trust are also experiencing high levels of stress and anxiety and musculoskeletal related illness. In addition, monthly sickness reports are produced from ESR to ensure that we are aware of all the cases and that they are being apporpriately managed.

Workforce - Staff Development - PADR



Aug 2022
79.0%

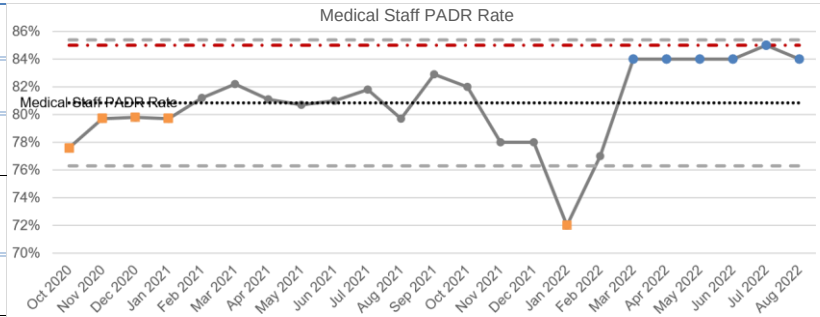
Target
85.0%

Variance

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

Assurance

Consistently failing the target



Aug 2022
84.0%

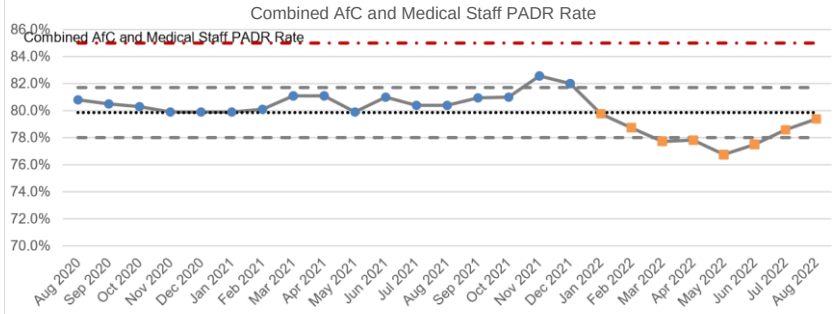
Target
85.0%

Variance

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

Assurance

Inconsistently hitting passing and failing the target



Aug 2022
79.4%

Target
85.0%

Variance

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

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Assurance

Consistently failing the target

Data Analysis:
PADR Rate: Performance has been stable and is within the expected range since March 21, however current data indicates that the target will not be met without action.
Medical Staff PADR Rate: Performance has been predominantly within the expected range for the past two years with an improvement seen over recent months. Current data indicates that the target will not be met without action.
Combined AfC and Medical Staff PADR Rate: Following eighteen months of stable or improving figures, performance has deteriorated in recent months and is now recording concern since January 22. Current data indicates that the target will not be met without action.

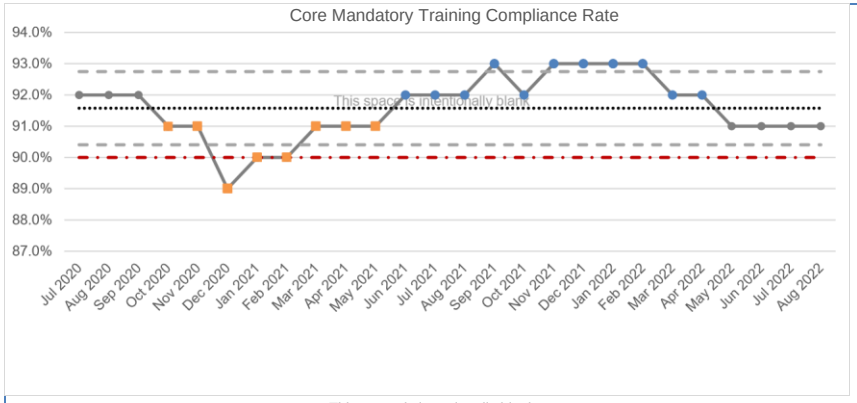
Commentary:
The ETD Team are preparing the refreshed Corporate Induction and new People Leader Induction, both of which include clear communications on the importance of completing and maintaining statutory and mandatory training. The forthcoming Leadership Individual Development Assessment (LIDA) online inventory includes assessing competency in the use of ESR for managing teams, including PADR and statutory and mandatory training compliance.Operational challenges continue to impact on staff capacity to be released to complete training/PADRs.

ETD are also working closely with the ESR Team to monitor compliance through Power BI for MT and PADR. This will allow managers to look at real time data so it is imperative that our data is accurate. Power BI is at the final sign off stage.

Over the last couple of years COVID has played a significant role within the medical appraisal process. National guidance and support was received for Doctors appraisals across the NHS from the GMC and NHSE/I that outlined how Trusts could support their doctors through their annual appraisals which resulted in doctors who had scheduled appraisals due between December and February having the ability to delay their appraisal to a later date. To date, the impacts of the pandemic on the appraisal process, i.e doctor's "catching up" with their appraisal, has levelled out and normal operations are now resuming. The Trust has also agreed and begun implementation from April 2023 that all doctors will have their scheduled appraisals between April and December as currently there is an imbalance of aprpaisal activity, i.e, one third of all doctors due for appraisal are schedule between December and the following February which puts pressure on our medical appraisers schedules, who are also senior medical staff with clinical commitments. This piece of work wil enable the Trust to have a balance of appraisal activity and will allow those senior medical staff, who are also appraisers, and medical staff generally to concentrate on patient activity during these months. This work has begun and doctors are being notified with 12 months advance notification that their appraisal month will change in 2023-2024. No doctor will have an appraisal between January and March going from 2023 onwards.

Staff Development - PADR

Workforce - Staff Development - Training



Aug 2022
91.0%

Target
90.0%

Variance

Common cause - no significant change

Assurance

Consistently passing the target

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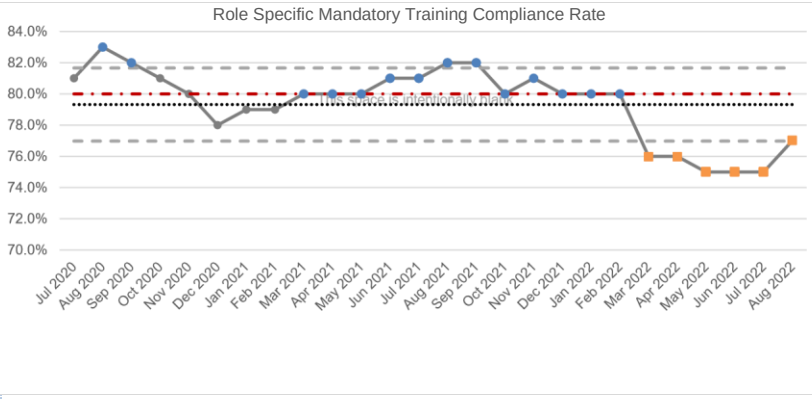

Aug 2022
77.0%

Target
80.0%

Variance

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

Assurance

Inconsistently hitting passing and failing the target

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Data Analysis:
Core Mandatory Training: Performance has recorded improvement for almost a year and the target has been consistently achieved during this time. The indicator can be reliably expected to achieve the target.
Role Specific Mandatory Training: After a long run of stable and improving performance, this indicator has deteriorated over the past six months and is now outside of the expected range, recording a concern. The target is expected to be randomly achieved and not achieved.

Commentary:
The ETD Team are preparing the refreshed Corporate Induction and new People Leader Induction, both of which include clear communications on the importance of completing and maintaining statutory and mandatory training. The forthcoming Leadership Individual Development Assessment (LIDA) online inventory includes assessing competency in the use of ESR for managing teams, including PADR and statutory and mandatory training compliance.Operational challenges continue to impact on staff capacity to be released to complete training/PADRs.

ETD Team are completing a deep dive on Stat and Mand training and are currently working with the MT Leads to look at the mapping of competencies to make sure all new and existing positions are mapped correctly. The team are also working with the HRBP's to target areas with low compliance. A data cleanse within ESR is being completed for Resus Training to streamline the process of booking onto relevant courses and also setting up Learning Pathways for new starters to attend classroom delivery sessions firstly, and then alternate elearning and classroom sessions from then on.

The work the ETD Team are completing will help with compliance as the process for staff to find the relevant courses will be easier and streamlining the mapping of competencies.

ETD are also working closely with the ESR Team to monitor compliance through Power BI for MT and PADR. This will allow managers to look at real time data so it is imperative that our data is accurate. Power BI is at the final sign off stage.

Appendix A - Benchmarking

Centiles from the Public View website have been provided where available (these are not available for all indicators in the IPR).
The Centile is calculated from the relative rank of an organisation within the total set of reporting organisations. The number can be used to evaluate the relative standing of an organisation within all reporting organisation)s. If NLAG's Centile is 96, if there were 100 organisations, then 4 of them would be performing better than NLAG. The colour shading is intended to be a visual representation of the ranking of NLAG (red indicates most organisations are performing better than NLAG, green indicates NLAG is performing better than many organisations. Amber shows NLAG is in the mid range). Note: Organisations which fail to report data for the period under study are included and are treated as the lowest possible values.

Source: https://publicview.health as at 13/09/2022

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

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Access & Flow	Planned	% Under 18 Weeks Incomplete RTT Pathways	Aug 2022	66.2%	92.0%	55	77 / 169	Jul 2022
	Planned	Number of Incomplete RTT pathways 52 weeks	Aug 2022	364	0	63	63 / 169	Jul 2022
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Aug 2022	32.8%	1.0%	34	102 / 155	Jul 2022
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Aug 2022	39.6%	85.0%	16	114 / 136	Jul 2022
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Aug 2022	59.1%	95.0%	16	109 / 130	Aug 2022
	Urgent Care	Number Of Emergency Department Attendances	Aug 2022	12,347	No Target	48	76 / 144	Aug 2022
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Aug 2022	563	0	11	135 / 152	Aug 2022
	Flow	Bed Occupancy Rate (General & Acute)	Aug 2022	93.2%	92.0%	32	107 / 157	Q1 22/23
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Aug 2022	7.1%	5.00%	60	66 / 163	Jul 2022
	COVID	Number of COVID patients in ICU beds (Weekly)	Aug 2022	0	No Target		97 / 203	Aug 2022
	COVID	Number of COVID patients in other beds (Weekly)	Aug 2022	15	No Target	52		

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Quality & Safety	Infection Control	Number of MRSA Infections	Jul 2022	0.000	No Target	100	1 / 137	Jun 2022
	Infection Control	Number of E Coli Infections	Jul 2022	0.300	No Target	88	17 / 137	Jun 2022
	Infection Control	Number of Trust Attributed C-Difficile Infections	Jul 2022	0.100	No Target	90	14 / 137	Jun 2022
	Infection Control	Number of MSSA Infections	Jul 2022	0.050	No Target	63	51 / 137	Jun 2022
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Mar 2022	102.7	As expected	41	72 / 121	Apr 2022
	Safe Care	Number of Serious Incidents Raised in Month	Jun 2022	7	No Target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Jul 2022	7.9	No Target	27	133 / 182	Jun 2022
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Jul 2022	95.8%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	May 2022	8.0	No Target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Number of Positive Inpatient Scores	Jul 2022	736 of 788	No Target	45	73 / 133	Jun 2022

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Jul 2022	6.6%	4.1%	25	160 / 214	Apr 2022

Appendix B - Access and Flow (F&P Sub-Committee)

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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Planned	Percentage Under 18 Weeks Incomplete RTT Pathways*	Aug 2022	66.2%	92.0%	Alert			Board
	Number of Incomplete RTT pathways 52 weeks*	Aug 2022	364	0	Alert			Board
	Total Inpatient Waiting List Size	Aug 2022	10,673	11,563	Alert			Board

	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Aug 2022	32.8%	1.0%	**Alert**			Board
	Number of Incomplete RTT Pathways*	Aug 2022	36,422	No Target	**Alert**		n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Aug 2022	16,557	No Target			n/a	FPC
	% of Inpatient Live Waiting List Risk Stratified	Aug 2022	100.0%	99.0%				FPC
	% of Inpatient Live Waiting List Overdue Risk Strat Date	Aug 2022	43.9%	37%				FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Aug 2022	33,762	9,000	**Alert**			Board
	Outpatient Did Not Attend (DNA) Rate	Aug 2022	7.1%	5.00%	**Alert**			Board
	% Outpatient Non Face To Face Attendances	Aug 2022	26.6%	25.00%	**Highlight**			Board
	% Outpatient summary letters with GPs within 7 days	Aug 2022	29.3%	50.0%	**Alert**			FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Aug 2022	84.9%	99.0%	**Highlight**			FPC
	% of Outpatient Waiting List Overdue Risk Strat Date (New and Review)	Aug 2022	30.9%	23.0%		n/a	n/a	FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Aug 2022	39.6%	85.0%	**Alert**			Board
	Cancer Waiting Times - 104+ Days Backlog*	Aug 2022	40	0	**Alert**			Board
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Aug 2022	12.5%	75.0%	**Alert**			Board
	Cancer Request To Test In 14 Days*	Aug 2022	82.8%	100.0%	**Alert**			Board
	Cancer Waiting Times - 2 Week Wait*	Aug 2022	91.6%	93.0%	**Alert**			FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Aug 2022	91.3%	93.0%				FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Aug 2022	63.3%	75.0%				FPC
	Cancer Waiting Times - 31 Day First Treatment*	Aug 2022	88.4%	96.0%	**Alert**			FPC
	Cancer Waiting Times - 31 Day Surgery*	Aug 2022	82.4%	94.0%				FPC
	Cancer Waiting Times - 31 Day Drugs*	Aug 2022	97.9%	98.0%				FPC
	Cancer Waiting Times - 62 day Screening*	Aug 2022	72.7%	90.0%				FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Aug 2022	59.1%	95.0%	**Alert**			Board
	Number Of Emergency Department Attendances	Aug 2022	12,347	No Target	**Alert**		n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Aug 2022	738	0	**Alert**			Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Aug 2022	563	0	**Alert**			Board
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Aug 2022	390	0	**Alert**			Board
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Aug 2022	40.3%	40.0%	**Alert**			Board
	% of Extended Stay Patients 21+ days	Aug 2022	13.2%	12.0%	**Alert**			Board
	Inpatient Elective Average Length Of Stay	Aug 2022	2.2	2.5				Board
	Inpatient Non Elective Average Length Of Stay	Aug 2022	3.9	3.9				Board
	Number of Medical Patients Occupying Non-Medical Wards	Aug 2022	183	No Target			n/a	Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Aug 2022	89.9%	90.0%				Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Aug 2022	16.5%	30.0%	**Alert**			Board
	Bed Occupancy Rate (G&A)	Aug 2022	93.2%	92.0%				Board
	Percentage of patients re-admitted as an emergency within 30 days	Aug 2022	7.6%	No Target			n/a	FPC
	% of Extended Stay Patients 7+ days	Aug 2022	47.1%	No Target	**Alert**		n/a	FPC
	% of Extended Stay Patients 14+ days	Aug 2022	25.6%	No Target	**Alert**		n/a	FPC

COVID	Number of COVID patients in ICU beds (Weekly)	Aug 2022	0	No Target			n/a	Board
	Number of COVID patients in other beds (Weekly)	Aug 2022	15	No Target			n/a	Board
	% COVID staff absences (Weekly)	Aug 2022	7.9%	No Target			n/a	Board

Appendix B - Quality and Safety

Northern Lincolnshire and Goole NHS Foundation Trust

Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)
*The figures for July 2022 are unvalidated

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Jul 2022	0.00	see analysis			n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Jul 2022	0.30	see analysis			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Jul 2022	0.10	see analysis			n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Jul 2022	0.05	see analysis			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Jul 2022	0.55	see analysis			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Jun 2022	102.9	As expected			As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Mar 2022	102.7	As expected			As expected	Board
	Number of patients dying within 24 hours of admission to hospital	Aug 2022	14	No target			n/a	Q&S
	Number of emergency admissions for people in the last 3 months of life	Aug 2022	128	No target			n/a	Q&S
	Out Of Hospital (OOH) SHMI	Apr 2022	137.8	110.0	**Alert**			Q&S
	Structured Judgement Reviews - Rate Completed of those required	Jul 2022	0.0%	100.0%	**Alert**			Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Jul 2022	100.0%	No target			n/a	Board
	Number of Serious Incidents raised in month	Jun 2022	7	No target			n/a	Board
	Occurrence of 'Never Events' *(Number)*	Jun 2022	0	0		n/a	n/a	Board
	Duty of Candour Rate	Jun 2022	100.0%	100.0%				Board
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Jul 2022	6.2	No target			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Jul 2022	3.1	No target			n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Jul 2022	95.8%	95.0%	**Alert**			Board
	Care Hours Per Patient Day (CHPPD)	Jul 2022	7.9	No target	**Alert**		n/a	Board
	Mixed Sex Accommodation Breaches	Jul 2022	22.0	0		n/a	n/a	Board
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	May 2022	8.0	No target			n/a	Board
	Complaints Responded to on time	May 2022	77.0%	85.0%	**Highlight**			Board
	Friends and Family Test (FFT)							
	Number of Positive Inpatient Scores	Jul 2022	736 out of 788	No target		n/a	n/a	Board
	Number of Positive A&E Scores*	Jul 2022	207 out of 347	No target		n/a	n/a	Board

	Number of Positive Community Scores	Jul 2022	77 out of 85	No target		n/a	n/a	Board
	Number of Positive Outpatient Scores	Jul 2022	47 out of 54	No target		n/a	n/a	Board
	Number of Maternity Antenatal Scores	Jul 2022	28 out of 32	No target		n/a	n/a	Board
	Number of Maternity Birth Scores	Jul 2022	120 out of 124	No target		n/a	n/a	Board
	Number of Maternity Postnatal Scores	Jul 2022	2 out of 2	No target		n/a	n/a	Board
	Number of Maternity Ward Scores	Jul 2022	46 out of 54	No target		n/a	n/a	Board
Observations	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Aug 2022	90.9%	90.0%				Q&S
	Percentage of Child Observations Recorded On Time (with a 30 min grace)	Aug 2022	100.0%	90.0%				Q&S
	Escalation of NEWS in line with Policy	Jun 2022	3.0%	No target		n/a	n/a	Q&S
	Clinical assessment undertaken within 15 minutes of arrival in ED	Jul 2022	40.0%	90.0%		n/a	n/a	Q&S
Sepsis	Rate of Adults Screened for Sepsis using the Adult Sepsis Screening and Action Tool *(based on Manual Audit)*	Jun 2022	47.0%	90.0%		n/a	n/a	Q&S
	Rate of those who had the Sepsis Six completed within 1 hour for patients who have a Red Flag - Adults *(based on Manual Audit)*	Jun 2022	0.0%	90.0%		n/a	n/a	Q&S
	Rate of Children Screened for Sepsis using the Sepsis Screening and Action Tool	Jun 2022	12.0%	90.0%		n/a	n/a	Q&S
	Rate of Children who had the Sepsis Six completed within 1 hour for patients who have a Red Flag - Children	Jun 2022	6.0%	90.0%		n/a	n/a	Q&S
Prescribing	Percentage of patients admitted to IAAU with an actual, estimated or patient reported weight recorded on EPMA or WebV *(based on Manual Audit)*	Jul 2022	65.0%	No target		n/a	n/a	Q&S
	Percentage of patients admitted to IAAU with an ACTUAL weight recorded on EPMA or WebV *(based on Manual Audit)*	Jul 2022	18.0%	No target		n/a	n/a	Q&S
	Percentage of patients admitted to IAAU whose weight was 50kg (+/- 6kg) who complied with prescribing weight for dosing standard	Jul 2022	83.0%	No target		n/a	n/a	Q&S
	Reduction in patients prescribed an antibiotic	Mar 2022	40.7%	50.0%		n/a	n/a	Q&S
	Percentage of Medication Omissions for Ward Areas Using EPMA	Jul 2022	2.0%	No target			n/a	Q&S
	Antibiotic prescriptions have evidence of a review within 72 hours	Mar 2022	69.1%	70.0%		n/a	n/a	Q&S

Appendix B - Workforce

Northern Lincolnshire and Goole NHS Foundation Trust

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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Vacancies	Unregistered Nurse Vacancy Rate	Jul 2022	18.5%	8.0%	Alert	H	?	Board
	Registered Nurse Vacancy Rate	Jul 2022	14.6%	8.0%	Alert	H	?	Board
	Medical Vacancy Rate	Jul 2022	16.1%	15.0%			?	Board
	Trustwide Vacancy Rate	Jul 2022	13.0%	8.0%	Alert	H	?	Board
Staffing Levels	Turnover Rate	Aug 2022	12.4%	10.0%	Alert	H	?	Board
	Sickness Rate	Jul 2022	6.6%	4.1%	Alert		F	Board
Staff Development	PADR Rate	Aug 2022	79.0%	85.0%	Alert	L	?	Board
	Medical Staff PADR Rate	Aug 2022	84.0%	85.0%		H	?	Board
	Combined AfC and Medical Staff PADR Rate	Aug 2022	79.4%	85.0%	Alert	L	F	Board
	Core Mandatory Training Compliance Rate	Aug 2022	91.0%	90.0%			P	Board
	Role Specific Mandatory Training Compliance Rate	Aug 2022	77.0%	80.0%	Alert	L	?	Board
Disciplinary	Number of Disciplinary Cases Live in Month	Aug 2022	0	No Target		L	n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Aug 2022	0	12		L	?	WFC
	Number of Suspensions Live in Month	Aug 2022	1	No Target		L	n/a	WFC
	Average Length of Suspension (Weeks)	Aug 2022	0	No Target		L	n/a	WFC

NLG(22)167

Name of the Meeting	**Trust Board of Director - Public**	
Date of the Meeting	4 October 2022	
Director Lead	Fiona Osborne, Non-Executive Director and Chair of Quality and Safety Committee	
Contact Officer/Author	As above	
Title of the Report	**Quality and Safety Committee Highlight Report (August and September)**	
Purpose of the Report and Executive Summary (to include recommendations)	The Trust board are asked to receive the Quality and Safety Committee highlight report and note: - Staffing remains a concern particularly in pharmacy, nursing and midwifery - The committee has increased its level of scrutiny on cancer services - The serious incident in maternity, where there was significant learning.	
Background Information and/or Supporting Document(s) (if applicable)	None	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	None	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None	
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Highlight Report to Trust Board

Report for Trust Board Meeting on:	October 2022
Report From:	Quality & Safety Committee 23 August and 27 September 2022

Highlight Report:

In August the Committee received a paper on the Oncology pathway shared with Hull Teaching Hospitals. The Committee was encouraged by the work underway to address issues but noted the concern in relation to radiotherapy was evident in the Oncology report and had been raised at the July meeting. It was noted that Hull Teaching Hospitals were working on a contingency plan.

In September the Committee received reports on lung cancer and skin cancer. It was identified one patient had an increase in the grade of their lung cancer due to delays.

Pathlinks presented a report on Governance and flagged the work to address the findings of the Human Tissue Authority in the Mortuary, a wax shortage and concerns with the DARTcom system to request tests. While immediate actions had been put in place to mitigate the risk to the IT system, it was recognized that due to age and lack of company support, the system remained a risk.

Pharmacy presented both a Governance report and the Annual Medicines Optimisation Report. The committee ratified the Medicines Optimisation Report, noting the progress on assurance on the Safe and Secure audit and on antimicrobials, but has referred a concern relating to Pharmacy staffing through to the Workforce Committee.

Surgery, Critical Care and Clinical Sciences division presented a governance report in September discussing the work on the deteriorating patient and sepsis. It was noted that further work was needed to translate the improvements being made into the Integrated Performance Report (IPR) data & narrative.

The Committee noted the progress on the Care Quality Commission (CQC) improvement plan.

A concern was raised through both the IPR and the CLIP report, in that the audit of patient weight was not showing improvements. The Committee supported the proposal to take the IPR and this issue to Trust Management Board (TMB).

The Committee recognized that the C-difficile target of 21 cases for the year would be difficult to achieve given the widespread use of antibiotics during the waves of Covid-19.

The Nursing Assurance report noted that staffing remained a concern for both nurses and midwives, with an increase in dependent patients. This has been recognized as a potential contributor to an increase in falls.

In August the Committee noted a new Serious Incident in Maternity, where a baby died following premature labour. This was declared due to the potential for learning, as the mother could have been referred to a new clinic which tried to support those at risk of

premature labour. It was felt there was learning in regard to the process for embedding a new service quickly. In September, a further Serious Incident was reported in Maternity, where a baby received a fractured skull following Caesarian section. Learning had been identified in the use of the fetal pillow which had been introduced on one site but not the site where the incident occurred. The Committee noted that all Never Event investigations had now concluded, and the actions and learning were being shared.

The Committee received a paper highlighting the changes required for Patient Safety Incident Response Framework (PSIRF) by September 2023 with a broad timetable to meet the requirement.

Integrated themes in the CLIP report continued to be assigned to documentation, management of care, communication, medication and discharge. The Committee were encouraged that End of Life was no longer appearing within the themes.

The Committee approved the removal of deviations from National Institute for Health & Care Excellence (NICE) NG38 (fractures) and NICE NG98 (hearing loss) but approved the continuation of NG128 (Stroke) anticipating a request to remove that within the next 6 months. All the deviations had been relating to MRI capacity, which was no longer a barrier to compliance, but a pathway was needed for safe implementation of the process for NG128.

The Quality Governance Group highlight report noted the annual Organ Donation report, which showed that the Trust had performed well in ensuring that the 5 potential donors had all followed the appropriate pathways to enable donation.

The Committee supported a proposal to amend the IPR for Structured Judgment Review (SJR) completion, to ensure that the data provided was four months in arrears to report delays in completion rather than including the time before the SJRs were due.

Confirm or Challenge of the Board Assurance Framework (BAF):

The next BAF review is due in October.

Action Required by the Trust Board:

The Trust Board are asked to receive the Quality and Safety Committee highlight report and note:

- Staffing remains a concern particularly in pharmacy, nursing and midwifery
- The committee has increased its level of scrutiny on cancer service
- The serious incident in maternity, where there was significant learning.

Fiona Osborne
Non-Executive Director

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 4 October 2022
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Linda Barker, Head of Infection Prevention & Control
Title of the Report	**Infection Control Annual Report**
Purpose of the Report and Executive Summary (to include recommendations)	• 20 cases of Hospital Onset Healthcare Associated • C. difficile cases which is a 29% reduction to last year and well within the allocated trajectory. No lapses in care identified. • Nil Hospital Onset cases of MRSA Bacteraemia • Gram negative blood stream infections remained a challenge, however a good performance achieved in • E. Coli Bacteraemia compared to peers • Good performance with orthopaedic primary hip and knee surgical site infections • Undertook the Infection Prevention and Control Board Assurance Framework Assessment which showed overall good performance • Prioritisation given to the management of COVID-19 surges caused by new variants – flow of new national guidance managed in a proactive robust manner • IPC shortlisted for a HSJ Patient Safety Award for management of COVID-19 • IPC presentation of a poster at International Conference (ECCMID) in Lisbon **Recommendation** Estates strategy, future builds and refurbishments to consider IPC requirements including enhanced ventilation, oxygen demands and isolation capacity.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Quality & Safety Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
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	☐ 1 - 1.6 **To be a good employer:** ☐ 2	☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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Northern Lincolnshire and Goole NHS
NHS Foundation Trust

INFECTION CONTROL ANNUAL REPORT
2021-22

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 2021 to March 2022.

The focus this year has been to continue the work around nosocomial infections, invasive devices, and antimicrobial stewardship. However, with the continuation of SARS CoV-2 variants of concern, managing the surge caused by new variants has also been the priority for the team and Trust for the last 12 months. The team continue to work closely with various colleagues such as Hotel services, procurement, estates, operational teams, laboratory and many other services to best manage the pandemic. Work also continues with the capital team in the design of new emergency care builds to consider the latest evidence around containment of SARS CoV-2. The management of COVID-19 continues to be a substantial challenge and significant strain on the IPC team compounded by a demanding on call rota. The establishment and continuation of the incident control centre has allowed the pandemic flow of new guidance to be managed in a proactive robust manner with excellent engagement from clinical staff.

Overall, there have been several achievements in the past twelve months, which include:

Performance

- There were no lapses/care associated with C.difficile infection from cases reviewed. Due to the pandemic multidisciplinary reviews were suspended and undertaken by the IPC team.
- 20 cases of Hospital Onset Healthcare Associate C.difficile cases which is well within the allocated trajectory and 29% reduction to last year.
- There have been no hospital onset cases of MRSA bacteraemia detected
- Gram negative blood stream infections which remains a challenge, however we have achieved good performance in E.coli bacteraemia cases compared to our peers.
- Good performance with orthopaedic primary hip & knee surgical site infections and infection rate in line with national average.
- 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 but progress being made and heading in the right direction.
- IPC shortlisted for a HSJ Patient safety Award for management of COVID
- Presentation of a poster at international conference (ECCMID)
- Continuation of the IPC newsletter produced bimonthly.

Governance

- IPC data reviewed and challenged at the Nursing Metrics Board
- Developed systems using Power BI to feedback ward / dept performance against KPIs.
- Undertook the Infection prevention and control board assurance framework assessment on the latest versions which showed overall good compliance
- Undertaken point prevalence surveillance across acute adult wards.
- The Infection Prevention & Control committee continued to meet throughout the pandemic.
- Providing Board with regular updates on IPC BAF

Areas for further improvement and support include:

There remain several challenges for the Trust that needs to be considered going forward.

The lack of single rooms across the trust have partly been addressed however SGH continues to be a challenge due to the historic closure of the Coronation wards and loss of 11 single rooms. The planned opening of ward 25 which has 14 single rooms will help address the imbalance and useful for future winter planning arrangements.

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. The physical layout of this unit is not conducive to segregate of staff.

As part of the estate's 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 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 widespread within the Trust as such have relied on the purchase of HEPA filtration units.

There are several six bedded bays at DPOW that currently do not have a wash hand basin in place. This needs to be factored in for future upgrade plans and indeed are now planned to be addressed.

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, with the position terminating in June 2021. This resulted in the Deputy DIPC and IPC team to pick up the additional COVID related workload.

The deep clean schedule unfortunately is subjected to operational pressures as such frequently cancelled. This needs to be led by divisions going forward and seen as a quality indicator within local audits such as 15 steps.

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 2021 to March 2022. Healthcare associated infection remains a top priority for the public, patients and staff and remains one of the Trust's strategic objectives 'to provide treatment, care and support which is as safe, clinically effective, and timely as possible'. Avoidable infections are not only potentially devastating for patients and healthcare staff, but they also consume valuable healthcare resources and impact on antimicrobial resistance pressure. Investment in infection prevention and control remains both necessary and cost effective and this has been demonstrated during the last 2 years in managing the COVID-19 pandemic.

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 2021-22 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 other related guidance e.g. IPC COVID-19 Board Assurance Framework. 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).

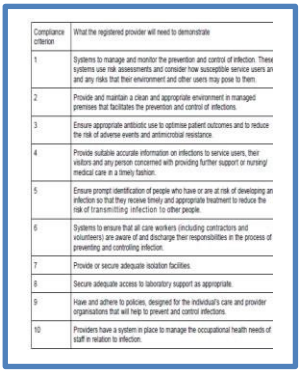
Infection prevention and control is the responsibility of everyone in the healthcare community and is only truly successful when everyone works together. Success is the product of everyone getting everything right first time, every time. This annual report shows how we are performing, where we do well and where we would like to do better. Due to the continuation of the COVID-19 pandemic much of the normal IPC activities have had to be prioritised yet again. However, some business-as-usual activities were still achieved and will be elaborated on further.

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 2020-23 incorporating the annual work

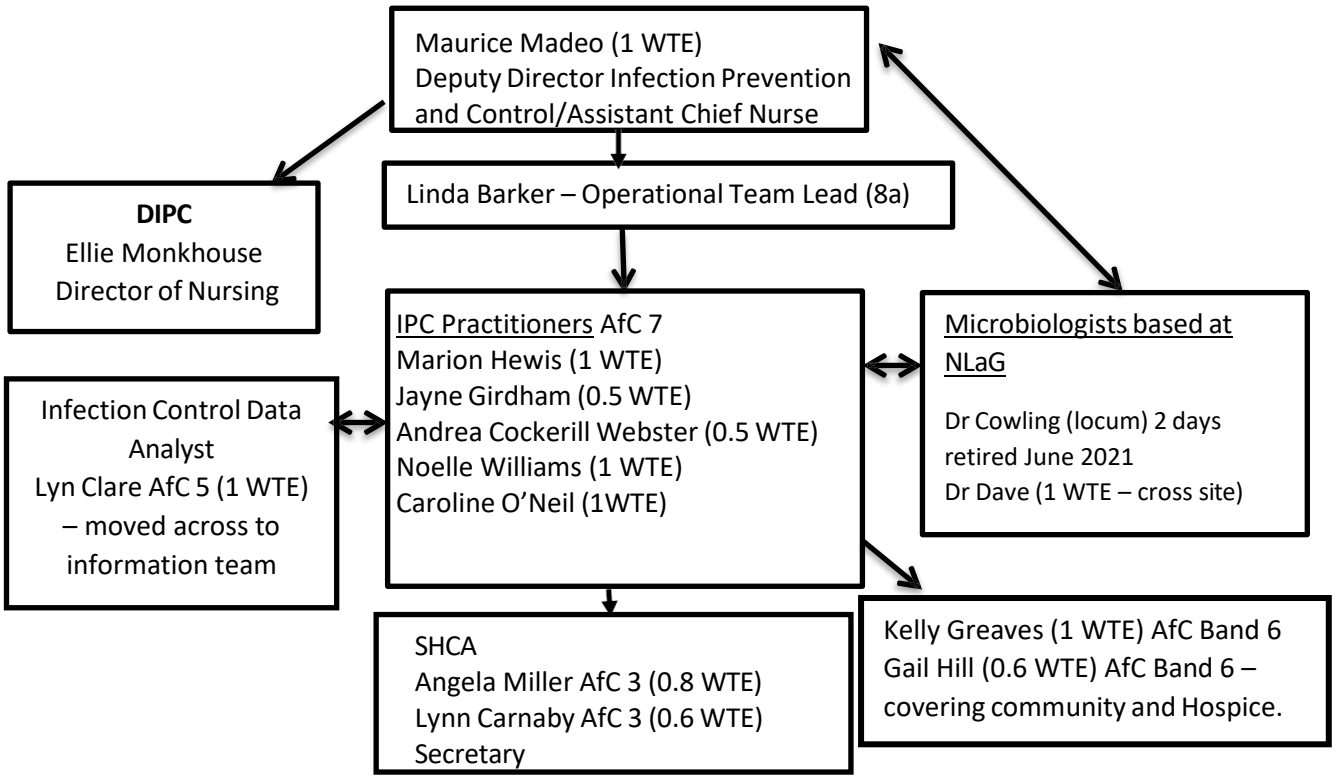
plan.



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 to provide on-site presence continues to have challenges with recruitment. The use of virtual meetings has helped to mitigate some of these issues especially during the COVID pandemic. However, since June there has not been a consultant microbiologist regularly present on the Strategic Incident forum. The limited availability of onsite consultant microbiologists has severely stretched the amount of ward rounds undertaken. A weekly Trust wide antimicrobial stewardship round is undertaken by the consultant antimicrobial pharmacist and consultant medical microbiologist which has been well received by colleagues.

Infection Prevention & Control Team at March 2022



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. The team has welcomed 2 new members, allowing the overall team structure to be reviewed, culminating in the recruitment of an associate nurse due to commence May 2022 to replace a vacant band 7 post. The team has also taken on a service level agreement to provide cover to the local hospice unit in Scunthorpe.

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 last 12 months the main remit was to continue with the management of the ongoing pandemic via the Incident Control Centre, where the Deputy DIPC and Consultant Microbiologist were core members. The ICC initially met daily, but this was deescalated to twice a week from the summer.

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 Antimicrobials Pharmacist, CCG representatives, Estates / facilities, nominated deputy for medical director and others co-opted as required. The attendance at IPCC has been variable as expected due to competing pandemic and OPEL pressures. The establishment of the Incident Control Centre has facilitated in the cascade of key messages and the many national updates received at short notice.

Surveillance of Healthcare Associated Infection

One of the main elements of Infection Prevention and Control 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

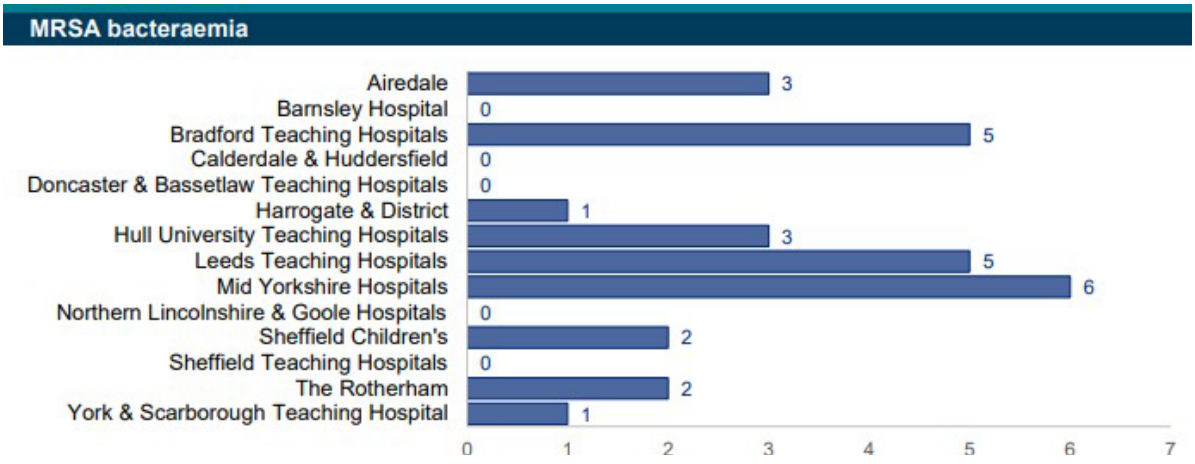
Nationally, there remains a zero threshold for preventable MRSA bacteraemia cases. Thus, once again the Trust had a trajectory of zero avoidable hospital-acquired cases. As in previous years, every case of MRSA bacteraemia undergoes a rigorous Post Infection Review Process to help identify any obvious root causes and learn lessons. I am pleased to report the Trust has not detected any hospital onset MRSA bacteraemia case for over 16 months and the 2 community onset cases detected had samples taken in ECC with no hospital links.

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
2021-2022	0	0

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 MARCH 2022



Clostridioides difficile (formerly known as Clostridium difficile) Infections

FIGURE 2 BREAKDOWN OF C.DIFFICILE CASES BY DIVISIONS

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.

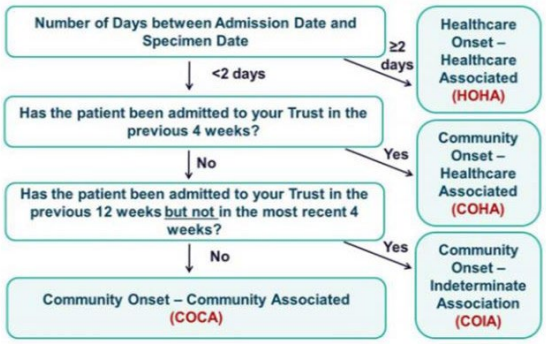
C. difficile cases by Site, Division and Ward

Financial Year	2021/22												Total
Site	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	
DPOW	1	1	1	0	2	0	0	1	0	0	1	1	8	8
Medicine	1	0	1	0	2	0	0	1	0	0	1	1	7	7
Surgery & Critical Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Women & Children	0	1	0	0	0	0	0	0	0	0	0	0	1	1
GDH	0	1	0	0	0	0	0	0	0	0	1	0	2	2
Medicine	0	1	0	0	0	0	0	0	0	0	1	0	2	2
SGH	0	1	0	0	4	3	1	0	0	0	1	0	10	10
Medicine	0	1	0	0	3	3	1	0	0	0	1	0	9	9
Surgery & Critical Care	0	0	0	0	1	0	0	0	0	0	0	0	1	1
Total	1	3	1	0	6	3	1	1	0	0	3	1	20	20

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 2019 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 2020/21 the Trust has been allocated a trajectory of no more than 33 cases combining the HOHA and COHA.



The trust had a CDI objective of no more than 33 cases and ended the year on 20 reported cases which is 40% within the allocated trajectory and 29% reduction to last year. There were no significant lapses in practice / care detected from the Post Infection Reviews undertaken with the main issues around antimicrobial prescribing, delay in sampling and previous CDI.

The SGH site had 10 cases, GDH 2 cases and DPOW 8 which is a significant turnaround as traditionally DPOW had the greatest number of cases. There have continued to be a number of ward moves during the last 12 months for a variety of reasons which makes identification of any links and determining a local prevalence rate very difficult. 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 very well for CDI rates in patients over 2 years of age for all England acute trusts based on 100,000 bed days and the best performing Trust in the region and in the lowest quartile nationally.

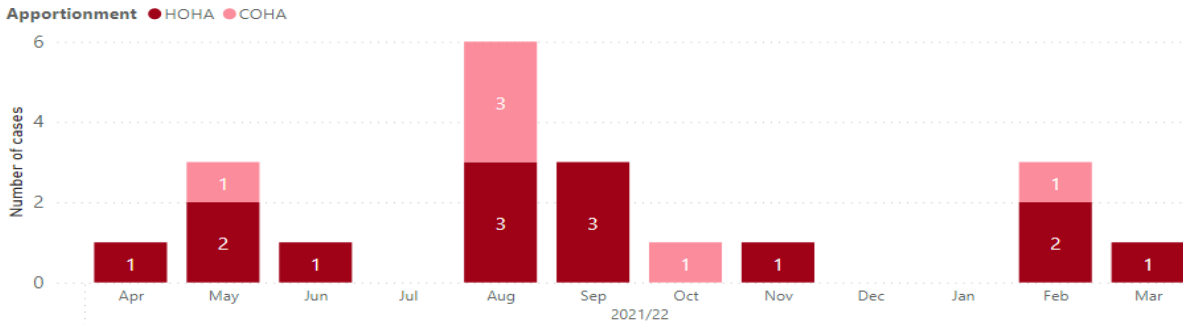
FIGURE 3 C.DIFFICILE HOSPITAL ONSET RATE FOR YORKSHIRE & HUMBER.

C. difficile infection counts and 12-month rolling rates of hospital onset-healthcare associated cases, by reporting acute trust and month **New data** Jan 2022

Crude rate - per 100,000

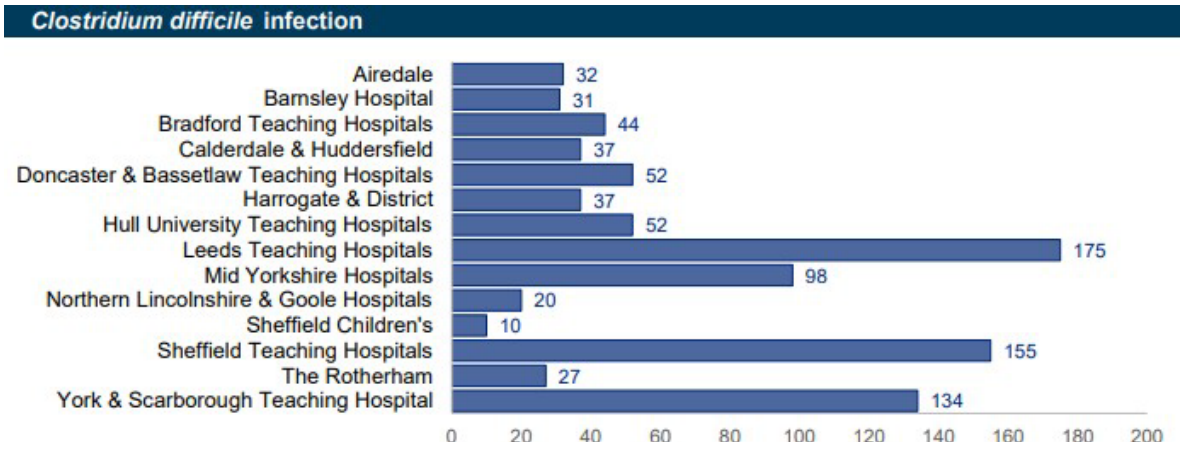
Area	Count	Value	95% Lower CI	95% Upper CI
England	5,880	18.9	-	-
acute trusts	588	19.5*	17.9	21.1
Harrogate and District	38	43.2	-	-
Sheffield Teaching Hospitals	123	29.4	-	-
Airedale	24	24.5	-	-
York Teaching Hospital	67	24.1	-	-
Leeds Teaching Hospitals	124	21.9	-	-
Bradford Teaching Hospitals	38	20.1	-	-
Barnsley Hospital	24	15.1	-	-
United Lincolnshire Hospitals	48	14.2	-	-
Hull and East Yorkshire Hospitals	40	13.5	-	-
Doncaster and Bassetlaw Hospitals	32	13.4	-	-
The Rotherham	17	11.7	-	-
Northern Lincolnshire and Goole Hospitals	13	6.2	-	-

FIGURE 4 NUMBER OF C.DIFFICILE CASES BY MONTH AND ALLOCATION.



The distribution of cases over the year does not show any abnormal trend although August did see an increase which coincides with junior doctors change and peak annual leave.

FIGURE 5 NUMBER OF HEALTHCARE ONSET CASES OF C.DIFFICILE APRIL - MARCH 2022

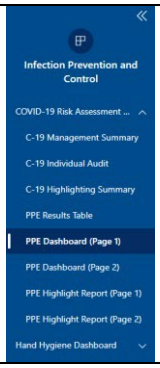


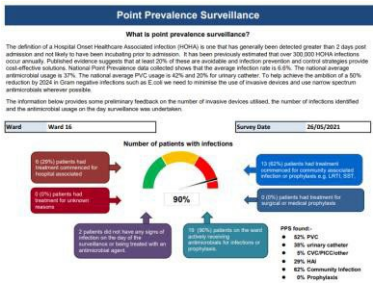
As the graph shows NLaG has the lowest number of cases detected for adults in the region.

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 and operational pressures 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 required. There were no significant contributory factors detected.

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

	The IPC continue to produce the newsletter at intervals throughout the year. 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/
Winter roadshow winner  	As part of the winter preparedness the IPC undertook a roadshow visiting wards / depts to update them on the management of COVID, use of PPE and traditional winter viruses such as norovirus and influenza. A number of light hearted competitions were implemented to allow staff to show off their artistic skills as well as quizzes and crosswords.
	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 reports have been updated and include data includes incidence per 1000 bed days.

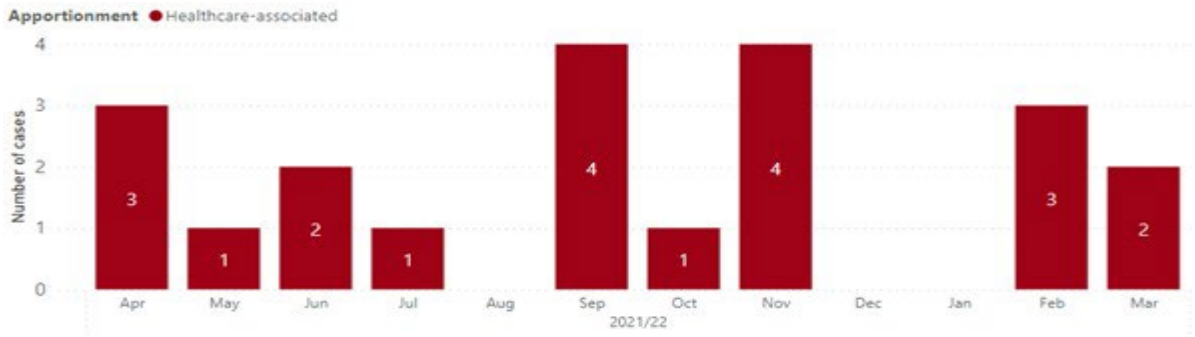


Point prevalence surveillance continues to be undertaken at least twice a year to monitor invasive device usage and antimicrobial adherence to Start Smart and Focus. The results are emailed to ward managers and Matrons once completed to close of any issues identified. The use of urinary catheters has increased slightly and will form part of an improvement project going forward.

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 can cause a wide range of infections from minor boils to serious wound infections and from food poisoning to toxic shock syndrome.

FIGURE 6 MSSA TRUST APPORTIONED CASES



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) bacteraemia's became mandatory from January 2011. Prior to that only voluntarily collected data was available.

The number of trust apportioned MSSA bacteraemia's detected during the current year is shown in Figure 6. 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 bacteraemia's will have the effect of minimising MSSA bacteraemia's. 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. Most cases have been detected within medical wards, however with the frequent reconfiguration of wards and bed pressures the specialty of the patient cannot be taken for granted.

Gram negative blood stream infections inc E.coli.

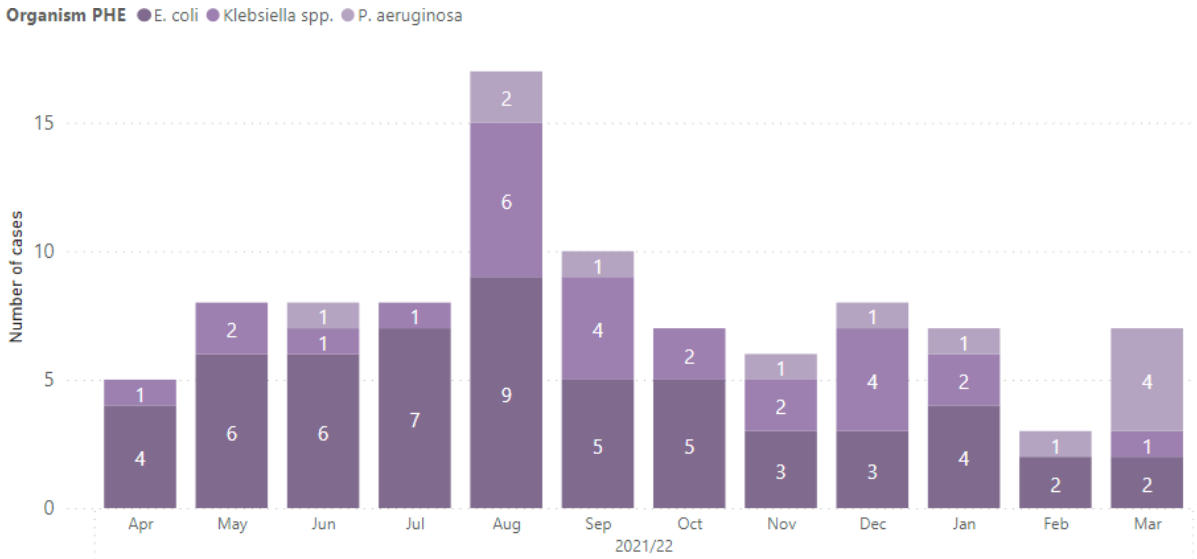
Halving the numbers of healthcare-associated Gram-negative bloodstream infections (GNBSIs) by 2024 is a key government ambition, announced as a key action in Lord O'Neill's Review of Antimicrobial Resistance (AMR). In 2017 we saw the implementation of a new national ambition to reduce the incidence of healthcare-associated Gram-negative bacteraemia's caused by Escherichia coli, Klebsiella spp. and Pseudomonas aeruginosa by 50% (compared to baseline year April 2017 to March 2018) by April 2024. However, given the last 2 years dealing with the COVID pandemic these ambitions will need to be revised.

Locally the number of E.coli bacteraemia cases remains a significant burden for patients. The number of E.coli blood stream infections detected after day 2 of admission has slightly increased from 49 to 56 which is a common finding during the pandemic. The days to detection ranged from 2-38 days with the mean age being 77 years of age. 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 239 cases which is a combination of Healthcare Onset and Community Onset cases. As seen most blood stream infections detected are 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. Due to the age profile of most cases 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 and improved surgical management are some of the key priorities to tackle this burden.

TABLE 2 TRUST APPORTIONED GRAM-NEGATIVE CASES

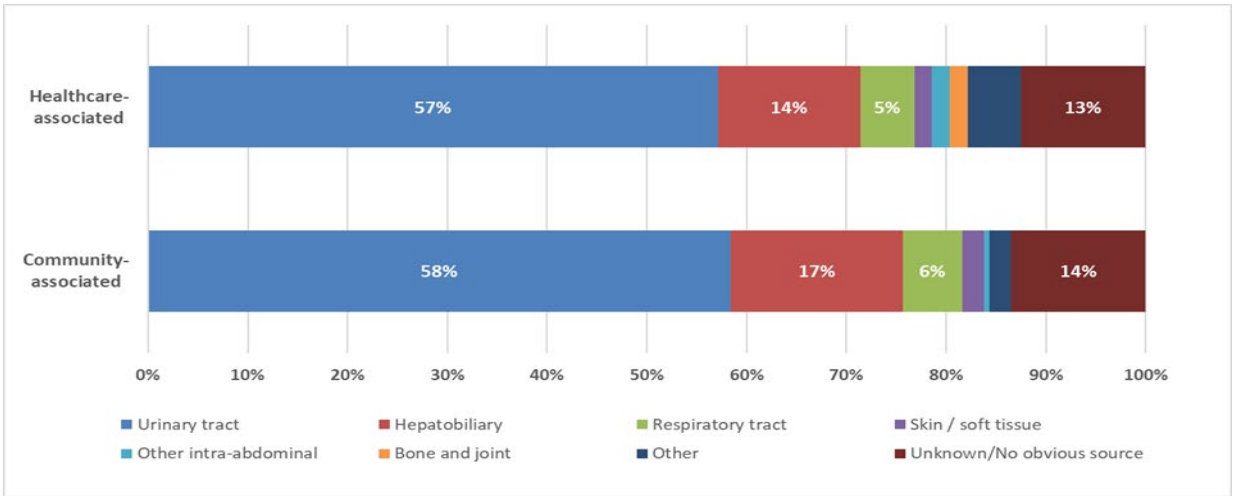
Financial Year	2021/22												
Site	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
DPOW	1	3	5	5	7	2	1	2	1	2	0	1	30
Medicine	1	3	4	3	3	2	1	2	1	2	0	1	23
COHA - DPOW Medicine	0	0	0	1	1	1	0	2	1	1	0	1	8
ECC DPOW	1	3	2	0	0	0	0	0	0	0	0	0	6
Integrated Acute Assessment Unit (IAAU) DPOW	0	0	0	0	0	0	0	0	0	1	0	0	1
Ward C2	0	0	1	0	1	0	0	0	0	0	0	0	2
Ward C6	0	0	1	2	1	1	1	0	0	0	0	0	6
Surgery & Critical Care	0	0	1	2	4	0	0	0	0	0	0	0	7
ITU	0	0	0	1	0	0	0	0	0	0	0	0	1
Ward B3	0	0	0	0	3	0	0	0	0	0	0	0	3
Ward B4 DSU	0	0	1	1	0	0	0	0	0	0	0	0	2
Ward B6	0	0	0	0	1	0	0	0	0	0	0	0	1
SGH	3	3	1	2	2	3	4	1	2	2	2	1	26
Medicine	1	3	1	2	2	3	3	1	2	1	1	1	21
A&E	1	1	1	0	0	0	0	0	0	0	0	0	3
COHA - SGH Medicine	0	0	0	1	1	2	3	1	1	0	1	0	10
Ward 17	0	0	0	0	0	1	0	0	0	0	0	0	1
Ward 22	0	0	0	1	0	0	0	0	1	0	0	0	2
Ward 23	0	1	0	0	0	0	0	0	0	1	0	1	3
Ward 24	0	1	0	0	1	0	0	0	0	0	0	0	2
Surgery & Critical Care	2	0	0	0	0	0	1	0	0	1	1	0	5
ICU	1	0	0	0	0	0	0	0	0	0	0	0	1
Ward 28	0	0	0	0	0	0	0	0	0	1	1	0	2

FIGURE 7 TRUST APPORTIONED GRAM NEGATIVE CASES



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 is not too dissimilar to our local position.

FIGURE 8 COMMON CAUSES OF E.COLI BACTERAEMIA IN CASES DETECTED IN NLAG



As a trust our rate of E.coli bacteraemia is better than comparible trusts however we always strive for improvement in reducing the number of cases. The charts below highlight E.coli bacteraemia cases by numbers and incidence.

FIGURE 9 ECOLI HEALTHCARE ASSOCIATED CASES AND RATE UP TO JANUARY 2022

Indicator
E. coli hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month **New data** Jan 2022 Crude rate - per 100,000 bed-days

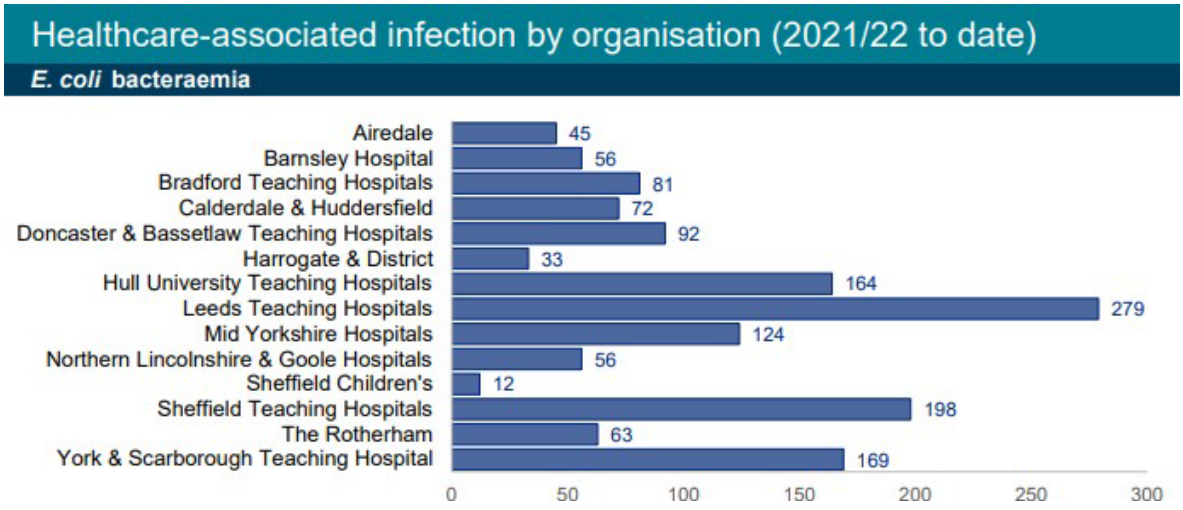
▶ Legend ▶ Benchmark ▶ More options

Areas All in your area list | All in England **Display** Table | Table and chart

Area	Count	Value	95% Lower CI	95% Upper CI
England	7,055	22.7	-	-
acute trusts	819	27.1*	25.3	29.0
Leeds Teaching Hospitals	200	35.3	-	-
Hull and East Yorkshire Hospitals	93	31.4	-	-
Sheffield Teaching Hospitals	131	31.3	-	-
Bradford Teaching Hospitals	54	28.6	-	-
The Rotherham	40	27.5	-	-
Airedale	26	26.5	-	-
York Teaching Hospital	73	26.3	-	-
Harrogate and District	21	23.9	-	-
Barnsley Hospital	37	23.3	-	-
Doncaster and Bassetlaw Hospitals	52	21.8	-	-
United Lincolnshire Hospitals	59	17.5	-	-
Northern Lincolnshire and Goole Hospitals	33	15.9	-	-

Source: HCAI Mandatory Surveillance Data

FIGURE 10 COMPARISON OF HEALTHCARE E.COLI BACTERAEMIA CASES REPORTED ACROSS THE REGION APRIL - MARCH 2022



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 38 cases of Pseudomonas aeruginosa with 8 Healthcare Onset, which was like 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 most 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 21 Healthcare Onset, which is an increase to the previous year.

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 2021 – MARCH 2022

	All Hospitals	Grimsby			Goole		
	National Rate	No. Operations	No. Infections	% Infection	No. Operations	No. Infections	% Infection
Hip Replacement	0.5%	326	0	0.0%	200	0	0.0%
Knee Replacement	0.4%	342	0	0.0%	322	1	0.3%

Overall, the infection rates remain within normal parameters, and this year the Trust has not received an outlier letter from UKHSA. 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.

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.

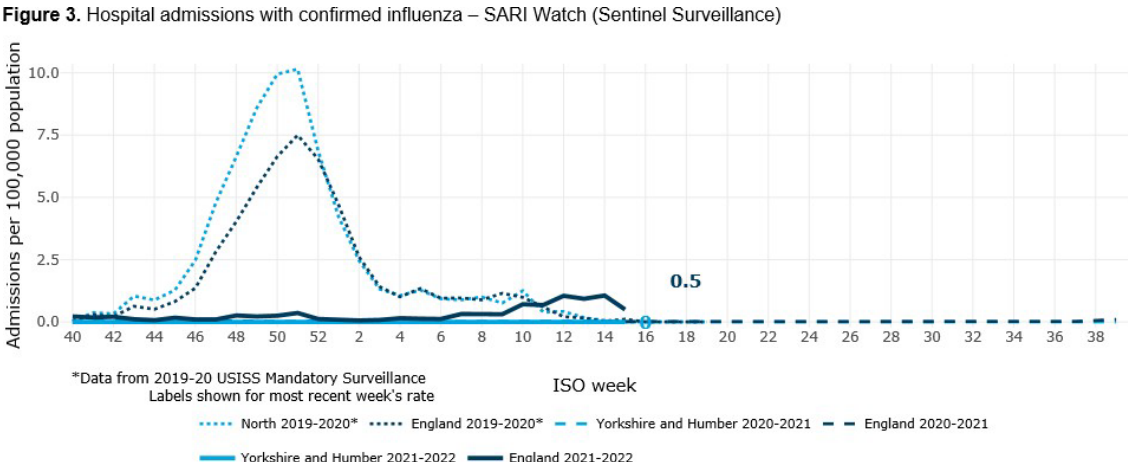
FIGURE 11 SURGICAL SITE HIGH IMPACT INTERVENTION FEEDBACK

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

As per last year the number of traditional winter respiratory viruses detected has been negligible. However, the influenza vaccination campaign continued to possibly help mitigate against any possible surge in cases in addition to the pandemic measures in place.

FIGURE 12 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. The overall uptake of influenza virus was lower than the previous year which may have been a consequence of low circulating levels of influenza numbers. Significant numbers of staff were receiving their COVID boosters at the time of the influenza vaccine roll out, to encourage uptake both vaccines were offered at the same time.

TABLE 4 INFLUENZA VACCINATION UPDATE BY FRONTLINE WORKERS

	Vaccinated at Trust	Vaccinated Elsewhere	Percentage of Staff who have received Dose of the Vaccine
Add Prof Scientific and Technic	97	4	64.7%
Additional Clinical Services	654	68	50.6%
Administrative and Clerical	204	24	57.3%
Allied Health Professionals	211	15	59.2%
Estates and Ancillary	277	8	56.8%
Medical and Dental	301	20	47.3%
Nursing and Midwifery Registered	979	97	60.5%
Students	2	1	100.0%
Grand Total	**2725**	**237**	**55.6%**

Point Prevalence Surveillance

As part of the ongoing review process the IPC team 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 quarter 1 and 3 of the financial year. The IPC team managed to undertake surveillance on 30 wards across the 3 hospital sites with 1092 patients monitored. The mean age of patients was 70 years with a range of 16-100 years.

The overall hospital onset infection rate has risen to 7.6% from 4.1% although this could be a reflection of the pandemic. It was noted that the number of antimicrobials prescribed remains around 50% compared to the recommended standard of around 30% and this is an increase from the baseline of 34%. Again, 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. The number of IV devices inserted remains constant although the number of PVCs not utilised for greater than 24 hours has increased from 11% to 18% and has required some focus interventions by the IPC team to improve practice. 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 soon with antimicrobial prescribing. 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.

The trust fortunately does not see many cases of CRE or CRO cases.

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

Facilities Service update (written by Karl Cliff)

2021-22 continued to require elevated levels of HSA support to the Organisation in support of the Covid Pandemic. Rapid changes to Wards resulting in quick changes of use and a requirement to flip areas from Red to Green in a swift timeframe, ensuring safe cleaning measures are achieved that further support operation pressures and patient flow.

Working closely and in partnership with IPC colleagues the HSA Team continue to adapt practice based on the latest scientific information. The change of cleaning procedures established in 2019 further supported by a change in chemical provision and a movement to disposable curtains continues to support in the delivery of service that has achieved the highest levels of assurance.

The HSA team are passionate about delivering the very best service possible, always striving to achieve the highest standards. To support this function, significant investment in new equipment that assists in reactive support and reduce time and labour has occurred. This has resulted in a team who can move quicker, respond faster, and deliver the high levels of assurance required. By embracing innovation and investing in market leading equipment the team is in a position of strength to support the next challenges that arrive.

With the new ED Departments soon to open, the Facilities team have created a model that will be able to react and provide the enhanced cleaning support to a Functional Risk 1 area. The model will provide 24/7 dedicated cleaning and support patient nutrition and hydration needs that will further support clinical colleagues to concentrate on patient care. A 24/7 dedicated Porter model has also been developed that will if supported will further assist with patient flow.

In April 2021 NHSI launched the new National Standards of Healthcare Cleanliness with implementation guidance provided to Organisations. A project team reporting to

Trust Management Board was established to implement the new standards. The new standards ensure we meet the requirements of CQC outcome standard regulation and the Health and Social Care Act. The new standards reflect modern methods of cleaning, infection prevention and control and important considerations for cleaning services during a pandemic.

IPC Environmental Audits

The IPC team undertake a yearly environmental audit of clinical areas and if required repeat the process depending on findings. Many 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 in table 6 below. The main areas for future improvement are generally associated with general 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. Areas that score below 85% are reaudited usually within a month period to allow any practice issues to be addressed. Below is an example of the feedback form emailed to clinical staff following the audit.

FIGURE 13 ENVIRONMENTAL AUDIT FEEDBACK FORM

Infection Prevention and Control Environmental Audit

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Site:	**DPOW**
Location:	**High Dependancy Unit**
Date:	**28/09/2021**
Observer / Auditor:	**Louise Dalby**

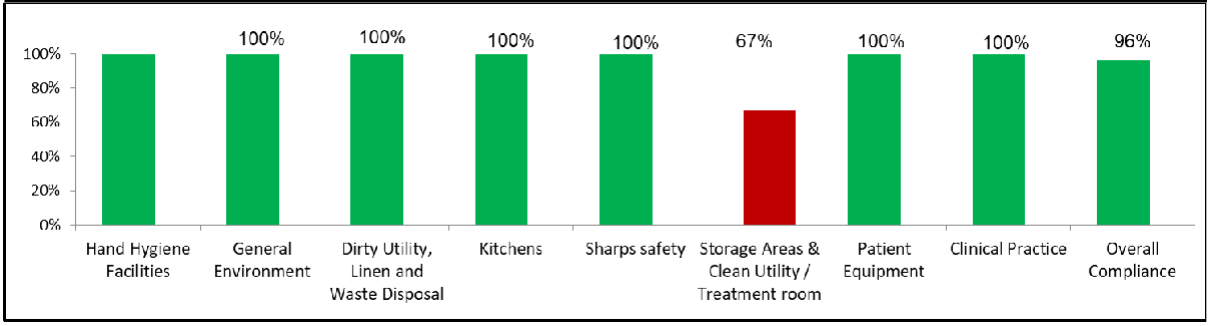
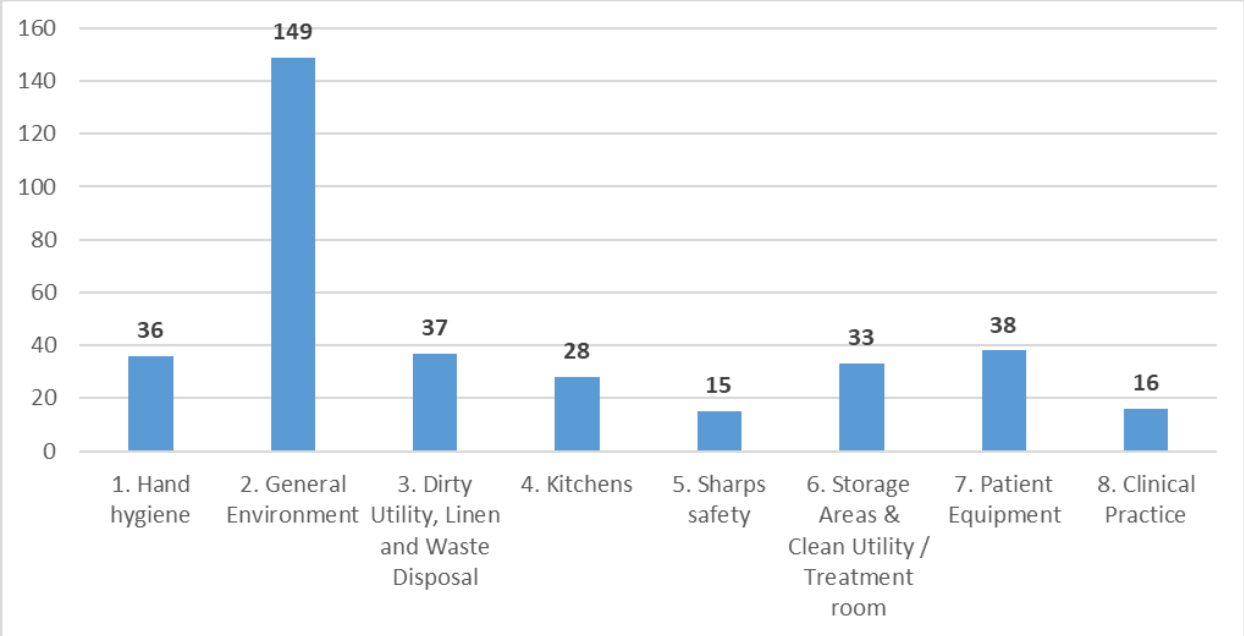


TABLE 5 IPC ENVIRONMENTAL AUDIT SCORES

Compliance by Ward and Division

Year	2021/22								
	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
DPOW	95%	77%	83%	83%	90%	80%	75%	79%	83%
Clinical Support Services	100%	83%	100%	100%	100%	100%	75%	100%	95%
Medicine	94%	74%	83%	82%	91%	76%	70%	73%	80%
Surgery & Critical Care	94%	84%	85%	88%	93%	81%	77%	76%	85%
Women & Children	96%	75%	83%	80%	86%	80%	78%	86%	83%
Community & Therapy Services	100%	78%	50%	67%	67%	100%	100%	100%	83%
GDH	100%	83%	90%	100%	92%	83%	86%	100%	92%
SGH	96%	83%	89%	86%	92%	84%	86%	95%	89%
Grand Total	96%	81%	86%	86%	91%	82%	81%	88%	86%

FIGURE 14 NUMBER OF IPC ENVIRONMENTAL AUDIT ISSUES BY TYPE



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 is a core member of this group to help ensure relevant guidance is adopted to help reduce the risk of waterborne infections such as Pseudomonas and Legionella.

Ensure appropriate antibiotic use to optimise patient outcomes and resistance

Antimicrobial Stewardship (written by Shilpa Jethwa consultant antimicrobial pharmacist)

Antimicrobials stewardship is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness' (NICE guideline NG15, 2015). It is therefore an important part of Medicines Optimisation.

Within the Trust the antimicrobial stewardship agenda is predominately led by the Consultant Pharmacist, Antimicrobials, who works closely with Pharmacy staff, the Infection Prevention and Control Team and with clinicians. This includes working with the ePMA implementation team to incorporate appropriate antimicrobial stewardship into the prescribing and administration system.

The close working relationship with the Infection Prevention and Control Team is essential with the UK's five-year national action plan - Tackling antimicrobial resistance 2019-2024 - (HM Government, January 2019) stating that the UK will "Ensure board level leadership with a combined IPC and antimicrobial stewardship role for all regulated health and social care providers".

The Trust's Antimicrobials Stewardship Strategy incorporates all elements of the national 'Tackling Antimicrobial Resistance 2019 – 2024: The UK's five-year national action plan'. The strategy aims to:

- ensure the optimal use of antimicrobials in the Trust
- minimise the risk of causing Healthcare Onset, Healthcare Acquired infections (HOHAs), antimicrobial related adverse effects and the development of antimicrobial resistance, whilst maximising their clinical and cost effectiveness.
- This report outlines the antimicrobial activities and progress with the action plan made in 2021/22 and activities related to antimicrobial stewardship

Guidelines

- Path links antimicrobial guidelines reviewed and approved February 2022
- APC antimicrobial guidelines reviewed and approved.
- Microguide purchased with the aim to launch in June 2022.

Education and Training

The following E & T activities have been delivered:

- Induction training for junior doctors
- Induction training for pharmacy staff
- Point of care training
- Monthly disease-based training
- Immunisation training
- Penicillin allergy training
- Primary care training around UTIs
- Teaching at post graduate institute

Audit and surveillance of antimicrobial use

There has been an improvement in the number of patients prescribed an antibiotic trust wide. The aim is for this trend to continue. This will be reviewed quarterly and will be fedback at relevant committees. Two of these standards have been included in the quality priorities for the forthcoming year namely the percentage of patients prescribed an antibiotic and the number of patients that have a review date documented. The following targets have been agreed for the forthcoming year:

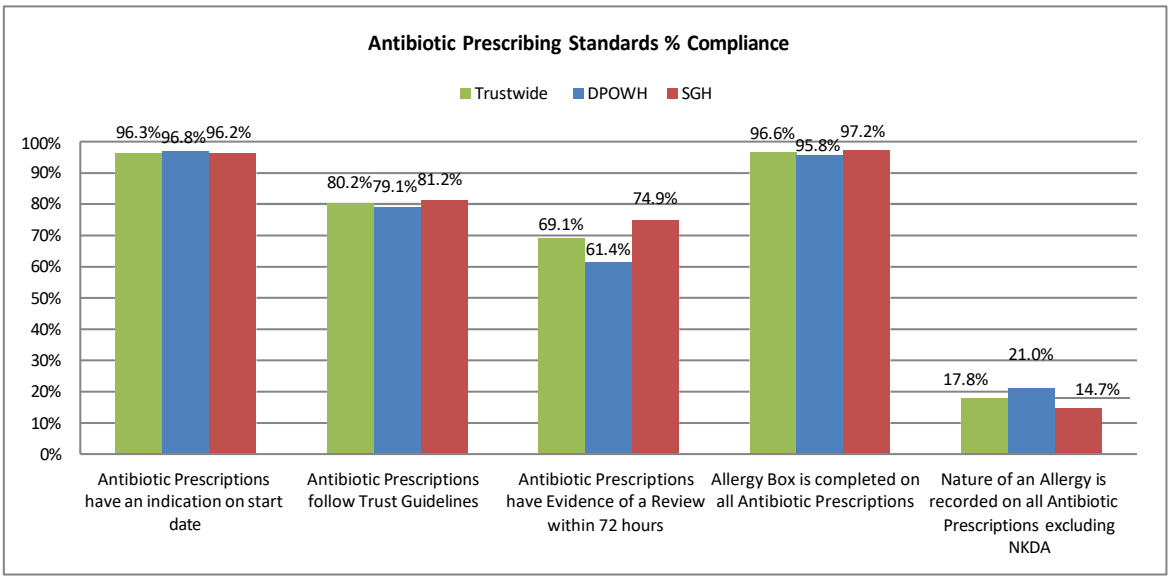
- Reduction in patients prescribed an antibiotic – target reduction to 50%
- Antibiotic prescriptions have evidence of a review within 72 hours – target 70%

	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4
% of Patients prescribed an Antibiotic Trustwide	66.4%	59.4%	60.7%	40.7%
% of Patients prescribed an Antibiotic DPOW	62.6%	42.0%	59.8%	42.8%
% of Patients prescribed an Antibiotic SGH	70.6%	82.5%	61.8%	38.5%

****Quarter 1 2021/22 based on April 21 bed occupancy data at midday divided by 30 days**

Standard Thresholds
Over 90%
Between 70% and 90%
Under 70%

Audit Prescribing Standards	Trustwide			DPOWH			SGH		
	No. Of Prescriptions Audited	No. of Prescriptions compliant	% Compliance	No. Of Prescriptions Audited	No. of Prescriptions compliant	% Compliance	No. Of Prescriptions Audited	No. of Prescriptions compliant	% Compliance
Antibiotic Prescriptions have an indication on start date	1260	1214	96.3%	598	579	96.8%	654	629	96.2%
Antibiotic Prescriptions follow Trust Guidelines	1260	1010	80.2%	598	473	79.1%	654	531	81.2%
Antibiotic Prescriptions have Evidence of a Review within 72 hours	847	585	69.1%	376	231	61.4%	466	349	74.9%
Allergy Box is completed on all Antibiotic Prescriptions	1260	1217	96.6%	598	573	95.8%	654	636	97.2%
Nature of an Allergy is recorded on all Antibiotic Prescriptions excluding NKDA	907	161	17.8%	420	88	21.0%	491	72	14.7%



Audit Prescribing Standards	Trustwide			DPOWH			SGH		
	No. Of Prescriptions Audited	No. of Prescriptions active 5 days or more	% Compliance	No. Of Prescriptions Audited	No. of Prescriptions active 5 days or more	% Compliance	No. Of Prescriptions Audited	No. of Prescriptions active 5 days or more	% Compliance
Antibiotic Prescription active for 5 days or more	1260	336	26.7%	598	153	25.6%	654	179	27.4%

72 Hour Review Decision	**Trustwide**	**DPOW**	**SGH**
Antibiotic was stopped	**10.6%**	**9.1%**	**11.8%**
Route changed e.g. IV to PO with no review / stop date	**2.6%**	**2.1%**	**3.1%**
Route changed e.g. IV to PO with review / stop date given	**12.1%**	**14.4%**	**10.5%**
Antibiotic was switched with no review / stop date	**3.7%**	**3.8%**	**3.7%**
Antibiotic was switched with review / stop date given	**5.2%**	**9.1%**	**2.4%**
No change to prescription and not re-written	**46.7%**	**40.5%**	**51.4%**
No change to prescription and re-written with no review / stop date	**5.4%**	**6.2%**	**4.6%**
o change to prescription and re-written with review / stop date given	**13.7%**	**14.4%**	**10.5%**

Prescribing Standard Trends

% of Antibiotic Prescriptions with an indication on start date

Year & Quarter	Trustwide	DPOW	SGH
2021/22 Q1	29.0%	92.1%	100.0%
2021/22 Q2	21.8%	100.0%	98.2%
2021/22 Q3	27.4%	98.8%	89.4%
2021/22 Q4	17.6%	98.4%	99.0%

% of Antibiotic Prescription active for 5 days or more

Year & Quarter	Trustwide	DPOW	SGH
2021/22 Q1	10.0%	47.6%	18.4%
2021/22 Q2	3.7%	4.5%	24.7%
2021/22 Q3	9.9%	21.2%	44.9%
2021/22 Q4	2.8%	16.8%	14.0%

% of Antibiotic Prescriptions with follow Trust Guidelines

Year & Quarter	Trustwide	DPOW	SGH
2021/22 Q1	21.2%	63.9%	76.3%
2021/22 Q2	17.8%	86.6%	76.5%
2021/22 Q3	24.8%	80.0%	89.4%
2021/22 Q4	15.9%	94.4%	82.0%

% of Antibiotic Prescriptions where there was Evidence of a Review within 72 Hours

Year & Quarter	Trustwide	DPOW	SGH
2021/22 Q1	54.8%	51.9%	58.3%
2021/22 Q2	71.3%	64.6%	74.5%
2021/22 Q3	78.4%	63.9%	87.9%
2021/22 Q4	72.8%	77.5%	72.0%

% of Antibiotic Prescriptions where the Allergy box was completed

Year & Quarter	Trustwide	DPOW	SGH
2021/22 Q1	30.2%	100.0%	100.0%
2021/22 Q2	20.6%	94.6%	92.2%
2021/22 Q3	27.9%	92.9%	98.0%
2021/22 Q4	17.2%	94.4%	99.0%

% of Antibiotic Prescriptions where the Nature of the Allergy was specified if an Allergy was recorded

Year & Quarter	Trustwide	DPOW	SGH
2021/22 Q1	11.3%	22.6%	2.5%
2021/22 Q2	19.3%	23.6%	16.3%
2021/22 Q3	15.6%	15.2%	16.2%
2021/22 Q4	20.1%	25.6%	14.0%

National work

- Participation in TEACH study
- NHS benchmarking presentation
- World Antimicrobial Awareness Week
- CO-GENT national audit and local gentamicin audit

Other activities:

- NICE compliance
- Chair of regional Antimicrobial group
- Feedback quarterly to YCP group

Action plan progress

The table below depicts the progress we have made with antimicrobial stewardship within the organisation in the last year.

Antimicrobial Stewardship Progress since January 2021

Actions	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Comment
Continue to develop strategies to reduce overall consumption of broad spectrum antibiotics in line with national targets where possible.						
Ongoing review of Path links formulary and prescribing advice documents for adults/children taking into consideration resistant patterns, most likely pathogen and risk of hospital acquired infection						
Continue to audit compliance against guidelines to ensure appropriate choice and dose prescribed. Feedback results to antimicrobial steering group, infection control committee and M & T						Quarterly PPS of all pts prescribed an antimicrobial – results feedback to relevant committees
Continue to use antimicrobial reduction and usage report to facilitate improvements in antimicrobial stewardship						Benchmarking ourselves against other organisations using DEFINE software
Reduce inappropriate duration of antimicrobials through effective stewardship programme.						Antimicrobial stewardship rounds and referrals reviewing pts and their prescriptions with clinical teams
Reduce unnecessary prescriptions for antimicrobials through effective stewardship programme.						Antimicrobial stewardship rounds and referrals reviewing pts and their prescriptions with clinical teams
Continued collaboration with regional antimicrobial pharmacists through regular network group meetings and email group to ensure shared good practice						Chair of YAHAP group – meets every 2 months
Regular review and implementation of national stewardship programmes and pathways for secondary care.						Review national polices and practice liaising with regional antimicrobial pharmacist
Ensure electronic prescribing supports stewardship to track prescribing rates and guidance compliance						Electronic report of pts prescribed an antimicrobial supports the stewardship rounds and is a valuable tool to conduct a targeted review of pts.
Potentially link prescribing activity to outcomes through linked datasets.						
Continue to review antimicrobial stock on clinical areas to ensure prompt administration of antibiotics for acute infections.						Currently ward configuration continually changing due to COVID
Continue to monitor antimicrobial stock shortages and develop action plans to ensure optimal patient care when continuous supplies affected.						Address these as and when they arise

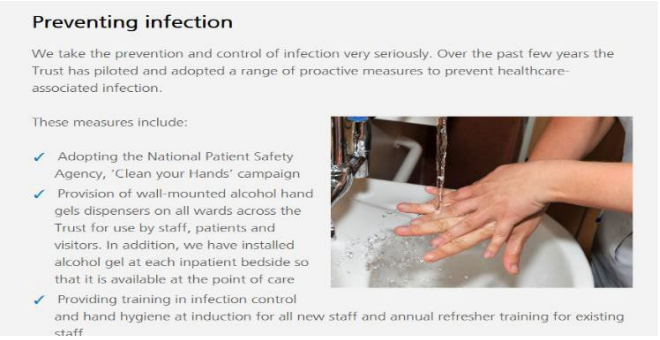
Quarterly audit and feedback on 24-72 hour antibiotic review to reduce extended use of broad spectrum antibiotics.						PPS antimicrobial audits - quarterly
Regular review and implementation of national guidelines for specific infections e.g. treating uncomplicated urinary tract infections.						Incorporated into review of Pathlinks guidelines
Ensure data is submitted as required for the Antimicrobial Resistance *CQUIN*. Progress to be reviewed at the Antimicrobial Stewardship Group meetings.						No active CQUIN for 2021/22
Facilitate education and training both practically on the wards and in a classroom setting for pharmacists, junior doctors and nurses						Monthly sessions to pharmacy team Formal sessions to doctors twice a year POC training during stewardship rounds Training delivered to different specialities when required
Continually assess suitability of new antimicrobials for inclusion on Trust formulary						
Introduction of Microguide to improve accessibility/compliance to Trust guidelines and improve stewardship						Purchased – plan to roll out June 2022
Support the introduction of OPAT pilot within the Trust						Pilot launched July 2021. Key member of the team to ensure smooth running of this service
Continue to support national research projects on new diagnostic or treatment strategies						TEACH study CO-GENT study Hydration Project
Continue to consider the use of point of care diagnostics for more infections						
Consider the use of genomic technology to improve prompt and appropriate treatment, as and when this technology becomes accessible for routine clinical use.						

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.

The intranet HUB has a multitude of information leaflets for patients that car 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.



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

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.

The IPC team in conjunction with WebV have developed a database that is linked to the pathology system. This allows all 'alert organism' positive results to be easily identified and then allows the team to take appropriate action. The system has taken a number of years to develop and refine but has been very useful during the last 2 years allowing early detection of COVID-19 cases.

WARD / UNIT	BED MANAGEMENT	ORIGIN SITE	ASSIGNEE	ORGANISM / SYMPTOM	STATUS	REVIEW
WARD 16	Red	Scunthorpe General Hospital	Caroline O'Neill	COVID Positive Contact	Open	28-Apr-2022
WARD 16	Red	Scunthorpe General Hospital	Caroline O'Neill	COVID Positive Contact	Open	28-Apr-2022
Ward 19	Red	Scunthorpe General Hospital	Kelly Greaves	COVID Positive Contact	Open	28-Apr-2022
AAUA (Ward 24)	Red	Scunthorpe General Hospital	Gail Hill	DART Alert GDH+ve Toxin -ve	Open	28-Apr-2022
Ward 29	Red	Scunthorpe General Hospital	Caroline O'Neill	Diarrhoea	Open	28-Apr-2022
Disney Ward SGH	Red	Scunthorpe General Hospital	Noelle Williams	Multiple Infections	Open	28-Apr-2022
Disney Ward SGH	Red	Scunthorpe General Hospital	Noelle Williams	Previous MRSA Infection	Open	28-Apr-2022
AAUA (Ward 24)	Red	Scunthorpe General Hospital	Noelle Williams	Escherichia coli	Open	29-Apr-2022

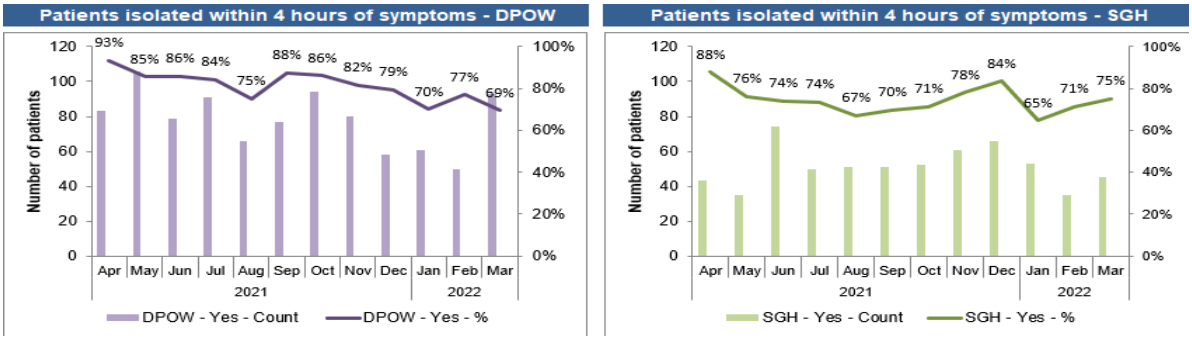
MRSA colonisation

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. Patients requiring major implant surgery are routinely swabbed for MRSA and now commenced on topical decolonisation agents to help reduce the risk of Methicillin sensitive Staphylococcus aureus which can cause significant post-operative issues.

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

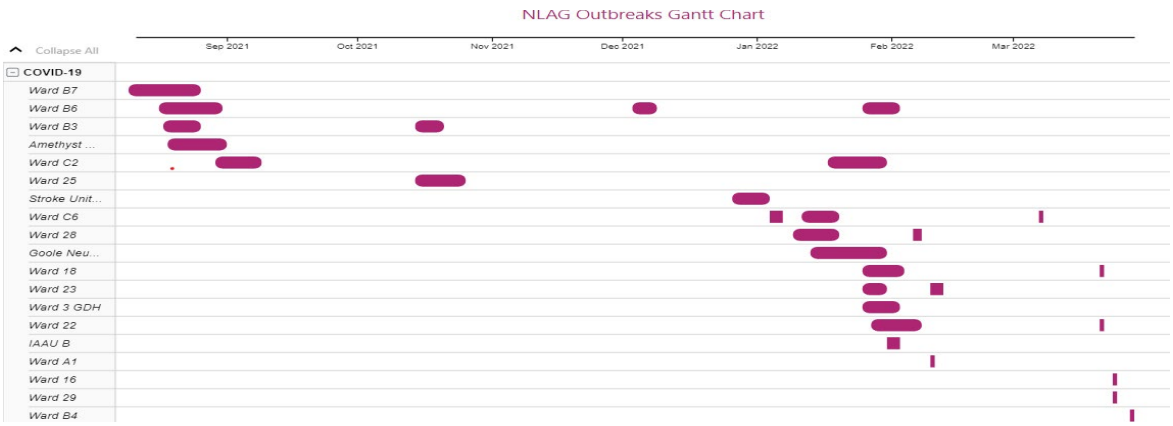


The IPC team also review whether the stool sample submitted is deemed appropriate based on clinical information. Staff are given feedback if samples are deemed inappropriate to help improve practice and reduce pressure on single rooms. There is ongoing education and stool sampling and correct management 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. However, in March we detected
a number of cases of norovirus within the short stay ward at DPOW with resulting dissemination to other settings including C1G and stroke ward. The outbreak on short stay resulted in 14 staff and 13 patients spanning over 10 days. There were also sporadic cases detected with fortunately no widespread dissemination.

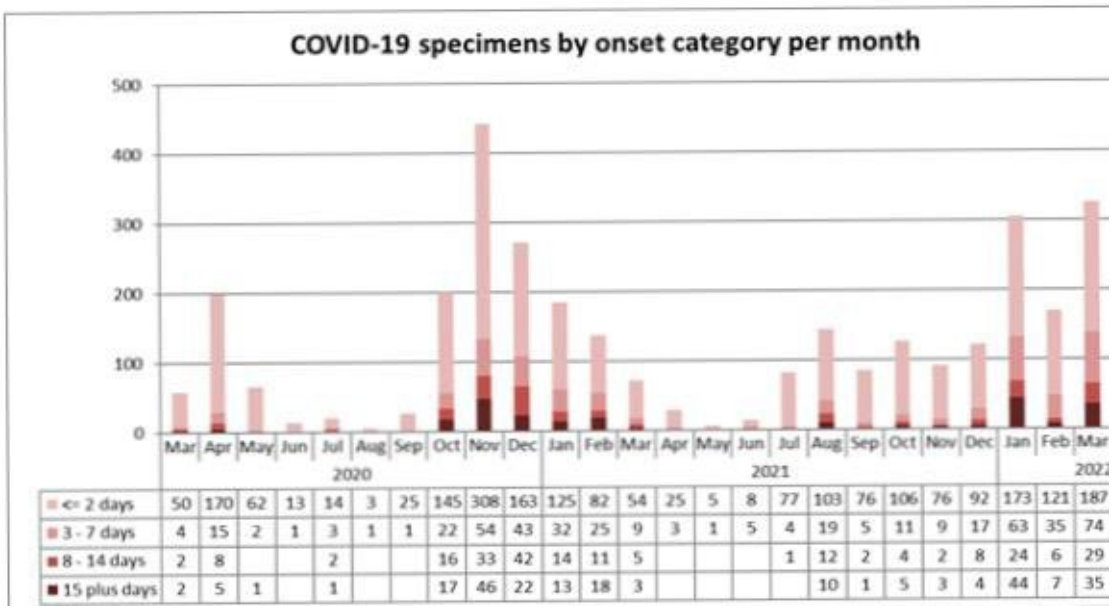
FIGURE 16 WARDS AND BAYS CLOSED FOR OUTBREAKS OF CONFIRMED COVID-19 OUTBREAKS



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.

FIGURE 17 COVID POSITIVE SAMPLES BY CLASSIFICATION



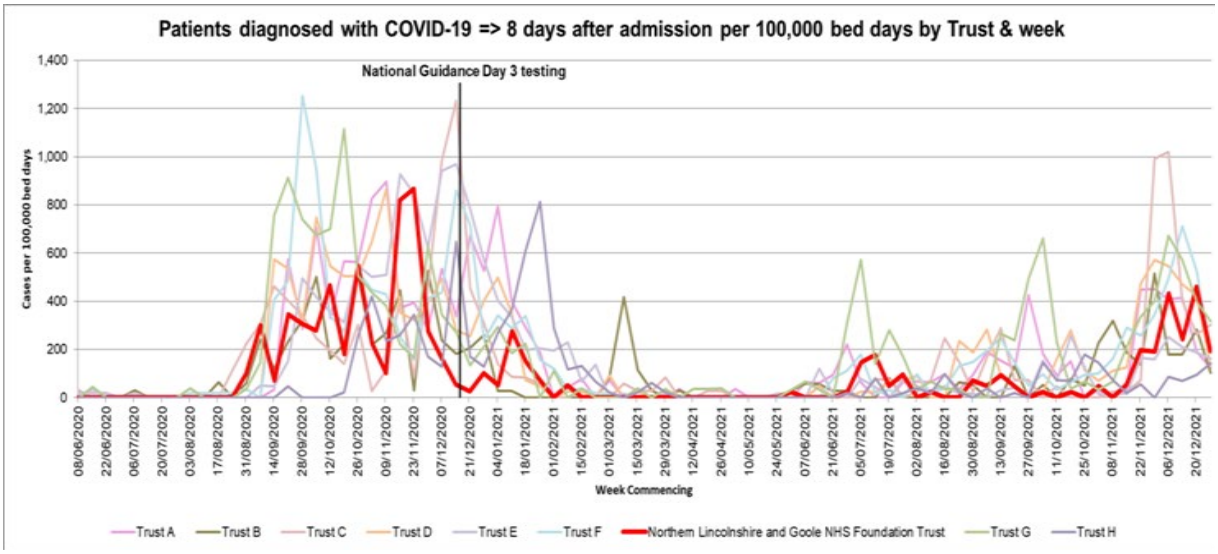
As can be seen the number of COVID cases escalated again during the winter because of the new variants of concern such as Omicron BA1 and BA2 lineage. Although the number of cases detected was not on the same scale as last winter it nevertheless still caused some considerable disruption to the hospital normal activity. It was noted the nosocomial rate of Omicron was higher than previous variants due to its increased transmissibility. Fortunately, Omicron did not present as virulent as previous variants and many patients were vaccinated and boosted which may have helped to reduce the severity of the illness and certainly this was seen in less nosocomial deaths, which reduced from 94 in the previous year to 21. Many of the nosocomial COVID deaths had a structured judgement review process undertaken to ascertain if any lessons could be learnt and avoid future cases. Most patients unfortunately had underlying comorbidities, some patients were not vaccinated, and, in the majority, no obvious intervention could have been implemented to avoid the infection. This is likely due to high community prevalence at the time resulting in asymptomatic infection in patients and staff despite testing regimes. The lack of effective ventilation to help dilute airborne particles which is important in a busy confined environment also cannot be overstated as an important mode of transmission.

The use of FFP3 masks was encouraged for clinical staff managing COVID positive patients within their infectivity period and within admission units where the status of the patient was unknown. The supply and availability of FFP3 masks is now much improved and most staff can find a disposable mask to fit their needs. The fit testing

supported by an external provider and clinical practice facilitator team is working well and helping to maintain the 2 year cycle of fit testing requirements. During the year over 500 additional staff were fit tested for disposable FFP3 masks.

As part of the COVID strategy the use of the Redirooms were deployed to enhance the isolation capacity. This was especially useful within the admission type wards or where a COVID contact was identified. As can be seen in the graph the performance of the Trust was generally very good in reducing the number of nosocomial infections compared to some of our peers, although this was a significant challenge with the Omicron variant during periods of high local prevalence.

FIGURE 18 DAY 8 OR ABOVE COVID CASES DETECTED COMPARED TO LOCAL TRUSTS



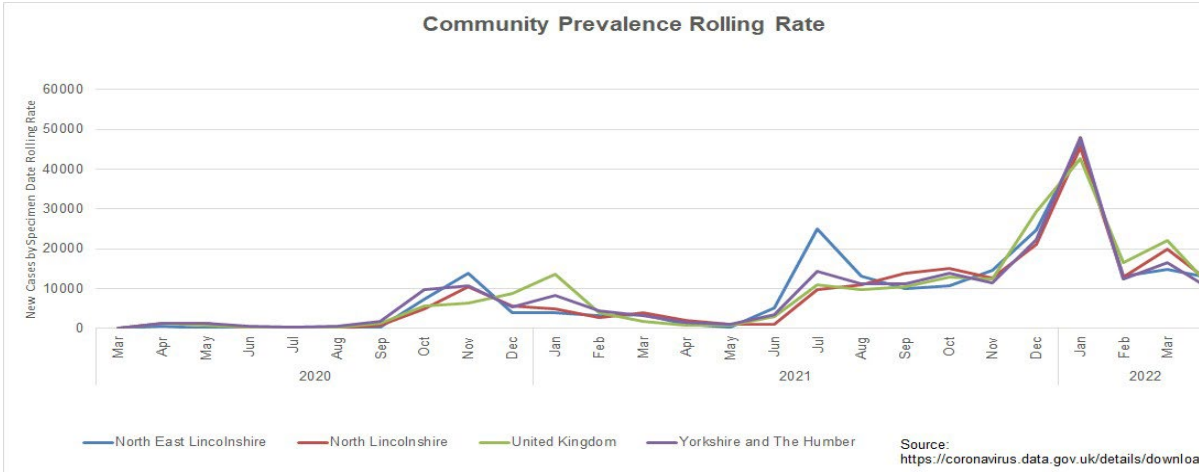


FIGURE 19 COVID COMMUNITY PREVALENCE RATE.

As part of the Duty of Candour process patients who acquired nosocomial COVID had a letter of apology sent to them. The patient or relatives were given the opportunity to get in touch with the Trust if they required any further information. During December and January, the IPC Team attended a number of scrutiny panel meetings with local councillors

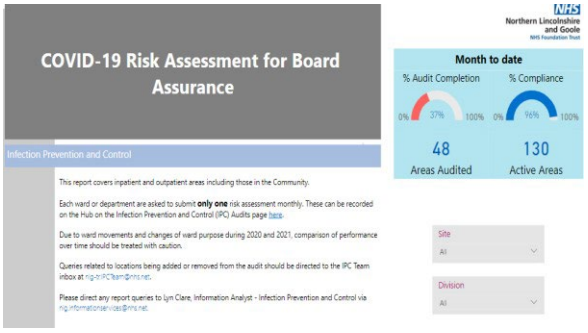
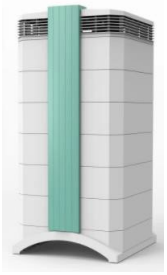
and local members of parliament. This provided an opportunity to discuss the current COVID situation and local measures being adopted to help reduce nosocomial transmission.

The IPC team submitted a piece of work to the Patient Safety award hosted by the HSJ. The work was around the multimodal approach adopted by the Trust in helping to manage the COVID pandemic. The nomination was shortlisted which was a significant achievement by the team, operations centre, and frontline staff.

The IPC team also submitted a poster to the European Congress of Clinical Microbiology & Infectious Diseases conference in Lisbon. This was accepted and presented on the use of the Redirooms in helping to manage the pandemic.

In line with the updated IPC national guidance the local COVID arrangements were updated which resulted in the removal of the 3 pathways of care in March once the prevalence of Omicron had subsided.

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

	A number of IPC Board Assurance Frameworks were updated nationally resulting in local reviews and updates. Staff undertook a monthly audit to check compliance with the standards. These were scrutinised at the Nursing Metrics panel to help identify any issues and actions required. The data is readily available for ward managers and Matrons to access.
	As part of the ongoing pandemic surveillance the IPC team undertook monitoring to ensure staff were complying with best practice in PPE management.
	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 6-12 Air changes per hour. Additional units were purchased to deploy within ECC and admission wards.

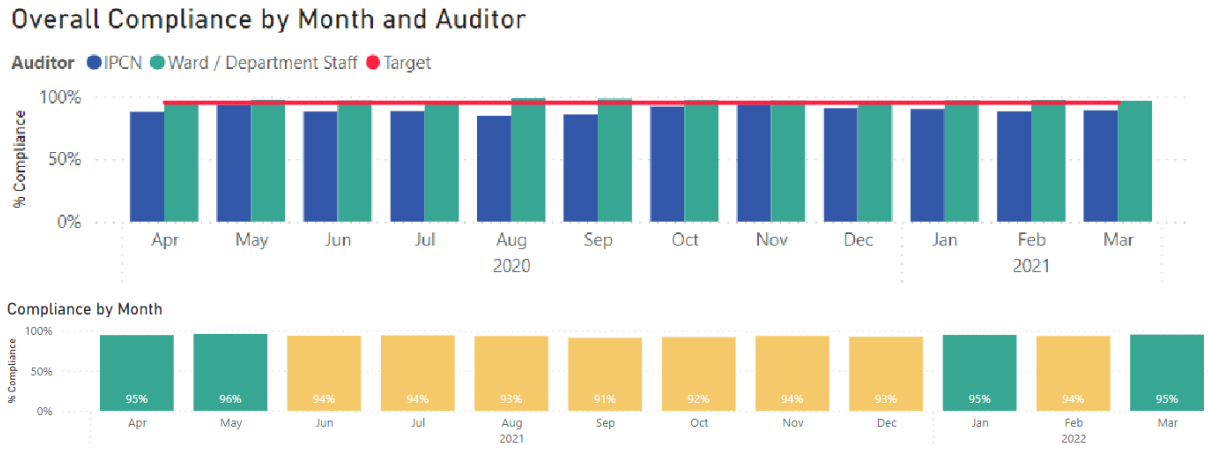
6. Ensure that all care workers are aware of their responsibilities in preventing and control of infection.

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 OVERAL 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)

Activity continues to be influenced by Covid-19. CCG activity typically remains at about 20-25% down on pre-pandemic workload whilst the two acute trusts NLAG & ULHT show about 35-40% over activity against the same baseline. Serology and molecular activity – Covid-19 testing aside – has continued to recover, but we have seen EBV serology 15% upon pre-pandemic levels, as well as Quantiferon B up 22% and Helicobacter pylori faecal antigen up 39%. The Quantiferon B testing has been affected by on-going outbreaks in the south Lincolnshire area, and also screening of Afghan refugees arriving at an initial handling facility in Lincolnshire following their evacuation from Afghanistan.

Implementation of Group B enrichment culture in accordance with RCOPG guidance started in March 2022 but is not anticipated to greatly affect workload at this stage. Enrichment culture for E.coli O157 has also been implemented in line with the UKHSA national SMI for those patients where it is indicated.

Routine Covid-19 PCR has continued to trend upwards but we are now seeing more use of rapid testing with a roll out of the Abbott ID Nows at Scunthorpe, Grimsby and Grantham during late Spring 2021, and again with a further roll out of ID Nows at Lincoln and Boston in January 2022. A second Alinity has been installed at Scunthorpe by Abbott under an extension to contract and this was planned to go live beginning April 2022 following completion of V&V. We have tested and reported 287,000 routine PCR and over 74,000 rapid tests April 2021-March 2022 (780 routine PCR and 205 rapid tests per day on average.). This situation will change over the next 3 months following a national letter addressing 'Living with Covid' issued on 30th March 2022, which is leading to the withdrawal of some testing funding, most noticeably for in-patient PCR testing at Day 3 and Day 5-7 except for outbreaks.

A second Alinity has been provided by Abbott Molecular under an extension to contract and has replaced an m2000 at Scunthorpe. Once this has settled in, the remaining m2000 at Scunthorpe will be removed. Scunthorpe has acquired a Qiagen Qiastat for the extended respiratory testing panel. The new panel allows same day testing to support patient flow and management, particularly high-dependency, ICU, Paediatric and immunosuppressed patients. It has also allowed us to gain a better real time picture of local respiratory infection trends.

Abbott ID Nows have been acquired from DHSC to support rapid Covid-19 testing and have assisted workflow in the laboratories as well as patient flow through the hospitals across Lincolnshire. In addition to the two microbiology sites, analysers are sited in blood sciences at Grimsby, Lincoln and Grantham removing the need for transport of rapid tests except where occasional rapid PCR tests are required. This has worked well with Scunthorpe and Grimsby live early 2021 and the remaining sites early 2022. Co-operation and support between the different sites and disciplines has worked well, with Microbiology providing technical and safety guidance, advice and support.

Enabling work for two new replacement autoclaves at Scunthorpe started at the end of March 2022 with completion anticpated by the end of June 2022.

The MALDI business case is still awaiting resolution due to cost pressures as NLAG Trust requires this to be from revenue. *C.difficile* PCR and TB PCR feature in our directorate objectives for 2022/23 and are dependent on successful business cases. We continue to work to repatriate work where possible, and we are about to start testing for the Hepatitis B markers of infection in the next couple of months in serology at Scunthorpe.

The UKAS inspection in March went very well and we are awaiting some minor findings before we can respond with evidence to clear these.

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 6 POLICIES UPDATED WITHIN LAST YEAR

Name of Policy	Date for review
Decontamination of Medical Equipment Prior to Inspection Service or Repair Policy	23/03/2024
Sharps injury and body fluid exposure management	01/09/2024
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)	04/08/2024
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

8. 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. Due to the ongoing pandemic and social distancing guidance most of the education has continued to be remote learning.

THE MATERIALS INCLUDE:-

- Surewash machines redesigned for ward-based training resource
- Workbooks for clinical and non-clinical staff updated into flip books
- Care Camp
- Induction
- Clinical updates
- New Doctors / HYMS training
- IPC blog site for staff and students

Over 7000 members of staff have undertaken some form of IPC training which is a significant increase from last year.

TABLE 7 TRAINING UNDERTAKEN

Count of Competency Match	Column Labels			
Row Labels	**No**	**Yes**	**Grand Total**	
208|LOCAL|Antimicrobial Stewardship|	325	1782	2107	85%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	94	735	829	89%
NHS|CSTF|Infection Prevention and Control - Level 1 - No Specified Renewal|	46	1422	1468	97%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	945	3266	4211	78%
Grand Total	**1410**	**7205**	**8615**	**84%**

Community & Therapies Services Infection Prevention and Control Annual Report 2021-2022

Information Provided by Mandy Hill IPCN

Overview

2021/2022 has seen tough challenges for all the community and therapy teams working under extreme pressure during the continuing Covid 19 Pandemic. Staff have excelled in providing a service to make our patients safe, given staff shortages and increased demands on the service.

The Community Infection Prevention & Control (IPC) team works within the overarching Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) Acute IPC team, based at Scunthorpe (SGH) and Grimsby (DPoW) providing a dual involvement across both acute and community working in the provider only role. The team also continues to deliver the IPC service for Goole hospital and Lindsey Lodge Hospice.

The Community Infection Prevention & Control (IPC) team comprises of a 0.6 wte Band 6 IPCN Community Staff Nurse (who commenced her position on 01/09/2021) The banding and the hours have been reduced from the previous year; and a 0.8 wte Band 3 AHCA.

Within the hours 7.5 hours per month is allocated to Lindsey Lodge Hospice providing IPC Support. The community IPC team and NLaG acute team work closely together and additional administration and searches are undertaken, and cover provided at times to the acute service when needed to ensure patient safety is not compromised.

Covid 19 continues to have had a significant impact on the traditional ways of IPC working and the numbers of patients being Covid 19 positive in our region has fluctuated throughout the year, and in most cases our prevalence was higher than the national average.

National IPC guidance has changed throughout the pandemic, thus numerous amendments and advice changes have been made throughout the year regarding PPE, Isolation and duration advice, shielding of extremely vulnerable patient categories, and home working. Maurice Madeo Senior Nurse/Deputy Director of Infection Prevention and Control has scrutinized Government updates and provided NLaG Acute and Community teams with relevant updated changes to staff throughout the year.

Community & Therapy Governance meetings have been held monthly; and ‘Looking Forward’ weekly blog information communicated to all staff within the Community and Therapy Services by Ant Rosevear has continued to deliver staff information and recognition for all their hard work throughout the pandemic. Minutes from this meeting, including actions and issues, are forwarded to the Infection Control Committee (and are available to view via the Hub). Teams has continued to be invaluable throughout allowing staff to meet virtually.

Mandatory Training

Face to face mandatory training continued to be postponed this year.

Surveillance organisms

Table below shows Alert Organism figures for the period April 2021- March 2022. The arrows indicate if increase or decrease from the previous year as there is no target figures set for MSSA or CPE at present. *C-Difficile* and *E-coli* bacteraemia are under trajectory, and MRSA bacteraemia is over trajectory.

TABLE 8 COMPARISON OF NORTH LINCOLNSHIRE PERFORMANCE AGAINST CAI SURVEILLANCE ORGANISMS FOR 3 YEARS

Organism	2019/20	2020/21	**Target for 2021-22**	**2021/22**
	Performance	Performance	Target	Performance
MRSA	3 ↑	0 ↓	**0 (+2)**	*** 2 Not NLAG**
C.difficile	15↓	10 ↓	**27 (-6)**	**21 ↓**
E.coli	165 ↑	125 ↓	**172 (-48)**	**124↓**
MSSA	41 ↓	31 ↓	No target set	**42↑**
CPE	0	0 =	No target set	**0 =**

*2 MRSA Bacteraemia:

X1 attributed to NHS NL Community Acquired (Sample taken SGH 19th July 2021 ECC

Minors) X1 attributed to York Hospital (Sample taken in A&E 11th November 2021)

Audits and findings

Board Assurance Framework (BAF) Covid risk assessments have been continued throughout the Covid 19 pandemic and community staff have been asked to complete monthly and input electronically via the HUB. Most areas have complied with the request.

Hand hygiene (HH) observations continue to be recorded electronically through Web V. Staff were asked to undertake 10 observations per month in their areas. (Areas with one or two staff are not expected to complete the monthly audits) The audits are required to provide assurance that HH is being undertaken with correct technique and BBE compliance. These audits are available to view via the IPC hub dashboards.

Annual Hand Hygiene practical assessment should have been undertaken for all Community & Therapy staff and inputted onto the Oracle Learning Management system (OLM). A new process for recording this in progress.

Community IPC audits have been undertaken in several areas during the last year, which can be viewed via the hub. These audits are additional to the community ’15 Steps’ audit programme which were introduced. With the continuation of the Covid 19 pandemic during 2021-2022 the ’15 Step’ audits were postponed.

Findings from the IPC Community Audits had several reoccurring themes: - examples below

- Environmental issues
- Decontamination / cleaning
- Practice related

Joint Equipment store

The Joint Equipment store (JES) has been identified as not fit for purpose by my predecessor and is an historical issue on the Risk register.

Covid Swabbing Teams

The Community IPC team visited both sites at SGH & DPoW and audited the premises. Several issues were raised (at both sites) regarding lack of social distancing given the amount of staff in the swabbing porta-cabins (and the layout of the space). Additional cleaning and decluttering was recommended and instigated.

Community & Therapy Link Practitioner Forum

There was no Link practitioner forum this year due to the Covid 19 pandemic All IPC guidance appertaining to Coronavirus/Covid 19 remains accessible on the Trust Hub. Link practitioners and all community staff could contact the Community IPC Team directly for support and advice.

Decolonisation Service

The decolonisation clinic has remained closed during the Covid 19 pandemic, and any decolonisation/suppression treatment prescribed has been done through the Primary care route. All results for MRSA that the community IPC team pick up are inputted onto SystmOne and passed onto the relevant clinicians/teams to follow up.

Activity and

Engagement FIT

Testing

FIT testing has been provided by the Clinical Education team and booked through the Hub. It was recommended that staff be FIT tested on two types of masks due to supply issues. On the sessions witnessed by the Community IPCT, It was reinforced to staff attending the sessions that they needed to be responsible for knowing which masks they passed on (make and model number) as this was essential information. Staff only FIT tested for the mask they passed on. If any changes to facial structure, for example losing weight, dental extractions altering facial shape or facial accidents they would need to be re FIT tested.

FFP3 masks to be worn by community staff dealing with a patient with a known Covid positive result or highly suspected.

Lindsey Lodge Support

IPC Support to Lindsey Lodge Hospice is a new additional service provided by the Community IPC team as a service level agreement between the two Organisations.

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

Use of a temporary patient isolation facility in reducing risk of hospital acquired SARS-CoV2 infection in a UK hospital

Maurice Madeo, Graham Jaques, Linda Barker. Northern Lincolnshire & Goole NHS Foundation Hospital. United Kingdom.

Background

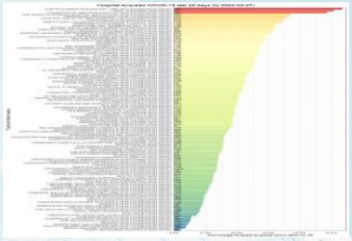
During the first COVID-19 wave (March –May 2020) the numbers of hospital onset cases were less significant as non-COVID patients were reluctant to be admitted, creating capacity to manage patients. The second wave (September 2020 – April 2021) coincided with winter pressure and increased admissions due to the more transmissible Alpha variant. Hospital isolation capacity was under 15% of beds and COVID-19 PCR test turnaround of up to 24 hours made isolation and appropriate placement a challenge.

Materials/Methods

Regional prevalence of COVID-19 was greater than the national UK average for considerable periods in the second wave, resulting in a surge of patients presenting with suspected or confirmed COVID-19. The use of a portable, rapidly deployed (under 10 minutes) isolation facility with HEPA-filtration of exhaust air (Redirroom™, GAMA Healthcare, UK) allowed staff to manage patients awaiting PCR result in a Redirroom until results became available. Redirooms were erected predominantly within the admission wards across two main hospital sites to expand the isolation capacity. A short survey was also undertaken to gain patient feedback on the use of the Redirooms (n=12).

Results

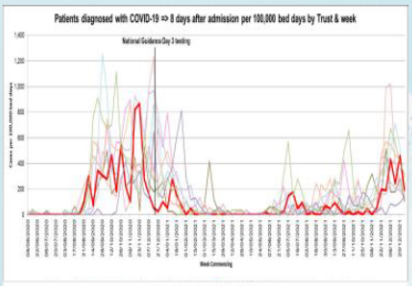
A significant number of COVID-19 patients were admitted from October 2020, peaking in November and December 2020. The most prevalent circulating variant was VOC-20DEC-01 (B.1.1.7). The admission wards normal isolation capacity was 5 beds, which was inadequate to meet demands. The hospital purchased 30 Redirooms in December 2020, which were installed in admission wards. The organisation incorporated additional day 3 PCR testing for in-patients in December 2020 in line with national guidance. The number of hospital onset COVID-19 cases (day 8 or greater) immediately fell compared to comparable hospitals in the region who had not increased isolation capacity, however due to potential confounders such as changing national guidance it is not possible to identify the exact effect of the additional isolation capacity, although likely a significant factor.

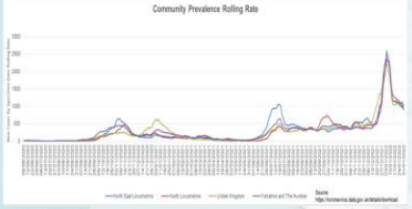


The patient survey conducted showed that 75% of patients found the redirroom easy or very easy to use. The majority of patients would recommend the redirroom to other patients.

Conclusion

A combination of increased isolation capacity and day 3 COVID testing considerably reduced the number of hospital-onset COVID-19 cases. Hospitals that have inadequate isolation capacity can temporarily erect mobile units to augment isolation capacity and reduce the risk of SARS CoV-2 dissemination.





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https://www.gov.uk/government/publications/wuhan-novelcoronavirus-infection-prevention-and-control/covid-19-guidance-for-maintaining-services-within-health-and-care-settings-infection-prevention-and-control-recommendations

m.madeo@nhs.net

NLG(22)169

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 4 October 2022
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jane Warner, Associate Chief Nurse
Title of the Report	**Maternity/Ockenden Update**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this report is to provide an update on progress with The Ockenden Report (2020, 2022). There remains one action from the Ockenden Report 2020: risk assessment throughout pregnancy. The Trust is meeting 24 of the 92 actions from the Ockenden Repot 2022. The Trust Board is asked to note progress against the actions to be met within the Ockenden Reports.
Background Information and/or Supporting Document(s) (if applicable)	https://www.donnaockenden.com/downloads/news/2020/12/ocken den-report.pdf https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Quality Governance Group
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other: Click here to enter text.

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

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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Trust Board of Directors – 4 October 2022
Maternity / Ockenden update

Introduction

The purpose of this report is to provide an update on progress with The Ockenden Report (2020, 2022); recommendations; Maternity Improvement Advisor support, Clinical Negligence Scheme for Trusts – year four, and on Continuity of Carer provision.

Ockenden report, 2020

Of the 12 Immediate and Emerging actions, there are 11 completed actions with audit on-going to provide evidence of compliance for the remaining action (Risk Assessment throughout pregnancy).
An Assurance visit by the Regional Chief Midwife occurred on 4 May 2022 and initial feedback was positive. Formal feedback has now been received which included –

- Positive assurance of serious incidents (Sis) being shared with the Trust Board and LMS
- Good collaborative working including cross-trust support regarding SI investigations.
- Complementary on the clear evidence of co-production with the Maternity Voices Partnership (MVP) and service user involvement.

Recommendations for further progress –

- To strengthen the audit process to ensure board assurance
- Continue with gathering further evidence as processes mature to demonstrate sustainability and embedding of the Immediate and Emerging actions
- To ensure cross-site learning.

There has been on-going work since the visit in May 2022 and therefore many recommendations have been or are being met.

Ockenden report, 2022

The 2nd report is much larger with 92 actions to be met. There is no requirement to provide evidence of compliance until the publication of the East Kent Maternity Report which is expected in October 2022, however work is on-going to ensure actions can be evidenced and currently self-assessment shows the Trust is meeting 24 of the 92 actions.

Developments from some actions are being made by the national and regional teams including –

- Bid for funding to support Clinical Leadership to support the Ockenden work, increasing bereavement midwifery provision and monies to support enhanced training for midwifery support workers.
- Local universities are designing an academic course to support labour co-ordinators
- An LMNS wide policy to manage conflict of clinical opinion is being drafted.

Maternity Improvement Advisor(s)

Support continues to be provided by the Maternity Improvement Advisor (MIA) programme and a visit by Sascha Wells-Munro, OBE – Deputy Chief Midwifery Officer who leads the programme occurred on 30 August 2022 with positive feedback received.

The midwife and obstetric advisors regularly join maternity meetings and visit the sites monthly.

The MIA QI lead, Sophie Kellaway, is to visit Scunthorpe Maternity Unit on 27 September 2022 to provide support for the on-going QI projects.

Continuity of Carer teams

Diana Princess of Wales maternity unit continues to provide care to a cohort of women from 2 teams – Daisy and Poppy. Current data highlights that 8% of women in our care received continuity throughout their pregnancy, labour, delivery and in the postnatal period. However, the targets set out in the Maternity Incentive Scheme (CNST) for women to be cared for in continuity teams has been removed as from 21 September 2022 until such time that the midwifery workforce nationally has improved. These targets did form part of the CNST compliance however are no longer required.

Maternity Incentive Scheme (CNST)

The Compliance with the 10 Safety Actions is proving difficult to achieve. There is an expectation that all 10 Safety Actions are met by 5 January 2023 however the mandatory training elements and Saving Babies Lives v2 are challenged in meeting the requirements. The reasons for this include workforce demands and ultrasonography establishment gaps and training requirements to meet expectation of Saving Babies Lives v2.

Safety Action	Expectation to meet compliance
1 Perinatal Mortality Review Tool	Yes
2 Maternity Services Data Set	Yes
3 Avoiding Term Admissions to the Neonatal Unit	Yes
4 Clinical Workforce	Yes
5 Midwifery Workforce	Yes
6 Saving Babies Lives v2	Tentative
7 Service User Feedback	Yes
8 Mandatory Training	Tentative
9 Safety Champions	Yes
10 NHS Resolution	Yes

With respect to the tentative compliance with Saving Babies Lives v2 and Mandatory Training, there is on-going close monitoring and weekly meetings to introduce and embed as much compliance as is possible within the timescales.

Jane Warner
Associate Chief Nurse – Maternity, Gynaecology and Breast Services

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(22)170

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

Report for Trust Board Meeting on:	4th October 2022
Report From:	Finance & Performance Committee – 24-08-22 and 21-09-22

Highlight Report:

ED performance remains low linked to continued increase in numbers and the flow in the hospital. There is a small increase in the 12hr trolley waits. UCS continues to be a success but the risk is GP coverage of service. SDEC continues to improve. Bed Occupancy remains high.

Integrated Urgent and Emergency Care was discussed with an in-depth conversation happening around the Lost Bed Days caused by the backlog of Discharge to Assess patients. It was however noted that NLaG are the 2nd best performing trust in percentage of patients with a 21 day+ length of stay. The Committee queried when the trust will get back to achieving 75% performance for the 4 hour waits and was informed that improvement should be seen from November onwards. It was also asked why the trust did not just off load all the ambulances as they arrive and were informed this is due to space but were reassured that patients were managed on ambulances whilst waiting.

RTT has seen an increase in the overall waiting list size but the 52+ week pathways have stabilized. Diagnostics has deteriorated but some areas are improving, CT is a problem area. Cancer continues to be a struggle with several challenges. The Committee was provided with a deep dive review of the elective performance including the recovery plans. The Committee questioned the increasing RTT waiting list size but were assured that the overall waiting list sizes are not increasing. The Committee also queried the Cancer position and was informed that although there are high volumes over 62 days a large proportion are undiagnosed and would not continue along a cancer pathway.

Facilities Services provide the Trust support service functions across all three Hospitals. The service currently employs 616 staff across a range of substantive and bank contracts. With a Whole Time Equivalent (WTE) of 470 and a pay and non-pay budget of almost £18m, the services included are cleaning, portering, patient food, waste, linen & laundry, post, pest control, deep cleaning, transport and fleet management. They also manage our outsourced Security & Car Parking services. The national food and cleaning standards were discussed and that the cleanliness standards have been implemented and that the food standards have yet to be published. The Committee questioned the rising food prices and how quality could be maintained within the current financial envelope, it was responded that it is difficult to mitigate against due to nutritional and calorific targets which have to be met although some cheaper alternatives e.g. swapping beef for chicken could be looked at as well as potential vegetarian days.

The Committee also reviewed the trusts green and travel plan. The Trust has performed well continuously for the last 12 months with significant decreases in carbon emissions since 2021. The Committee asked questions specifically around the opportunities for the future and are recommending this report which will be presented to Trust Board for approval.

Confirm or Challenge of the Board Assurance Framework:

A deep dive into SO1-1.6 was carried out and assurance was given on the risks, control gaps and plans.

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

Highlight Report to the Trust Board

NLG(22)171

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	04 October 2022
Director Lead	Michael Whitworth, Non-Executive Director and Chair of Workforce Committee
Contact Officer/Author	Michael Whitworth Non-Executive Director and Chair of Workforce Committee
Title of the Report	**Workforce Committee Highlight Report and Board Challenge**

Purpose of the Report and Executive Summary (to include recommendations)	The Committee recommended highlighting the following matters to the Board, namely:
	• The Approval of the Staff Lottery Committee Annual Report on behalf of the Board
	• Endorsing the direction of the work to strengthen flexible working arrangements in line with national principles
	• Assuring the following 3 reports from the Medical Directorate:
	  ○ Medical Education Annual Report
	  ○ Guardian of Safe Working Annual Report
	  ○ Doctors in Difficulty Annual Report

Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
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Financial implication(s) (if applicable)	N/A

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

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BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	04 October 2022
Report From:	Michael Whitworth, NED & Chair of Workforce Committee

Highlight Report: Workforce Committee – 20 September 2022

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

Items Highlighted by the Committee for the Attention of the Board

The Committee reviewed, discussed and endorsed the work done and direction of travel recommended for the further development of flexible working in the Trust. This will be further discussed by the whole board at the Board Development Day on 1st November 2022.

The Committee received an update on the Culture Transformation Programme and thanked Alison Dubbins for all her work on the programme and insight she had shared with the Committee, and wished her well in her new role.

The focus of the Humber Acute Services Review was workforce and the Committee welcomed the alignment of Trust workforce data and plans with the in-depth HASR work.

Items for Committee Ratification and Assurance

The Committee approved the Staff Lottery Committee Annual Report on behalf of the Board.

The Committee reviewed the following 3 reports from the Medical Directorate for assurance purposes:

- Medical Education Annual Report
    - The improvement in year-on-year trainee feedback was welcomed and the Committee commended Dr Gimba, his team, and the wider medical community within the Trust for the significant improvements that were being seen.
    - Although there is still considerable work to be done the Committee were assured that the Medical Directorate and Education team were fully cognisant of the challenges and barriers, and were continually looking at opportunities within the Trust and wider partnerships to improve things further.
- Guardian of Safe Working Annual Report
    - The Committee welcomed and endorsed the annual report.
    - The importance of the work to improve engagement with junior doctors was highlighted and supported by the Committee
    - Dr Evans was thanked for her work during the year

- Doctors in Difficulty Annual Report
    - The Committee reviewed the annal report and discussed the contents and supporting processes
    - The Committee endorsed the on-going work of the Doctors in Difficulty Group and its approach

Confirm or Challenge of the Board Assurance Framework:

No changes were recommended for the Board Assurance Framework.

Action Required by the Trust Board:

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

NLG(22)172

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	04/10/22
Director Lead	Dr Elizabeth Evans
Contact Officer/Author	Dr Elizabeth Evans
Title of the Report	**Guardian of Safe Working Annual Report**
Purpose of the Report and Executive Summary (to include recommendations)	The Annual Guardian of Safe Working Report has been revised from previous years. It was felt the Board would appreciate oversight of the exception reporting and trends and work that has been done and needs to be done to make the learning experience at NLaG a good one. In this years report we have concentrated on the trends in reporting from year to year, both in the types of report submitted, and in the prevalence throughout different stages of the yearly cycle. Exception reporting have remained low and primarily focus on additional hours. There are a small number of reports for missed educational opportunities, for which the Director of Medical Education (DME) provides support in finding an agreeable resolution. We have undertaken a number of engagement events throughout the year to try to improve the numbers of reports received, and hopefully this will be reflected in the year to come. <u>Recommendations</u>: 1. To continue to support and encourage the work of the Guardian and the DME in engaging Educational Supervisors and Consultants in the exception reporting system. 2. To ensure a positive regard for the education of trainee doctors recognizing the importance of the medical workforce and safeguarding the balance of service provision and education. 3. To support initiatives to improve the experience of doctors in training at NLaG. The main areas of focus are the Medical departments, with an aim of removing Health Education England (HEE)'s requirement for improvement. This will strengthen the Trust's reputation and attractiveness as a training provider/employer. 4. To promote the engagement of the Junior Doctors in the exception reporting process, and to promote the system as an agent for positive change and patient safety within the trust.

Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ü Other: Workforce Committee
Which Trust Priority does this link to	ü Our People ü Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	ü Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
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Financial implication(s) (if applicable)	N/A	
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Recommended action(s) required	ü Approval ü Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Annual Report

Dr Liz Evans
Guardian of Safe Working
July 2022

Contents

Executive summary

The Annual Report of the Guardian of Safe Working Hours shows the exception report information for the annual period of July 2021 to June 2022. Quarterly reports continue to be generated and shared at TMB, JLNC, the Junior Doctor's Forum (JDF) and with colleagues at Health Education England (HEE).

There are no trainees within the Dentistry service at NLaG and so the Annual Report applies only to doctors in training.

We are now in the sixth year of the 2016 national contract for doctors in training which aimed to encourage stronger safeguards to prevent doctors working excessive hours. Exception reporting (ER) of extra hours, missed breaks and missed educational opportunities is well established in Northern Lincolnshire and Goole NHS Foundation Trust and we continue to positively promote exception reporting through induction, training, drop ins and the monthly Junior Doctors' Forum.

The 2016 contract was subject to review in 2019 and although largely unchanged there were some notable differences which the Trust has implemented.

Exception reporting is a valuable instrument that provides up to date information regarding pressure points in the system. It ensures safe working hours and improves the morale of doctors in training, the quality of medical training and patient safety. It is also the agreed contractual mechanism for ensuring that trainees are paid for all work done.

The safety of patients is a paramount concern for the NHS and for us as a Trust. Staff fatigue is a hazard to both patients and staff. The safeguards for working hours of doctors in training are outlined in the terms and conditions of service (TCS) and are designed to ensure that this risk is mitigated, and that this mitigation is assured.

Fill rates for doctors in training at the Trust continue to be high, over 80%, which has helped with rotas, working hours, and ensuring access to educational opportunities.

Rota design and co-ordination now sits within the Workforce Resource Centre. This provides oversight of rota design and ensures that the terms and conditions of service as per the Junior Doctors Contract are met within that design.

High level data – as of June 2022

Number of training posts (total): 240

Number of doctors in training posts: 198

Number of LTFT trainees: 26

Number of training post vacancies 41

Source: Recruitment via establishment spreadsheets and vacancy spreadsheets.

Exception report analysis

The table below, from the Allocate software, provides a breakdown by speciality of the total number of exception reports received during the period July 2021 to June 2022.

Department	Total number of exceptions submitted
Accident and emergency	1
Acute Medicine	25
Anaesthetics	15
Cardiology	4
Diabetes & endocrinology	3
Gastroenterology	44
General medicine	135
General surgery	29
Geriatric medicine	5
Obstetrics and gynaecology	12
Ophthalmology	1
Paediatrics	3
Respiratory Medicine	2
Rheumatology	2
Trauma & Orthopaedic Surgery	9
Urology	1
Grand Total	**291**

This data shows the areas that generate the highest number of exception reports. This enables specific focus to be given to the areas identified in order to support the specialty in reducing exception reporting and providing a good learning environment for the doctors in training.

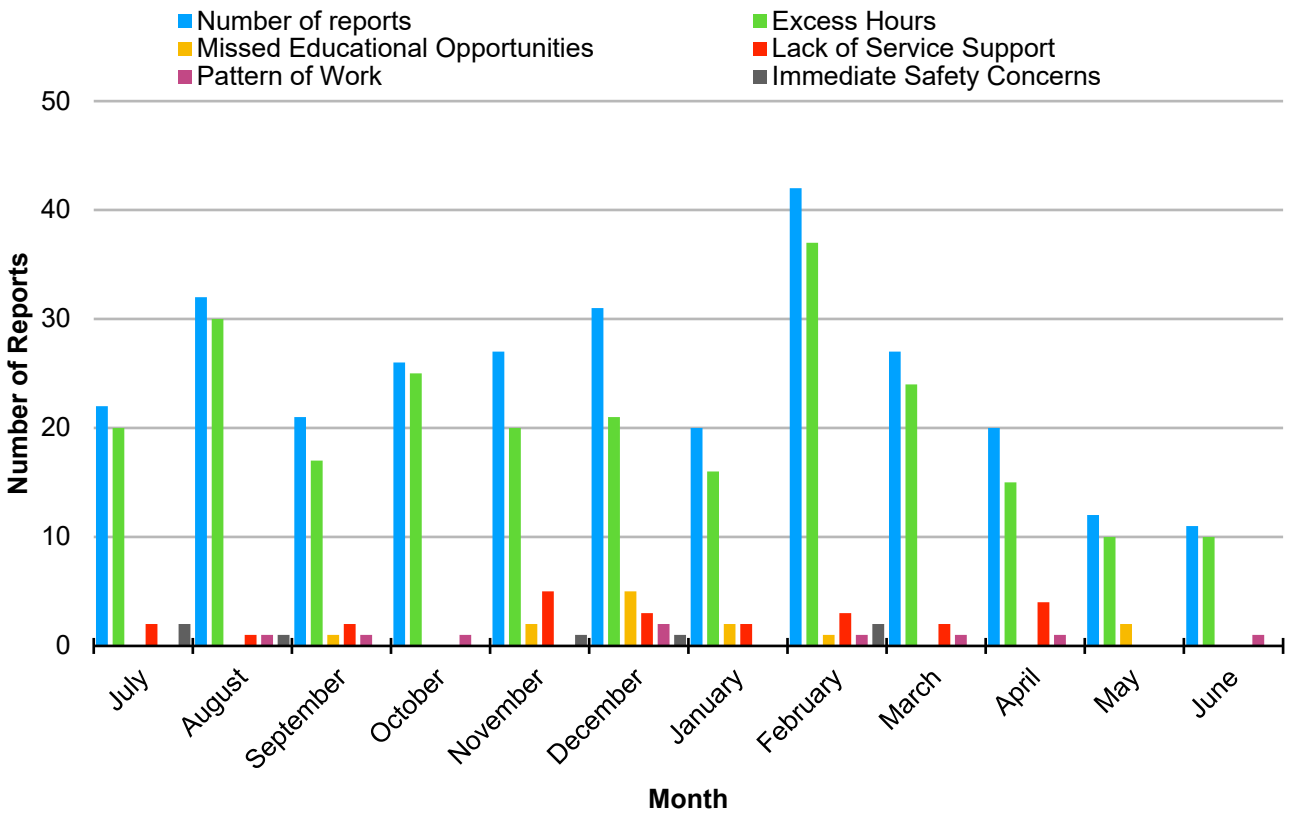

Figure 1: Reasons for exception reporting by month.

The above table (figure 1) shows the number of exception reports submitted from all departments by month, with a breakdown to show the reasons reports were submitted. As is usual the vast majority of the reports received concern excess hours worked. The reason for this is likely to be that it is an easily recognisable incident which can be quantified, and thus is more likely to be reported. There appears to be a large increase in the number of reports submitted in both August and February, which is to be anticipated owing to the Junior Doctors rotating jobs. The February reports were particularly high, which reflects a high number of reports from the gastroenterology department owing to an issue with new doctors starting in role. This issue was resolved by the department swiftly once highlighted, and the lower number of reports in March reflect that.

This report shows a marked decrease in the number of reports received concerning the gastroenterology department, this is likely to be due to the actions taken in the previous year to improve staffing rates and trainee experience. There has been an increase in the number of reports received by the acute medicine department across both trusts, which reflects clinical pressures in dealing with the COVID-19 pandemic.

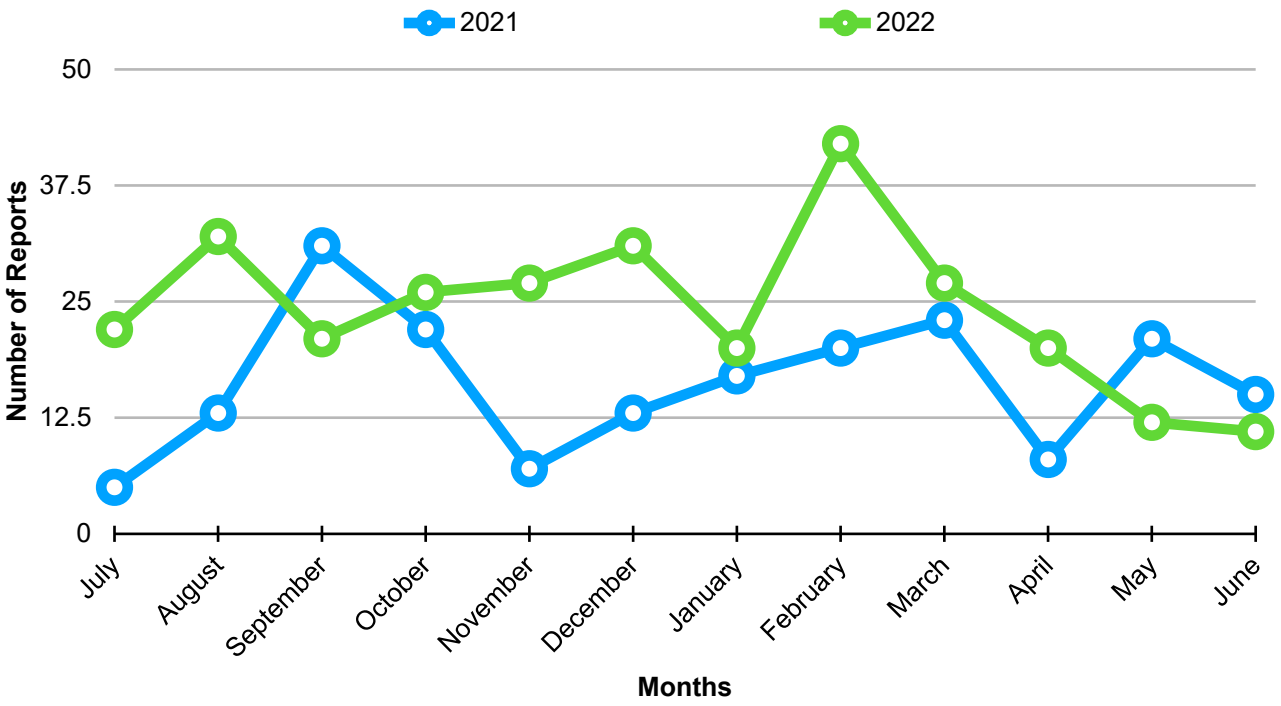

Figure 2: Exception reports by month

As figure 2 shows the rate of exception reporting has increased between 2021 and 2022 . This is likely to be due to the engagement work with the doctors in training, with improved engagement being reflected by an increased rate of reporting. The peak rate of reports received occurred within the same two two month periods in both years. This reflects the rotation of the doctors to new jobs, as there is always a settling in period. There is also a reduction in the number of reports received during June in both years, which is possibly due to the doctors having worked in their jobs for the longest possible period, which leads to improved efficiency.

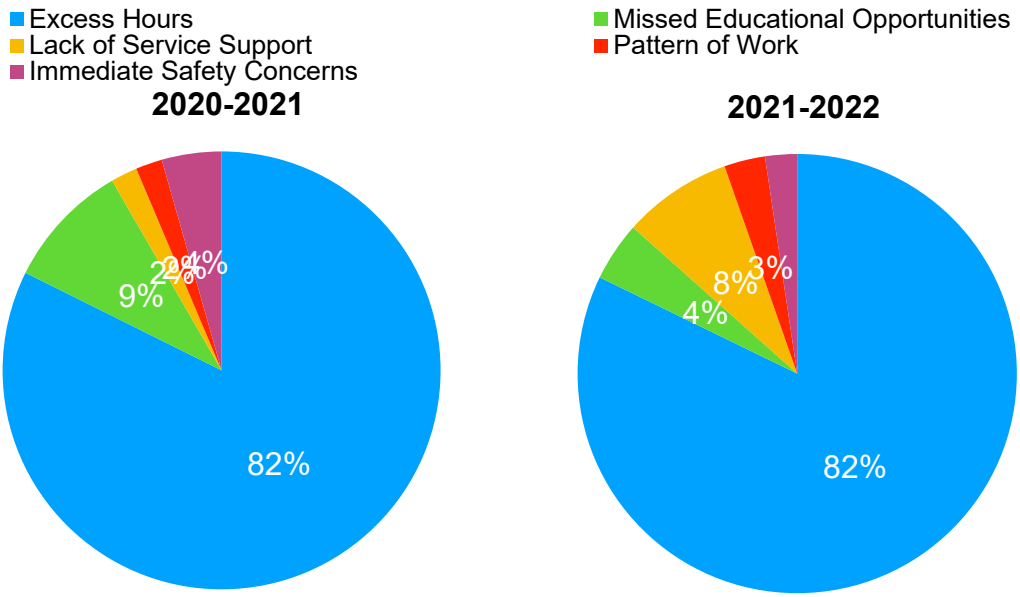

Figure 3: Reasons for Exception Reporting by Year

As shown in figure 3, the reasons for exception reporting show consistency comparing this year with the last. By far the most common reason for exception reporting remains excess hours, and this is a pattern we would expect to see continue moving forward. This is because excess hours is the most easily quantifiable type of breech, which makes the doctors much more likely to report it. An increase in the number of exception reports for other reasons may suggest improved engagement in the exception reporting process. This is something we hope will increase as our engagement strategies, for example induction and our new leaflet campaign take effect.

Summary

1. The Trust was granted £60,000 of national money in 2021 to improve facilities for doctors in training and working in partnership with the doctors this has now been used to upgrade the doctors rest facilities and enhance the doctor's mess. This work has now been completed, and upgraded rest areas are available on both sites.

2. Fill rates remain high but this does not always translate in the reduction in need for locums and further work at Directorate level is required to understand the demands for locums, with the aim to reduce the reliance on locum doctors.

3. There have been 2 fines imposed for breaches of the Doctors in Training Contract. These fines were imposed for doctors missing breaks, and for excessive working hours. This money has now been spent on wellbeing resources for the doctors, after discussion at the Junior Doctors Forum.

4. This past year has continues to see an improvement in engagement with our doctors in training. We will continue to build on this during the next academic year.

5. The GoSW attends meetings between the Trust and HEE to monitor the learning environment. During the past year these meetings have concentrated on Medicine and Gastroenterology, following concerns raised in the GMC annual trainee survey.

6. The GoSW holds Junior Doctor Forums every month and these are a valuable opportunity for our Doctors representatives to meet with the Guardian, MD office, Director of Medical Education (DME) office, BMA and LNC in one place. Issues addressed over the past year have included:

    - Rota concerns
    - Working conditions
    - Continued progression on the Fatigue and Facilities Charter
    - Attendance at the JDF

7. There is now a defined slot at the JDF to discuss quality improvement and there is a dedicated point of contact within the quality improvement office to support the Junior doctors.

Recommendations

1. To continue to support and encourage the work of the Guardian and the DME in engaging Educational Supervisors and Consultants in the exception reporting system.

2. To ensure a positive regard for the education of trainee doctors recognising the importance of the medical workforce and safeguarding the balance of service provision and education.

3. To support initiatives to improve the experience of doctors in training at NLaG. The main areas of focus are the Medical departments, with an aim of removing HEEs requirement for improvement. This will strengthen the Trust's reputation and attractiveness as a training provider/employer.

4. To promote the engagement of the Junior Doctors in the exception reporting process, and to promote the system as an agent for positive change and patient safety within the trust.

Dr Liz Evans - Guardian of Safe Working

Date: July 2022

NLG(22)173

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	4 October 2022	
Director Lead	Lee Bond, Chief Financial Officer	
Contact Officer/Author	Brian Shipley, Deputy Director of Finance	
Title of the Report	**Finance Report – M05**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights the reported financial position of Month 05 of the 2022/23 reporting period. The Trust Board are asked to note: • The Finance Report, Month 05 • The £2.59m year-to-date deficit	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: F&P Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Contained within the report.	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	☐ Information ✓ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
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1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Finance Report Month 5

August – 2022/23

Executive Summary Month 5 2022/23

The Trust had a £0.15m deficit in August, £0.05m worse than plan. The Trust now has a £2.59m year-to-date deficit, £3.73m worse than plan. The trust is forecasting a balanced position, but is highlighting a downside potential downside deficit risk of £8.8m. The Trust is currently assessing the potential mitigating actions it can take.

Income was £0.01m below plan in month.

• The ERF income plan was again recognised as fully achieved, per system requirements. However the Trust did not achieve the 104% activity target for August, despite spending the Capacity Reserve set aside in the plan, meaning an estimated £2.29m Elective Recovery Funding received year-to-date would be at risk if not protected from clawback for H1.

• Clinical income was £0.19m below plan due to low high-cost drug spend (£0.31m) and a £0.1m shortfall on the Lincs ICB Contract, partly offset by injury recovery income (£0.14m above plan) and Cancer Alliance funding (£0.06m above plan). Other income was £0.23m above plan because of several minor favourable variances, including Path Links ULHT, accommodation and education income. There was a £0.05m adverse variance on Covid-19 Outside Envelope income due to lower testing costs. The Trust is over-performing on CCG pathology contracts but these are block-funded.

Pay was £0.94m overspent in month.

• Medical staff was £1.11m overspent. Increased Non Elective and Emergency activity continues to drive overspends across Medicine Acute Care and ED (£0.19m). Non-delivery of CIP, mostly recruitment, caused a £0.22m overspend. Premium pay covering sickness and vacancies caused overspends in Gastro (£0.04m), Geriatrics (£0.02m), Goole Medicine (£0.02m), Orthopaedics (£0.09m), Ophthalmology (£0.11m), General Surgery (£0.08m) and Urology (£0.06m). £0.04m overspends across the trust were due to additional activity payments, despite low productivity vs 19-20 baselines. £0.21m Anaesthetics overspends were due to consultant intensivists awaiting job plans, premium pay covering vacancies and junior WTE over budget (awaiting updated HEE income statement). Staff covering UCS GP contracts caused a £0.06m overspend but is offset by non-pay underspends.

• Nursing was £0.09m underspent in month. £0.28m vacancy underspends across Maternity, Community District Nursing and NICU, and £0.04m trainee ACP underspends obscure cost pressures that would otherwise amount to £0.1m from at least 31 additional escalation beds (per SitRep). Additional duties in ED and SDEC agency premiums (£0.16m) are the other key overspends. Non-delivery of CIP, mostly recruitment, caused a £0.1m overspend

• Other Pay was £0.08m underspent in month. However, over-delivery of non-recurrent CIP within Corporate functions masks overspends across E&F support staff (£0.03m), Care Navigators and Site Management in the Workforce Resource Centre (£0.02m), and WTE over budget across Surgery (£0.02m) in Urology and Ophthalmology and CS admin. £0.04m Medical Support Worker overspends were offset by income.

Non Pay was £0.83m underspent in month

• This was due to ERF activity being below plan, and non-elective patient activity being down 2.3% in month vs April-July averages, causing £0.27m underspends on clinical supplies and £0.52m outsourcing underspends.

Post EBITDA items were £0.11m underspent in month

• This was mainly due to a high cash balance in the month, resulting in interest received and a reduced PDC charge.

COVID-19 expenditure was £2.77m year-to-date

• The inside envelope costs were £0.21m below plan YTD.

Income & Expenditure to 31st August 2022

Income & Expenditure	Annual Plan to 31st March 2023 £'000	Current Month Plan £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
Clinical Income	374,338	31,195	31,006	(190)	155,970	155,590	(379)
Block Top Up	58,394	4,866	4,866	(0)	24,331	24,331	(0)
Covid Inside Envelope Block	11,387	949	949	(0)	4,745	4,745	(0)
Covid Outside the Envelope	1,700	142	87	(54)	708	356	(352)
Other Income	39,338	3,308	3,539	231	16,221	17,312	1,092
Donated Income	0	0	9	9	0	122	122
Total Operating Income	**485,157**	**40,460**	**40,456**	**(5)**	**201,974**	**202,456**	**482**
Clinical Pay	(256,495)	(21,298)	(22,315)	(1,017)	(107,063)	(111,822)	(4,759)
Other Pay	(65,707)	(5,458)	(5,379)	78	(27,409)	(27,333)	76
Total Pay	**(322,203)**	**(26,756)**	**(27,695)**	**(939)**	**(134,472)**	**(139,155)**	**(4,683)**
Clinical Non Pay	(70,187)	(6,127)	(5,855)	272	(28,692)	(29,661)	(969)
Other Non Pay	(71,403)	(6,001)	(5,441)	560	(29,378)	(28,059)	1,319
Total Non Pay	**(141,590)**	**(12,128)**	**(11,296)**	**832**	**(58,070)**	**(57,719)**	**351**
Operating Expenditure	**(463,793)**	**(38,884)**	**(38,991)**	**(107)**	**(192,542)**	**(196,874)**	**(4,333)**
EBITDA	**21,364**	**1,576**	**1,465**	**(111)**	**9,433**	**5,582**	**(3,851)**
Depreciation	(16,169)	(1,265)	(1,272)	(7)	(6,216)	(6,338)	(122)
Interest Expenses & Other Costs	(233)	(19)	44	63	(97)	140	237
Dividend	(6,251)	(503)	(450)	53	(2,513)	(2,190)	323
Total Post EBITDA Items	**(22,653)**	**(1,787)**	**(1,678)**	**110**	**(8,826)**	**(8,388)**	**438**
Remove Capital Donated I&E Impact	1,289	107	59	(48)	537	219	(318)
I&E Surplus / (Deficit)	**0**	**(104)**	**(154)**	**(50)**	**1,144**	**(2,587)**	**(3,730)**

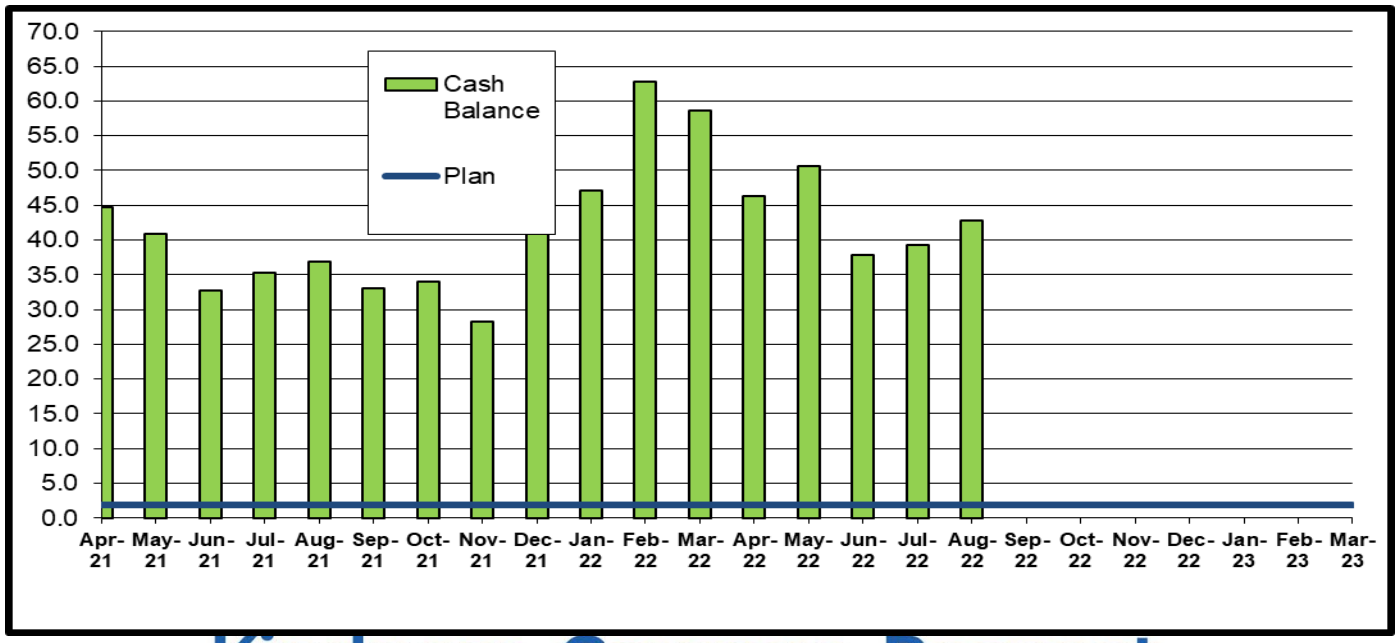
COVID-19 Expenditure

Expenditure Category	Year-to-date 21-22		
	Pay (£k)	Non-pay (£k)	Total (£k)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	1,845	0	1,845
Existing workforce additional shifts to meet increased demand	3	0	3
Backfill for higher sickness absence	405	0	405
Decontamination	0	132	132
After care and support costs (community, mental health, primary care)	0	19	19
COVID Medicine Delivery Unit (CMDU) service	52	0	52
COVID-19 virus testing - rt-PCR virus testing	59	11	69
COVID-19 virus testing - Rapid / point of care testing - locally procured reagents costs	136	105	241
Total COVID-19 Expenditure	2,501	266	2,766
Total Trust Operating Expenditure (including COVID-19 expenditure and all other operating expenditure)	139,155	57,719	196,874
COVID-19 % of Total Trust Operating Expenditure	1.8%	0.5%	1.4%

Cash

The cash balance at 31st August was £42.75m, an in-month increase of £3.4m.

	£m	£m
Cash Balance as at 31st August		**42.75**
Commitments:		
Income received in advance	3.14	
	5.86	
Capital plan underspend	7.35	
Capital loan repayments	0.39	
Aug PAYE/NI/Pension	10.87	
Public Dividend Capital payment	2.19	
To support other creditors due	11.05	
		(40.85)
NHSi minimum balance		**1.90**



Balance Sheet as at 31st August 2022

	Last Month	This Month
	£mil	£mil
Total Fixed Assets	263.31	262.38
Stocks & WIP	3.53	3.55
Debtors	12.18	10.46
Prepayments	7.02	6.83
Cash	39.35	42.75
Total Current Assets	62.07	63.58
Creditors : Revenue	41.17	41.45
Creditors : Capital	6.16	5.86
Accruals	21.34	23.40
Deferred Income	4.66	3.14
Finance Lease Obligations	1.63	1.44
Loans < 1 year	0.71	0.72
Provisions	2.44	2.87
Total Current Liabilities	78.10	78.89
Net Current Assets/(Liabilities)	(16.03)	(15.31)
Debtors Due > 1 Year	1.25	1.25
Creditors Due > 1 Year	0.00	0.00
Loans > 1 Year	8.21	8.21
Finance Lease Obligations > 1 Year	14.48	14.48
Provisions - Non Current	5.50	5.50
TOTAL ASSETS/(LIABILITIES)	220.35	220.14
TOTAL CAPITAL & RESERVES	220.35	220.14

- Debtors have reduced in month, NHS debtors by £0.8m and other debtors by £1m relating to vat claims.
- The Trust cash balance has increased in month. The Trust had limited payment runs during the month following a cyber attack on Advanced systems.
- Deferred income reduced in month, the August education income has now been released.
- Capital creditors have reduced in month, progress on schemes is slow at present. Revenue creditors have remained stable and accruals have increased, a reduced number of invoices were registered and processed on the system during August, therefore costs have been accrued.
- The total BPPC figures for the Non NHS and NHS invoices continues to be above 90%. We may see a reduction during September due to the delay in registering and authorising invoices following the cyber attack. We are continuing to monitor the BPPC and are communicating to staff the importance of authorising invoices.

Northern Lincolnshire and Goole NHS Foundation Trust

Name of the Meeting	**Trust Board of Directors (public)**	
Date of the Meeting	Tuesday 4th October 2022	
Director Lead	Jug Johal – Director of Estates and Facilities/Health Inequalities Lead	
Contact Officer/Author	Jug Johal – Director of Estates and Facilities/Health Inequalities Lead	
Title of the Report	**Estates and Facilities Executive Report**	
Purpose of the Report and Executive Summary (to include recommendations)	The report provides a brief overview of the highlights, lowlights and risks within the services in the Estates and Facilities Directorate. Updating the board of key successes and outcomes and current/future projects. The Trust Board is asked to: a) Note the Estates and Facilities Report b) Note the Key highlights, low lights and risks across all Estates & Facilities functions	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	-	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-	
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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FACILITIES SERVICES

Highlights	Lowlights	Risks
• National Standards of Healthcare Cleaning - Implemented amendments for compliance against standard, auditing officers in post and training.		• Impact on cleaning quality outcome / Star Ratings as a result of revised monitoring process
• DPoW ED H.S.A Resource recruited & trained commenced 19th September 2022	• No additional Porter Resource approved for DPoW & SGH EDs	• Impact of additional tasks and transfer times creating delays
• SGH ED H.S.A Resource model submitted in line with DPoW, awaiting approval to progress	• Confirmation delay impacts recruitment & Training	• Resource available at point space available for use
• Independent NHS Food Service report released November 2020. No further updates shared	• Prevents detailed inclusion into Business Plan	• Unable to review standard to understand Trust need for compliance
• Recruitment of staff into Facilities roles, competing with minimum wage, high pay frequency roles and rates in food industry	• Recruitment & Retention Issues	• Agenda for Change (AFC) T&Cs no longer competitive, lengthy recruitment process often fails to secure appointment
• Security Car Parking Contract mobilised – CCTV Project Install completed		• NLaG equipped with market leading CCTV system, improved capacity to monitor key flash points
• Inflation impacting costs of Fuel, food and plastic consumables pricing and availability	• Costs above budgeted Inflation	• Service leads aware of costs pressures, presenting evidence based reports for additional funding
		• Financial pressure, supplier issues, inconsistency of stock, impacts patient menu
• Car Parking Variable Message Signage Review to improve communication of site spaces post ED works	• Existing signs no longer supported or compatible	• Costly to replace

COMMERCIAL SERVICES

Highlights	Lowlights	Risks
• Accommodation configuration adjusted at SGH to support the increase in HYMS Students. Students now occupy most of the single rooms across the Trust. This limits flexibility to support other staff groups, at SGH in particular. DPoW benefits from a significant number of flats in addition to rooms. • Overall Trust activity value rose during May, achieving MSP or above. Minimum Services (MSP) adjustment refund of £4.5k received following increased activity levels in May. Receipt of £15.6k refunded credits. • Utilisation of Decontamination Services Agreement (DSA) to facilitate instrument repair and purchases through Services Provider realised additional vat recoverable of £1.3k via invoicing process. • Significant increase in Private Patient demand. Opportunity to target waiting lists if theatre slots are available. • No reported Cancelled Operations relating to Decontamination Services. • Confirmation has been received from North Lincolnshire Council (NLC) that the Trust can re-occupy children's centre's for Maternity Services, specifically Barton. • The disposal of Monarch House and relocation of services to New Beacon House reducing property rental costs.	• 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 SGH exceeds supply. • Unable to implement Hybrid working paper. • Minimum Services adjustment payments of £36.9k for DSA. • Transition to new financial management system caused negative impact to pay monthly invoices on time. • Progress on lease arrangements with NLC for the Community Equipment Store remains challenging with NLC seeking to apply additional cost pressures to the Trust. • Awaiting consultation process for the children's centres in NEL to enable services to resume. • IFRS 16 making lease arrangements less attractive. 2021 Rate Review.	• Ability to provide surgery slots to meet demand for Private Patients. • If the Trust is unable to provide accommodation this can impact workforce and patient care. • Severe potential that we will not be able to offer admin space to teams (especially at DPOW) or adhere to Space utilisation policy. • Trust highly unlikely to achieve Minimum Services Level with DSA creating a financial pressure. • Underutilisation of DSA instrument purchase managed service will not yield potential VAT savings.

SAFETY & STATUTORY COMPLIANCE

Highlights	Lowlights	Risks
• Phase two of the fire alarm replacement programme at DPOW completed and new alarm system now fully operational. This advanced fire alarm system will reduce the risk of fire not being detected at the earliest stage and is fully addressable to allow for future usage changes and names changes • Estates Return Information Collection (ERIC) submitted and validated within the required deadlines. This information will allow us to benchmark our estates and facilities performance more accurately against other trusts and also between sites within NLAG to improve the patient and staff environments • Ongoing involvement in capital projects. This includes involvement with both new Emergency Department (ED) projects, Same Day Emergency Centre (SDEC) design, Ward 25 as well as new projects including Gamma Camera • Ongoing participation in national Premises Assurance Model (PAM) working group for future development. This means that NLAG is helping to develop the information contained with the PAM process for national trends to be identified as well as NLAG developing their processes and policies to improve patient experience. NLAG have also been involved in the development of the PAM portal to submit returns electronically and also working towards inclusion with Model Health. • Fire face to face training resumed and Fire Wardens Training revised and training commenced. This will enable the Trust to meet the requirements of face to face training for all staff at least once every four years. • Discussions with community lone worker system providers now giving usage information to follow up. Increasing the usage will help the staff who are lone workers within the community to be better protected and able to summon assistance quickly. • Compliance training ongoing with nearly 50% committed/spent in Month 5 so all statutory specialist training for Estates and Facilities (E&F) staff will be completed.	• Community lone workers alarm usage very poor – working with providers and comms to increase to ensure that staff are protected adequately when working in the community. • Project work and issues with fire alarm at SGH impacting on work programme. Whilst statutory compliance performance monitoring is being maintained some development of the processes is restricted. • Time to recruit – the overall process from getting the job description to appointing and then starting date can act as a discouragement to some candidates	• Still trying to recruit to vacancies which will allow more development of processes to be undertaken and maintain and expand the internal auditing programme. • No dedicated training venue for E&F (currently used for Practice Development Nurses) so may affect ability to “catchup” delayed training

ESTATES & ENGINEERING

Highlights	Lowlights	Risks
• Continued drive to modernise and create a culture with the right skills and abilities developing a more proactive, forward leaning team in an era of constant change. Transformational, instilling a culture of continuous learning and development. • The NHS long-term plan focuses on digitalization. The estates team has taken the first steps toward digitalization of the estate; Building Management System (BMS) role, asset tagging, energy metering, laser scanning & Building Information Modelling (BIM) modelling of Queens Building (SGH), leading to estates operational management improvement via Computer Aided Facilities Management (CAFM) system. • Enhanced information gathering and appreciation which has enabled a more defined, understood picture of the estate to be escalated, to ensure accurate data Estates Return Information Collection (ERIC) and Premise Assurance Model, and thus creating a detailed backlog maintenance programme. • The pandemic, and on-going support to projects, has put pressures on all teams, however, it has developed closer collaboration with clinical counterparts as we strive to make the environment better for staff and patients alike. • Enhanced GDH maintenance team to support the new energy centre, which will improve engineering compliance. In accordance with the NCZ40 and supporting the Trusts Green Plan.	• Lack of resource support to new EDs, MRIs (pay and non-pay) and GDH Energy Centre (non-pay only), which are additional m2 to the estate. Continued financial pressure on budget due to CIP saving (£200k) to support the Trusts financial position, external economic situation, £107m Back Log Maintenance (BLM). • Unable to achieve full compliance requirements due to pressure to deliver Trust strategic projects. • Positive Trust drive to improve NLaG: Ask Peter, Patient Led Assessment of Care Environment (PLACE), Patient Advice and Liaison Service PALS, 15 Steps, generating lists of reactive work which compounds budgetary pressures, creating a negative perception of the estate. • Due to Trusts financial position, it was unable to support 2021/22 business case for specific resource to manage water risk at SGH, which leads to increase risk of enforcement action, thus doing reputational damage. • Loss of key Site Manager at key hand over of new ED facility at SGH.	• Resource impact due to influenza/Covid combined with continual business as usual pressure, compounds risk to patient environment delivery due to lack of additional resource provision, supported by accepted risk on risk register. • Mismatch between finance, staffing and operational requirements, results in increased risk to patients & staff. • Increasing estate (ED & MRI), decreasing operational resources. • Continued operational pressures (Moving from COVID to Capital Projects) resulting in dwindling good will of maintenance team impacting compliance work. • Financial position currently under pressure at 6 month point before winter period, which historically has cost more, driven by aging estate and economic climate. • Workforce risk. Constant issue with recruiting and retaining staff linked to agenda for change (AFC). • So what… Combined, impacts ability to support operational delivery as risk factors are all elements considered external.

CAPITAL PROJECTS

Highlights	Lowlights	Risks
• Further to the previous update, several projects have now successfully completed or are nearing completion including: • Upgrade of the Oxygen Infrastructure at DPoW, increasing the supply of oxygen available on medical wards, enabling better treatment of respiratory patients needing high oxygen flows and an increased number of patients to be treated in one area. Resilience of the oxygen system to potential problems has also improved • Removal of the old CCU modular building and entrance ramp, to enable essential repairs to the old ITU roof and improved patient / staff welfare on C level. Overall improved C level and pond area environment due to removal of scaffolding, window cleaning and window replacement. Improved footprint due to the creation of an additional office along C7 corridor • DPoW Endoscopy refurbishment of staff areas, creating welfare facilities including the creation of a staff rest room / kitchen • Replacement of the failing Fire Alarm System at DPoW, providing a safer environment for patients and staff throughout the entire hospital • New MRI Suite at SGH, increasing the hospital footprint by creating an additional MRI suite, with a modernised scanner, supporting the reduction of waiting times for MRI patients and by increasing the electronic diagnostic capability • Ward 25 full refurbishment, creating a fully modernised single room ward environment improving the patient experience whilst having medical treatment, in line with improved infection control guidance. • A number of projects have also commenced, either on site or at design stage, including: Theatres 7, 8 and A; Gamma Camera; Ward refurbishment 2023/24; SGH Fire Alarm; Critical Water Infrastructure; Fire Door Surveys / Replacement; Changing Places / Disabled Access Routes; Maxillo Facial Rooms.	• Difficulties and delays in recruiting / maintaining sufficient staff to deliver projects effectively and sustainably • Project delays due to supply chain and material shortages • Impact of Covid-19 on project works on site	• Supply chain and material resource availability impacting on ability to deliver projects • Ongoing inflationary pressures within the supply chain impacting on ability to deliver projects within budget constraints. • Difficulty in recruiting staff to both permanent and fixed-term roles

NLG(22)175

Name of the Meeting	**Trust Board - Public**	
Date of the Meeting	Tuesday 4th October 2022	
Director Lead	Jug Johal - Director of Estates and Facilities	
Contact Officer/Author	Mark Edgar - Associate Director of Estates Projects	
Title of the Report	**Fire Alarm Replacement**	
Purpose of the Report and Executive Summary (to include recommendations)	To formally minute approval from the Trust Board to replace the fire alarm system at Scunthorpe Hospital.	
Background Information and/or Supporting Document(s) (if applicable)	Virtual Trust Board approval received in September 2022	
Prior Approval Process	☐ TMB ☐ PRIMs	✓ Divisional SMT ✓ Other: BLM & Capital Group and CIB
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ✓ Restoring Services ☐ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Included within paper	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☑ Information ☐ Review ☐ Other:

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
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1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

TRUST BOARD: CAPITAL PROJECTS
Fire Alarm Replacement Project

Report from: Capital Projects **Contact:** Jug Johal / Mark Edgar	**Date of Meeting:** 5th September 2022

Introduction

In 2020, the Trust obtained competitive bids through the SBS framework for the renewal of the fire alarm systems at all three hospital sites. The successful Contractor was Galliford Try (previously NMCN plc). A phased approach to the renewal has been adopted, with the first phase of works being at the DPoW site, which is now nearing completion.

Funding for the renewal of the fire alarm system at Scunthorpe Hospital has now been made available and the proposal is to appoint Galliford Try to undertake these works following on from the works at DPoW.

Proposal

Total funding available: **£5.5m** (incl. VAT and fees)

Spend 2022 / 2023: **£2.5m** (incl. VAT and fees)

Scope of Works

- The proposal is for Galliford Try to undertake and complete the works, allowing the new fire alarm system to be fully operational by June 2024

Letter of Intent

- A letter of intent was issued to Galliford Try on the 18th of August 2022 to ensure swift mobilisation of essential survey works, up to the value of £57,988.10

Recommendations

Trust Board are requested to approve the following:

- Confirm the agreement to appoint Galliford Try as the contractor for the works
- Agree to an order being raised to Galliford Try to the value of £4,282,257.68 (excl. VAT).

NLG(22)176

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	4th October 2022
Director Lead	Lee Bond, Chief Finance Officer / Ivan McConnell, Director of Strategic Development
Contact Officer/Author	Lee Bond, Chief Finance Officer / Ivan McConnell, Director of Strategic Development
Title of the Report	Overview of Major Capital Submissions and Strategic Capital Status
Purpose of the Report and Executive Summary (to include recommendations)	The attached paper provides the Board with an overview of the current status of significant Capital Investment Submissions The Board is asked to note: • The status of those submissions • The risks associated with the delivery of the submissions if approved • The strategic capital risks we face even we secure a place on the National Hospitals Programme
Background Information and/or Supporting Document(s) (if applicable)	The Trust is currently engaged in five major capital programmes: • Targeted Investment Fund Bid for refurbishment of Theatres 7 & 8 (DPoW) and Theatre A (SGH) – Total Value £6.3m • Community Diagnostic Centres in Grimsby and Scunthorpe – Total Value £29.5m • Strategic Capital Investment EOI - £470m – to include the development of a new Scunthorpe General Hospital • Development of an OBC to develop a Humber Wide EPR. £12m funding is available NLAG to support the implementation with a requirement for matched investment over a longer period. This is likely to be a significant, long-term revenue investment requiring significant clinical transformation. • Preparation for a grant application, totalling £31m to the PSDS with a £9m Trust contribution. The proposed scheme will deliver significant carbon reduction and backlog improvements and will be delivered over the next two years. Expected submission of application is October 2022 The Board is asked to note: • The Trusts participation in these national schemes • The status of each application • The risks associated with the delivery of each funding application • The residual capital risk that remains regarding the Hospitals' physical infrastructure even if we are successful in achieving all of the funding being applied for.

Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: SDC Discussion
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	✓ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

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Humber and North Yorkshire
Health and Care Partnership

Major Capital/Overarching Capital: Update

Existing Bids
Strategic Capital Investment

Lee Bond, Chief Finance Officer
Ivan McConnell, Director of Strategic Development

NLaG Board: 4 October 2022

The Trust has a number of outstanding capital investment applications

Humber and North Yorkshire Health and Care Partnership

- Targeted Investment Fund
- Community Diagnostic Centres
- Strategic Capital EOI
- Digital Capital EPR
- PSDS

- Business Cases are at different stages of development
- Business Cases/grant applications vary in scale from £6.3m - £470m
- Business Cases are at various levels of approval
- Whilst these business cases are important we still have significant residual capital infrastructure risks which are currently unfunded

Targeted Investment Fund Submission

Humber and North Yorkshire Health and Care Partnership

Description

- Refurb Theatres 7, 8 (DPoW) and Theatre A (SGH)
- Estimated Cost: £6,300,000
- Estimated go-live May 2023

Benefits

- Increased sessions:
  - 15 additional theatre session per week – DC/IP – 3.5 cases per session
    - 2,625 additional cases over annum / 50 weeks
- Reduced ALoS to 2 days
- Modern design – Laminar Flow – improved infection control & greater clinical flexibility.

Risks

- Potential additional increase of 4 beds – mitigated through reduced LoS
- Existing infrastructure ability to support – utilities
- Inflation – cost increase
- Resources to complete – contractor availability, materials availability

Community Diagnostic Centres

Humber and North Yorkshire Health and Care Partnership

Potential Fixed Site: Scunthorpe

Potential Fixed Site: Grimsby

Multiple Mobile Pads

Drivers

- Nationally funded programme – H&NYHCP £36m plus potential for addn £11m
- Demand increase over the next ten years significant:
  - MRI c10% per annum
  - CT c15% per annum
- Hospital services do not have enough capacity to meet demand

Potential Costs

Grimsby	£m
Build	12.2
Equipment	4
Total	**16.2**

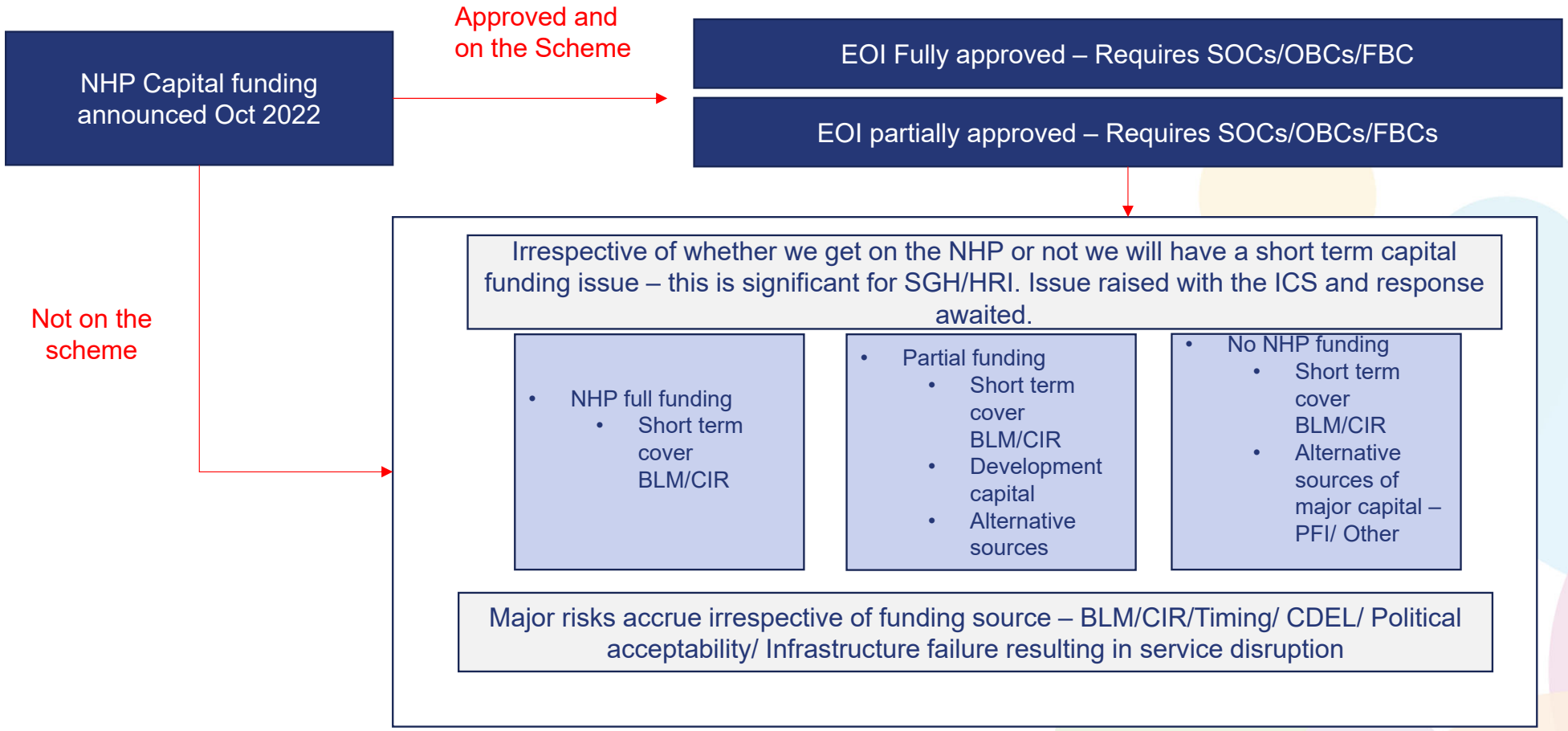
Scunthorpe	£m
Build	9.3
Equipment	4
Total	**13.3**

Risks/Issues

- Value for money with significant build costs?
- Affordability – Regional allocation does not cover cost of planned services
- Implementation will be phased - no plan agreed
- Workforce – availability of radiography/radiology
- Site location – availability – alignment to Local Authority Priorities/Funding
- Potential for external funding – Local Authority – IFRS16 impact
- Timescales to deliver – nationally determined

Our capital position is precarious and even if we get NHP funding we will be challenged

Humber and North Yorkshire Health and Care Partnership



Digital Funding: Provision of a Humber wide Electronic Patient Record

Humber and North Yorkshire
Health and Care Partnership

- £12m funding per Trust being made available to NLAG and HUTH. A combination of Capital and Revenue available over 3 years
- Requirement for matched funding over a 5 year period
- Funding intended to cover majority of costs of implementing an EPR solution
- Major transformation of clinical and non-clinical practices would be essential
- Outline Business Case planned for Autumn 2022

Public Sector Decarbonisation Scheme

Humber and North Yorkshire
Health and Care Partnership

- Building on work done in 2021/22 at Goole and SGH
- Further grant application for circa £31m with a requirement for £9m of Trust funding. To be spent over a 2 year period 2022/24
- Replaces some ageing infrastructure so contributes to backlog maintenance reduction
- Application Process expected to commence in October 2022

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(22)177

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

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	4th October 2022
Report From:	Finance & Performance Committee – 24-08-22 and 21-09-22

Highlight Report:

The Trust has a £2.59m year-to-date deficit, £3.73m worse than plan. If no mitigating actions are taken, initial forecast assessments project a potential risk of a £8.8m end of year deficit, which would also worsen the underlying deficit position. The Committee questioned the actions in place to correct this and reassurance was given that all plans would be brought to the Committee as they are generated. There was no immediate risk from rising energy prices, as the Trust had bought this in advance. Temporary staffing costs were the main driver of the overspend. A new agency ceiling had been introduced. The Committee queried a significant increase in unsocial hours rates.

ERF income was again recognised as fully achieved, per system requirements. However, the Trust did not achieve the 104% activity target for July. It is anticipated that no clawback of ERF will be enacted for the H1 period. The Committee queried the risk going forward of not achieving the 104% and assurance was given that new processes are being put in place to make sure that activity levels are being booked at 19/20 levels within core capacity which would mitigate the potential £3.2m risk in H2.

Pay was £0.09m overspent in month and non-pay was £0.83m overspent in month.

COVID-19 expenditure was £2.77m year-to-date which continues below plan.

The Trust delivered its CIP in July and August with an under delivery of £249k, mainly due to medical and nursing workforce plans, supported by corporate underspends.

The Capital programme is behind plan on ward 25 and ED schemes, there is also a knock-on effect from the ED slippage onto the IAAU plan, which could jeopardise completion within this year.

The Recovery Support Programme letter was discussed, as the Committee were concerned about the potential for the current financial position to jeopardise the Trust's ability to exit from the Recovery Support Programme for finance.

The business case for the refurbishment of 3 theatres had been approved by the ICB and had now gone to the DOH.

Confirm or Challenge of the Board Assurance Framework:

A deep dive into SO3-3.1 was carried out and assurance was given on the risks, control gaps and plans. The Committee requested that the rising level of inflation was included as a risk moving forward.

Action Required by the Trust Board:

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

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

NLG(22) 178

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	4th October 2022
Director Lead	Ivan McConnell, Director of Strategic Development
Contact Officer/Author	Kerry Carroll, Deputy Director of Strategic Development Claire Hansen, HAS Programme Director
Title of the Report	Key Issues - Strategic & Transformation
Purpose of the Report and Executive Summary (to include recommendations)	The attached report provides the Board with an update and overview of our progress against the delivery of: **Strategic Objective 1 - 1.3: To give great care** **Strategic Objective 4: To work more collaboratively** The Board is asked to note: The progress that is being made on the delivery of the Humber Acute Services critical milestones of Programme 2 Core Service Change and the changes to the proposed consultation timeline following discussion and agreement by the Humber & North Yorkshire Integrated Care Board: • Consultation now planned to commence summer 2023 The progress that is being made on the development of a Capital Strategic Outline Case to support major capital investment within NLAG and HUTH and the associated capital financing risks we face: • Potential announcement of the New Hospitals Programme (NHP) for the remaining 8 Hospital Trusts by end October 2022 • Residual capital risks we face even if we gain a place on the NHP, in particular within SGH Our continued participation in and leadership of collaborative ventures through partnership working, notably: • Membership of Place Boards • Leadership of Collaborative of Acute Providers (CAP) Strategy • Leadership of CAP Planned Care Strategy and Operational Planning/Delivery • Leadership of South Bank Community Diagnostic Centres Programme The Board is asked to note that whilst significant progress has been made in the delivery of the agreed milestones for Humber Acute Services there are potentially significant risks and key issues that still remain to future implementation and delivery: • The timing of consultation has moved to summer 2023 but could be impacted by wider system change in that time period • The risk of not being selected as one of the remaining 8 Trusts to become part of the New Hospitals Programme limiting our potential access to National funding and leaving us with a significant capital infrastructure and

	funding risk	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Directorate SMT
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ✓ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Capital funding	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk

	to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Strategic Service Development and Improvement – October 2022

Strategic Objective 1 (1.3) - To give great care

Strategic Objective 4 – To work more collaboratively

- With partners in the Humber Acute Services Review, we will engage fully in leading and supporting the development of a Pre-Consultation Business Case (PCBC) for the delivery of new models of care for ***(programme 2) linked to submission of a Capital Expression Of Interest (EOI) and Pre- Strategic Outline Case (SOC) (Programme 3) for:***

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

- We will play a full part in the development of the Humber and North Yorkshire Health & Care Partnership, including the:

    - Humber & North Yorkshire Integrated Care Board (H&NY ICB)
    - Acute Collaborative
    - Community Collaborative
    - Primary/Secondary Care Interface Groups – North and South Bank
    - Place Boards - North and North East Lincolnshire, East Riding of Yorkshire and working groups
    - HNY Cancer Alliance and associated professional networks
    - HNY Clinical and Professional Leaders Group
    - Community Diagnostic Centres

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

Highlights	Lowlights	Risks

Overall
• Early engagement with the H&NY ICB re the HAS Programme – potential options and consultation approach/timeline
• Continued attendance at the Overview Scrutiny Committees (OSC) and discussion re the timescale for setting up a Joint Health OSC to oversee the Consultation and Decision
• Review potential capital development options to include becoming one of the remaining 8 Trusts on the New Hospitals Programme (NHP) Place, or potential next steps should we not be a member of the NHP
• NHSE/I monthly assurance reviews continue with positive challenge and support
• Collaborative procurement of consultation and engagement external support with H&NY ICB – 2x contractors appointed
• Ongoing briefings of individual ICS Executive Team members, Place Directors and Primary/Secondary Care interface Groups
• Development of agreed work programme with Place Directors to support the design and implementation of a short list of essential out of hospital programme changes in the next 6 months
• Place Director x4 and wider system – ongoing briefings Doncaster/Lincoln
• Delivery of training sessions for NHSE National Improvement Directors and targeted regional updates
• Engagement with Donna Ockenden for potential further support
• Clinical Senate Review to be published – H&NY ICB asked for additional review of final options to c/f to consultation – ongoing discission with Senate Manager
	• Complicated acute review spanning all programmes and aligning to out of hospital and community diagnostic changes
	  • Out of Hospital (OOH) programme requires new governance and leadership – HAS team to support Place Directors for next 6 months and set up Programme Management Office to govern
	• Challenges of continuous engagement and involvement / time commitments for busy operational staff (including key clinical leads during recovery phase)
	  • Associate Medical Director Strategy/Programme Director and Deputy Director Strategy undertaking and maintaining continuous Divisional engagement on ongoing basis – this will be an increased requirement given timescale changes
		• Potential further movement of consultation timelines – political
		• Pathways in P2 look beyond hospital boundaries and require out of hospital transformation – OOH programme governance is not sufficient to deliver
		• Potential options may be subject to OSC, Public challenge resulting in Independent Review (IRP), Judicial Review (JR) or Secretary of State (SoS) review
		• Potential options may displace activity to neighbouring health economies
		• The delivery of changed pathways will require capital investment in digital as well as wider infrastructure – funding sources not yet known
		• Planned care pathways must align to wider ICS Elective recovery and Community Diagnostic Hub programme implementation
		• Potential further COVID wave and impacts on elective delivery and ability to continue with engagement and evaluation of key stakeholders
		• Potential impact on staff who have been engaged in process due to legislation delay – may lose interest and enthusiasm

Programme 2 (P2):

- H&NY ICB briefings x 2 – recommendation to ICB to move the timeline for consultation till June 2023 (agreed Wed 14 Oct)
- Finalisation of PCBC contents – final chapters added – Travel/IIA/Displacement/Enablers/Workforce/Plan to Implement
- Funding capital under review with NHSE Regional Team (approach to be agreed post NHP announcements)
- Agreed appointment of 2x external contractors – ORS and Verve Consulting – to support consultation document design, consultation and engagement process

Programme 3 (P3)

- Awaiting announcements on final 8 Trusts selected to become part of New Hospitals Programme – potentially mid/end October 2022
    - If selected multiple business cases will be required to support funding applications
    - If selected will still require significant capital cover for Back Log Maintenance/Critical Infrastructure Risks – particularly in SGH during any design/build phase
- Capital options in support of Expression of Interest (EOI) Strategic Outline Case (SOC) developed:
    - Investment Objectives
    - Options – Business as Usual (BAU)/Do minimum/Do Maximum
    - Phasing considered
    - Risk analysis undertaken
    - Funding options considered

- Capital funding sources not yet agreed – raised issue with Regional Finance Director – funding sources and capital gaps
- Delays to capital submission outcomes and potential extension of timelines for delivery of NHP – impact on funding short term Back Log Maintenance and Critical Infrastructure Risks costs
- Lack of affordability from internal capital for priority capital investment in the short term

- Potential for developments in ICB Strategy, Place Strategies and Collaborative Acute Providers Strategies to change prioritisation and focus of effort

Partnership and System working

- We will play a full part in the development of the Humber and North Yorkshire (HNY) 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 and North Yorkshire Health & Care Partnership: NLaG is an active member of a number of Boards/Groups across the Humber and North Yorkshire ICS: • Trust is member of HNY Partnership Board • The Trust is an active member of the Collaboration of Acute Providers Board and other members of the Trust leadership community participate in sub groups • The Trust is an active member of the Community Provider Collaborative • The Trust is actively involved various community collaborative (i.e. Outpatients Transformation, Planned Care Programme, Diagnostics, Urgent & Emergency Care Network, Community Paediatrics) • The Trust COO and Head of Cancer are members of the HNY Cancer Alliance Board • Senior leaders from across the Trust are active participants in HNY Clinical Networks • Linkages and alignment to the ICS Out of Hospital Programme Board as part of the HAS Programmes. • The Trust is an active participant in the emerging Place Based Partnerships • HAS leads are part of the primary/secondary care interface groups • The Trust is an active member of the HNY Clinical and Professional Leaders Group **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 HNY review of ENT, Urology and Orthopaedics • As part of the HAS Programme the Trust is actively engaged with National and Regional Network and GIRFT leads on Urgent Emergency Care, Maternity and paediatrics and a number of planned care specialties	• Pace of design and development of Place Base Partnerships – at different stages of development • Place Based Boards – lack of PCNs clarity of role	• Aligning the /strategies/ objectives/ priorities of the to HASR

NLG(22)179

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	4 October 2022
Director Lead	Lee Bond, Chief Financial Officer
Contact Officer/Author	Ellie Monkhouse, Chief Nurse; Joint Clinical Lead Dr Kate Wood, Medical Director: Joint Clinical Lead Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee; Author
Title of the Report	**HTF Trustees' Committee Highlight Report –** 8 September 2022
Purpose of the Report and Executive Summary (to include recommendations)	The highlight report summarises key issues presented to and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 8 September 2022. The Trust Board are asked to note the HTF support of the hospital courtyard gardens and ponds, and the approval of recommended works and items for 6 SGH wards.
Background Information and/or Supporting Document(s) (if applicable)	HTF Trustees' Committee Terms of Reference
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: HTF Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other: Click here to enter text.

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Northern Lincolnshire and Goole NHS Foundation Trust

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	4 October 2022
Report From:	Health Tree Foundation Trustees' Committee held on 8 September 2022

Highlight Report:

HTF Support of Hospital Courtyard Gardens & Ponds

- The topic of care and maintenance of courtyard gardens and ponds was discussed, following a comment about how both patients and staff benefitted from time spent in the relaxed and tranquil surroundings of such sites across all NLAG hospitals. These enhancements to personal welfare and well-being are heightened when courtyard gardens and pools are kept in good condition. The Charity Manager advised that her team had already been in talks with Estates and Facilities staff, with a view to seeking volunteers to adopt and tend these amenities on a medium to long term basis. The HTF would fund any reasonable expenses associated with this endeavour and potentially partner with the relevant hospital's League of Friends as well as the Trust itself.

Fairchild Legacy Project Plan

- Further to the Fairchild Legacy report to the August Public Board meeting, HTF Trustees were briefed on several items and works that could be provided by the Fairchild Legacy. This information had been derived from national research and additional liaison with appropriate dementia specialists. The aim of providing, amongst others, alternative flooring, additional signage, artwork, colour coding and seating areas on wards would be to give dementia patients more stimulation and encourage their continuing independence as well as enhancing the intrinsic safety of their environment. Trustees approved the suite of recommended works and provision of items for 6 SGH wards, with the aim of having one ward completed by the end of December 2022 if possible.

Confirm or Challenge of the Board Assurance Framework:

Not Applicable

Action Required by the Trust Board:

The Trust Board is asked to note the Health Tree Foundation support of the hospital courtyard gardens and ponds, and the approval of the recommended works and items for 6 SGH wards.

Neil Gammon
Independent Chair of Health Tree Foundation Trustees' Committee

NLG(22)181

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	4 October 2022
Director Lead	Linda Jackson, Vice Chair
Contact Officer/Author	Linda Jackson, Vice Chair
Title of the Report	**Strategic Development Committee Highlight Report & Board Challenge**
Purpose of the Report and Executive Summary (to include recommendations)	The Strategic Development Committee met on 22 August 2022, where members considered: - Community Diagnostic Hubs - Humber Acute Services Review Programme 2 and 3 - Strategic Digital Update on the Interim Clinical Plan - Review of the strategics risks within the Board Assurance Framework, namely, strategic objective (SO) 3-3.1, SO3.2 and SO4 - Committee Meeting Frequency The Trust Board is asked to consider: a) Three key items from the Strategic Digital Update on the Interim Clinical Plan: - The need for the Joint Development Board to agree what the standardised model of care will be across the different specialties, as without an agreed position it will impact on the digital roll out - The impact of competing requests for development activity of not only this workstream but also the work being undertaken for the Integrated Care System, Collaboration of Acute Providers, Place, along with local trust requirements is having on the staffing resources available. There is also a difficulty in deciding what work takes priority with the limited resources available. - As a result of the above discussion the committee felt that it would be useful to have some Trust Board time out discussing the differing requests being received from external stakeholders in a number of areas (not just the digital agenda). b) Reviewing the risks, mitigations and actions for strategic risk rating of Strategic Objective 3-3.2: To secure adequate capital investment for the needs of the Trust and its patient; at a future Board development meeting.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ☐ Other: Click here to enter text.

Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ☐ Finance ✓ Capital Investment ✓ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	4th October 2022
Report From:	Strategic Development Committee – 22nd August 2022

Highlight Report:

Community Diagnostic Hubs

The committee received a paper outlining the work being undertaken within the ICS on the CDH roll out .The committee were informed that a strategic outline case will produced by the end of August recommending that the CDC at Scunthorpe is taken forward first with an anticipated go live date in 2023. There is a funding issue with the overall scheme which will require a sequenced approach to investment moving forward

HASR Programme 2 and 3

The committee received a comprehensive update on progress**.** There is ongoing dialogue with the ICB on the "go live" date for the consultation on Programme 2 as there has been a level of nervousness raised about the November date with a possible move to June 2023.

Strategic Digital Update on the Interim Clinical Plan (ICP)

The committee received an update on the digital activity that forms part of the ICP roll out. There were three key messages to highlight to the Trust Board for further discussion.

- The need for the Joint Development Board to agree what the standardised model of care will be across the different specialties (i.e. centralised/decentralised admin functions, same model on both sites versus hybrid approach etc.) as without an agreed position it will impact on the digital roll out
- The impact of competing requests for development activity of not only this workstream but also the work being undertaken for the ICS, CAP, Place along with local trust requirements is having on the staffing resources available. There is also a difficulty in deciding the what work takes priority with the limited resources available.
- As a result of the above discussion the committee felt that it would be useful to have some Trust Board time out discussing the differing requests being received from external stakeholders in a number of areas (not just the digital agenda) and try and work through how we respond smarter and get things better joined up and influence the way forward

SO3.2 – To Secure adequate Capital Investment for the needs of the Trust and its patients.

The committee were presented with the following risk ratings:

- Inherent risk – 20
- Current risk – 20
- Target risk - 20

There had been challenge at the last Trust Board on the target risk rating of this strategic objective and a further review and lengthy discussion at the committee. The committee concluded that in most cases the target risk score should be lower than the inherent and current risk. However, with the real uncertainty about the new hospital's monies being available this puts us back in the scenario of having a failing estate with significant BLM issues with no real plan at the moment on how to mitigate this. It is therefore the recommendation of the committee that Trust Board time is allocated to fully understanding these risks, mitigations and agree actions

SDC Committee Meeting Frequency

The committee discussed the frequency the committee should meet moving forward due to recent meeting cancellations. The committee members agreed it could adequately service the workplan by holding committee meetings bi-monthly. This will allow more time for progress to be made against the items on the Committee's work plan. Any extra ordinary items occurring in between meetings which require attention will be dealt with virtually or via a short, extra ordinary meeting depending on the issue.

Confirm or Challenge of the Board Assurance Framework:

The BAF strategic risks SO1.3, SO3.2 and SO4 were reviewed. The committee commended the detailed work that had been put into the narrative and were satisfied that the BAF reflected the strategic risks facing the organization. The committee agreed with the risk scoring of risks SO1.3 and SO4, comments on SO3.2 are above

Action Required by the Trust Board:

The Trust Board is asked to note the key points made and consider the requests for further Trust Board discussion on the two points identified

Linda Jackson
Vice Chair / Chair of Strategic Development Committee

NLG(22)182

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	4 October 2022
Director Lead	Simon Parkes, NED / Chair of Audit, Risk and Governance Committee
Contact Officer/Author	Simon Parkes
Title of the Report	**Audit, Risk & Governance Committee Highlight Report – July 2022**
Purpose of the Report and Executive Summary (to include recommendations)	The attached highlight report summarises the key issues presented to, and discussed by the Audit, Risk and Governance Committee at its meeting on 27 July 2022: **1.** **Internal Audit**: Substantial assurance from Internal Audit reports on areas subject to review, and position with overdue recommendations is improved. New monthly status report on recommendations for Executive Directors introduced. **For Board to Note.** **2.** **HFMA Financial Governance Checklist**: Trust required to complete HFMA publication '*Improving NHS financial sustainability: Are you getting the basics right?*' self-assessment checklist and commission Internal Audit to review. Condition for additional funding in 2022/23 for all organisations. **For Board to Note.** **3.** **Fraud Awareness Training**: Case to be made to the new Portfolio Governing Board for fraud awareness training to be mandatory for staff every three years. **For Board to Note.** **4.** **Information Governance**: IG Toolkit submission made on 30.6.22 with an improvement plan showing a status of 'Approaching Standards'. IG training compliance missed target of 95%, achieving 91%. **For Board to Note.**
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk & Governance Committee Agenda Papers – 27 July 2022
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable

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

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

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
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3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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Report for Trust Board Meeting on:	4 October 2022
Report From:	Audit, Risk & Governance Committee – 27 July 2022

Highlight Report:

1. **Internal Audit** - The Committee continue to receive substantial assurance from Internal Audit reports on areas subject to review. The position with overdue recommendations is also much improved and an additional follow-up reporting process has been implemented to facilitate easier Executive Director oversight for recommendations relating to their respective areas, to ensure that the position does not deteriorate during the year.
2. **HFMA Financial Governance Checklist** - The Committee received a briefing paper on the recent NHSE requirement for NHS organisations to complete a self-assessment exercise involving the HFMA publication '*Improving NHS financial sustainability: Are you getting the basics right?*' This is required to be completed, with appropriate supporting evidence gathered where necessary, and subject to audit by the organisations Internal Auditors as a condition for receiving additional funding as part of the 2022/23 Operational Planning Round. HFMA checklist to be completed by the Trust, reviewed by the Executive and signed off by the CEO by 30.9.22. IA review to be completed by 30.11.22, with the final internal audit report received by the ARG Committee. Improvement actions arising from the exercise to be implemented by 31.1.23. Organisations will be encouraged to share their reports with system partners in order to consider best practice and provide peer challenge.
3. **Fraud Awareness Training**: The Trust is an outlier within the counter fraud collaborative organisations in terms of the level of training undertaken by staff. The issue of fraud awareness training is to be considered by the new Portfolio Governing Board at its meeting in September, at which the Trust's LCFS will present the case for making it mandatory every three years. The Committee acknowledge the competing pressures for mandatory training requests but are supportive of this request to ensure staff receive formal fraud awareness training periodically.
4. **Information Governance Update -** The Trust's IG Toolkit submission was made on 30.6.22. An improvement plan was produced and submitted with a status of 'Approaching Standards'. The level of compliance for IG training stood at 91% at the time of the submission. Despite best efforts by the IG team to encourage staff to complete it, the target of 95% was not achieved this year.

Confirm or Challenge of the Board Assurance Framework:

The Committee received and considered the BAF report for Q1 of 2022/23, and heard that it remained work in progress with further development during the year, including mapping the high level risk register to the BAF. The Committee felt the table of page 4 was a useful summary.

A query was raised in relation to the current and target scores for SO3.1 and SO3.2 (with target scores being higher than current scores), which the Director of Corporate Governance will pick up with the Chief Financial Officer.

Action Required by the Trust Board:

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

Simon Parkes
Non-Executive Director / Chair of Audit, Risk & Governance Committee

NLG(22)183

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	4th October 2022
Director Lead	Shaun Stacey, Chief Operating Officer
Contact Officer/Author	Ashley Leggott, Emergency Planning Officer
Title of the Report	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report for 2021/22**
Purpose of the Report and Executive Summary (to include recommendations)	The Emergency Preparedness, Resilience and Response (EPRR) Annual Report provides a summary of the work completed during 2021/22 and highlights the EPRR work and training programme for 2022/2023. This year's annual report also includes a summary of the Trust's response to Covid-19 pandemic and transition to business as usual. The Trust's EPRR arrangements are in place to ensure the Trust is complaint with: • Statutory obligations under the Civil Contingencies Act 2004 • NHS England EPRR Framework 2015/2022 • NHS Standard Contract SC30 In summary, there continues to be a considerable amount of work in developing the Trust's EPRR arrangements due to the continuously changing landscape. Nationally, there is a high level of focus with the increasing amount of guidance and expanding range of threats the Trust must be prepared for. It is essential that there is a continued focus on the Trust's EPRR and Business Continuity arrangements. It is important that the Trust maintains its positive reputation within the EPRR arena and contributes towards the Region's collaborative working and exercising. The Board is asked to: • Note the current compliance against the NHS England Core Standards for EPRR for 2021/22 • Note the training and work programme for 2022/23 (Appendix B and C)
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ✓ Restoring Services ☐ Reducing Health Inequalities ✓ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable

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Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
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Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Operations

Annual Report for Emergency Preparedness, Resilience and Response 2021/22

Report Date:	22 September 2022
Number of Pages:	18
Report Author:	Ashley Leggott, Emergency Planning Manager
Director Sign-Off:	Shaun Stacey, Chief Operating Officer

1.0 Background and Introduction

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG), in common with other NHS organisations, needs to be able to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could range from extreme weather conditions to an infectious outbreak, a major transport accident or an act of terrorism. As a Category one responder under the Civil Contingencies Act 2004, the Trust has a legal obligation to plan for and respond to these risks and threats working in partnership with other parts of the NHS, the emergency services and local authorities.

2.0 NHS Emergency Preparedness, Resilience and Response (EPRR) Assurance

NLAG is required to undertake an annual self-assessment against the NHS England Core Standards for EPRR. These core standards cover all aspects of the Trust's EPRR work, including the Trust's statutory obligations under the Civil Contingencies Act 2004.

Due to the impact of the Covid-19 pandemic the self-assessment process for 2021/22 was adjusted to represent the impact that the response to covid-19 was having within the field of EPRR. The training element of the standards was removed from the assessment process as NHSE/I had taken into account that training had to be stepped back to allow staff to continue to deal with the impact of the pandemic. The Trust was rated as substantially compliant as we are 89-99% compliant with the required core standards, a high rating the Trust has continued to maintain.

There were two standards that the Trust reported partial compliance (appendix A); these are standard 57- HAZMAT/CBRNe Planning arrangements and standard 59 – Decontamination capability and availability. Compliance with these standards continues to be a challenge with the number of ED staff trained to respond to a HAZMAT/CBRNe incident. This has been further compounded by the limitations that Covid-19 has brought to training being provided due to pressures experienced across the Trust's Emergency Departments. To support this, the Emergency Planning Team arranged train the trainer courses to be delivered to a number of staff from the emergency departments allowing for more training dates to be provided to all staff within the departments. More training days will be added to allow staff to be trained in the new decontamination rooms that are being built at both Emergency Departments, where a rolling programme of training for the ED's will ensure all staff receive their required competencies.

The self-assessment against the NHS England Core Standards for EPRR 2022/23 was issued in August 2022. It is believed there will be a small number of gaps within the section for training due to the impact of the pandemic which NHSE is expecting to be the case across all providers. NHSE are expecting a number of Trusts to report a lower compliance rating this year to previous due to the impact of the pandemic and pressures being experienced within the health sector. The process will involve the Trusts completing each of the 64 standards providing evidence for each and giving a rating as non-compliant, partially compliant or fully compliant. Once self-reviewed, a peer review will take place before submission to the Integrated Care Board (ICB).

The Deep Dive subject for 2022/2023 has been confirmed as Local Evacuation and Shelter arrangements.

The Trust continued to embed learning from the covid-19 pandemic including implementing the Incident Coordination Centre (ICC) for long-term use on a daily basis and sharing of information through the Strategic Covid Management Meetings held weekdays to ensure that the Trust was managing the oversite of the operational response and strategic forward planning. All strategic meeting key decisions and actions were captured on a central incident log through a loggist with a daily sign off process. The Trust has engaged in Regional Health Test exercises to ensure lessons learnt from the first and second wave were implemented correctly.

The inclusion of progress and learning being implemented in the Trust's Winter Planning preparation was ensured by the set-up of the winter planning group for 2021/22. This was established during June 2021 and met regularly to ensure preparedness for managing the challenges that winter brings aligned to national submission deadlines. It is recognised that as winter approaches there are significant challenges with weather, Covid-19 and seasonal flu. An action plan was closely monitored as part of the winter planning group with escalation into the ICC strategic coordination group meetings.

3.0 Testing, Training and Working Together with Local Partner Agencies

As a Category one responder, NLAG must carry out training and exercising of our emergency plans and contribute towards collaborative exercising of local partner agencies' emergency plans. The EPRR Training Programme (Appendix C) lists the internal and external training and exercises completed during 2021/22 and those currently planned for 2022/23.

Emergency plans must be validated through an exercise every three years as a minimum unless a live incident occurs when the emergency plan is implemented. Section 5.0 within this report refers to live incidents that have occurred over the past 12 months.

3.1 Live Decontamination Exercise

The EPRR team carried out a Live Decontamination Exercise in 2018 at Scunthorpe General Hospital (SGH) to test the Trust's response to contaminated casualties self-presenting at the Emergency Centre. The team had a further Exercise planned for 2021 at Diana Princess of Wales Hospital (DPOW) but due to the COVID-19 Pandemic this had to be cancelled and will be re-scheduled for 2022. With the new Emergency Department builds including a dedicated decontamination room facility all staff will have a live training exercise on the new equipment. A multi-agency exercise is being planned for 2023 when the new builds have become operational.

3.2 CBRNe/HAZMAT Training

Emergency Care Centre staff are required to complete CBRNe/HAZMAT training annually. This includes the Initial Operational Response (IOR) and Step 123+ principles for contaminated self-presenters and the use of dry decontamination. The training also includes practical elements such as the fitting and use of the Powered

Respiratory Protective Suits (PRPS) and the deployment of the decontamination tent for both wet and dry decontamination in order to maintain patient dignity (soon to be replaced by the new build decontamination facilities).

EMAS conducted a CBRNe/HAZMAT audit at DPOWH and SGH during February 2022 to assess the Trust's preparedness to respond to an incident. The audit included serviceability and maintenance of equipment, emergency plans in place and the specialist training provided in-house. NLAG successfully passed the audit with no gaps in planning identified. A potential barrier that was noted was the difficulties in releasing operational frontline Emergency Department staff to undertake the specialist training required. This barrier has become more apparent as the number of staff who have not completed their annual refresher training has remained high. The risk this presents to staff safety and the Trust's ability to respond to contaminated self-presenting casualties has meant this has been added to the risk register by the Medicine Division. Training had significantly reduced due to the pandemic but plans for training to re-commence during 2022/23 are now in place.

3.3 Bank Holiday Preparedness

The Bank Holiday planning approach for the operational impacts and mitigations is now well established and continues to be in place ahead of all Bank Holidays. This involves the check and challenge of medical rotas, nursing rotas, senior management cover and service provisions through a multi-directorate planning group. An assurance spreadsheet is distributed within the Trust and to the Gold and Silver on-call teams.

3.4 Working with Local Partner Agencies

In respect of partnership working with local partner agencies, the Trust is represented at the Local Resilience Forum (LRF), the Local Resilience Forum's Sub-Groups, and the Local Health Resilience Partnership. In addition, NLAG locally attend the Emergency Preparedness and Resilience Group in Northern Lincolnshire which has recently also been attended by North Lincolnshire CCG Emergency Planning lead. NLAG participates in joint planning and testing of regional plans and regularly attends multi-agency exercises to evaluate response plans and identify lessons to be learned that can be incorporated into NLAG plans.

3.5 Learning Lessons from Terrorist Attacks

NLAG proactively reviews its emergency plans and arrangements to ensure that any lessons to be learned from incidents across the UK are assessed, and where applicable, incorporated into our local plans. The debrief reports from the terrorist attacks (Westminster, Manchester Arena, and London Bridge) have been shared with NLAG and relevant identified learning opportunities incorporated into the Trust's emergency plans and training. The initial Salisbury Incident findings have been shared with the Trust, however, a full review will be conducted when the final report is published.

3.6 New EPRR National Guidance

In July 2022, new EPRR national guidance has been published by NHS England for all NHS organisations and in particular category one responders, which includes NLAG.

The National Occupational Standards for EPRR guidance now mandates set minimum competencies that all leaders and managers involved in leading an incident response or part of the decision-making process must achieve. The two main elements of this are that:

- All Strategic, Tactical and Operational Managers must attend the relevant national Health Commander Course (e.g. Gold On-Call rota participants must attend and complete the national Strategic Health Commander Course)
- All Strategic, Tactical and Operational Managers must maintain a Personal Development Plan (PDP) with evidences their continuous professional development to meeting the National Occupational Standards for EPRR for their role

The new training requirement is being rolled out through a phased approach across the region. A new EPRR Framework has also been released that captures the changes in escalation and incident response at regional levels, aligning the responsibilities between NHS England and the newly established Integrated Care Systems. These changes will be incorporated into the Trust's emergency plans and escalation procedures.

4.0 Emergency Preparedness, Resilience and Response - Work Programme

The EPRR Work Programme (Appendix B) provides a high-level overview of the work to be carried out that ensures compliance with the NHS England Core Standards for EPRR. The EPRR Work Programme will continue to develop in line with the ever-developing guidance and legislation to ensure the Trust maintains its compliance and readiness to respond to an incident.

5.0 Incidents – Implementation of Emergency Plans

Between 1st April 2021 and 31st March 2022, the Trust activated its emergency plans to support the response to one live incident.

Description of Incident	Date	Emergency Plans Activated
NLAG COVID-19 Pandemic	Jan 2020 - Ongoing	• Business Continuity Plans • Pandemic Influenza Response • Patient Flow, Escalation and Surge Policy • Critical Incident Plan • Incident Coordination Centre Manual • Major Incident Plan • COVID-19 Pandemic Surge Plan

5.1 Covid-19 Response

At the end of January 2020, the Trust received the first email relating to an emerging situation in the Wuhan region of China in relation to Wuhan Novel Coronavirus Virus that was infecting large numbers of the population. The EPRR team held a teleconference with local CCG's to establish the risk to our local Health and Social Care services could possibly face should the virus arrive within the UK. In February 2020 it was established that cases were emerging within the UK, so planning was prioritised to ensure an appropriate and proportionate response was established. The situation with Covid-19 (Wuhan Novel Coronavirus) increased as the pandemic escalated in the proceeding months with a large number of patients presenting to the Trust with Covid-19. An Incident Coordination Team was established to deal with the demands of the pandemic and in March 2020 the Trust set up physical ICC to centrally manage the on-going incident. The Trust experienced the highest number of inpatients related to Covid-19 during November 2020, which placed the Trust under extreme pressure. During this month a Major Incident was declared due to concerns of demand on the oxygen provision at both DPOWH and SGH sites. The Trust continued to respond to the demands being placed upon our services caused by the pandemic with the numbers of patients requiring treatment fluctuating month by month. During the period of December 2021 and January 2022 the Trust experienced high levels of staff absence caused by the pandemic and large number of ward/bed closure. The pandemic is still ongoing at present as the UK experiences the fourth wave but currently numbers and covid related acuity is lower than the initial waves. The national management of the incident is currently at level 3 as Trusts are required to transition from a covid response to living with covid as part of business as usual.

In March 2022 the government announced that the country would start to reduce restrictions relating to the pandemic in a phased approach. The Trust subsequently started to implement a phased response in reducing the restrictions that had been implemented during the pandemic. In April 2022 the restrictions that were reduced included the social-distance spacing between beds reverted back to pre-pandemic levels, non-clinical areas were reverted to pre-pandemic social distancing and the removal of face masks within some areas. Day 5 and 7 testing was stopped at the end of April 2022 with the continuing admission and day 3 testing continuing until the end of May 2022 when day 3 testing was also stopped. The requirement to wear face masks within the hospital was removed in June 2022 but remain within clinical areas (e.g. wards, ED). All restrictions that were removed are continually under review by the Infection Prevention Control Team to ensure the ongoing safe management of covid within the Trust.

NLAG has also been preparing for the national Covid-19 inquiry commenced this year, including collating evidence that could be potentially requested and issuing all staff and targeted communications messaging to retain all records as per the national request. A covid-19 inquiry working group has been established, Chaired by the Director of Corporate Governance, who are coordinating preparations and attending inquiry training delivered by the Trust's legal team Capsticks.

National learning lessons from the first wave of the pandemic identified the need for organisations to bolster and expand their EPRR teams and that Trusts should not rely on just a few individuals, as this has caused extreme fatigue and unprecedented workloads within EPRR and restricted the flow of the specialist knowledge these roles have when dealing other emergency situations and the planning.

Lesson Identified	Action Required	Completed
Isolation Facilities across the Trust were very limited and caused operational flow issues, due to lack of facilities	Increase capacity of isolation facilities across the Trust. Action taken purchased 30 redi-rooms which were split between DPOWH and SGH. Included in Ward refurbishments to include isolation facilities	Yes and Ongoing programme with ward refurbishments
Oxygen Flow rate within DPOWH and SGH identified as being a potential risk for cohorting of high oxygen usage patients	Full review of oxygen flow rates and stress testing completed across the Trust. Oxygen dashboard to show pull from system for each area created on WebV. Installation of new oxygen supply	Ongoing oxygen upgrade works in progress
Use of loggists – recording of decision making	Ensure the Trust has a robust pool of trained loggists that can be called upon during a prolonged duration incident. Training Programme to commence October 2022 to increase trained pool	Ongoing

6.0 Summary and Next Steps

In summary, there continues to be a considerable amount of work in developing the Trust's EPRR arrangements due to the continuously changing landscape. Nationally, there is a high level of focus with the increasing amount of guidance and expanding range of threats the Trust must be prepared for. It is essential that there is a continued focus on the Trust's EPRR arrangements and that we transition away from a covid response and re-focus on other risk and threats and recovering EPRR training programmes.

7.0 Trust Board Action Required

The Board is asked to:

- Note the current compliance against the NHS England Core Standards for EPRR for 2021/22
- Note the training and work programme for 2022/23 (Appendix B and C)

Appendix A

Action Plan for Compliance with NHS England Core Standards for EPRR 2021/22

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	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
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	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	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
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	• 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	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

Emergency Preparedness, Resilience and Response Work Programme 2022-23

Emergency Preparedness, Resilience and Response Work Programme 2022-23				
Subject	**Task**	**Deadline**	**Status**	**Notes**
Work in Progress and Updates				
NLAG Winter Planning and Potential Covid 19 Action Plan	Meetings arranged to run from July 2022 through winter	**Pre-Winter**	**On-going**	
EPRR Annual Report	Part of annual reporting cycle	**August 2022**	**In Progress**	
Adult Critical Care Services Surge Procedures				
Management of surge and escalation in critical care services SOP for Adults Critical Care	National Policy	**01/03/2022**	**Completed**	
Management of surge and escalation in critical care services SOP for Adults Respiratory ECMO	National Policy	**01/03/2022**	**Completed**	
Adverse Weather Response Tools				
The Cold Weather Plan for England	Ensure relevant actions can be activated during Cold Weather Alerts	**01/05/2022**	**Completed**	National Plan updated 2021

Adverse Weather Coordination Template	Excel Spreadsheet	**01/11/2022**	**To Do**	For Review prior to Winter 2022
Cold Weather Assurance SITREP Example	Excel Spreadsheet	**01/11/2022**	**To Do**	For Review prior to Winter 2022
Emergency Accommodation for Staff on DPOWH Site Template	Word Template	**01/11/2022**	**To Do**	For Review prior to Winter 2022
Hotel Accom near DPOWH Template	Word Template	**01/11/2022**	**To Do**	For Review prior to Winter 2022
Redeployment of Admin Staff Availability Sheet	Word Template	**01/11/2022**	**To Do**	For Review prior to Winter 2022
Volunteer Drivers and Additional Vehicles Details Template	Excel Spreadsheet	**01/11/2022**	**To Do**	For Review prior to Winter 2022
Burns Plan				
Burns Major Incidents and Burns Mass Casualty Incident Plan - Draft 16 July 12	Regional/National Plans	**01/10/2022**	**In Progress**	To review updated regional Plans
Management of Surge and Escalation in Critical Care Services - SOP for Burns Services	Regional/National Plans	**01/10/2022**	**In Progress**	To review updated regional Plans
Business Continuity Plans				
Business Continuity Policy **DCP219**	Review policy	**01/03/2022**	**Completed**	Reviewed and updated May 2022. Next review due March 2025
Business Continuity Plan Template	Update BCP template to provide additional detail on preparedness	**01/03/2022**	**Completed**	Updated template agreed and rolled out to all service-level BC plans
Guide to Completing the Business Impact Analysis	Guide to completing Impact Analysis section within BC Plan	**28/03/2022**	**Completed**	
Business Continuity Plans	BC Plans circulated to be reviewed - Updated by Divisons	**Monthly**	**Ongoing**	BC plan compliance reported at the EPRR Steering Group and monthly to divisions upon request.
Business Continuity Critical Services Overview	Updated following the return of BC Plans from the divisions	**Monthly**	**In Progress**	Last updated September 2021 - Hayley currently updating
Training and Exercise Section	To look at a training sessions for managers	**01/12/2022**	**To Do**	July 2022 - to look at training session for BC Plans and BIA's

Business Continuity Plan Tests	Validate BCPs through scenario testing	**Ongoing**	**In Progress**	Live testing during the Covid-19 pandemic.
CBRN/HAZMAT				
CBRN/HAZMAT Plan **DCM109**	Review and update plan	**01/11/2022**	**Ongoing**	Minor Changes made June 2022 still to be finalised, awaiting sign off through EPRR Steering Group and Medicine
DPOW Exercise	Live Decontamination exercise at DPOW	**01/06/2023**	**To Do**	Training to be completed on new decontamination facilities
SGH Exercise	Live Decontamination exercise at SGH	**01/06/2023**	**To Do**	Training to be completed on new decontamination facilities
CBRN/HAZMAT Training	Deliver 'train the trainer' sessions to A&E trainers and assist in improving compliance by supporting training delivery	**Rolling Programme**	**Ongoing**	**2017** - 'Train the trainer' session delivered at DPOWH and SGH. EP Training Officer supporting A&E training sessions. **2020** - Requested EMAS train the trainer training to be delivered to a set amount of staff across the Trust **2021** - EMAS to provide a train the trainer session - Refresher for EPRR and also new staff, awaiting confirmation date for training to be delivered within June 2021 **2022** - PRPS instructors coursed delivered to a number of Trust staff Feb **2022** - Department training to commence August 2022
CBRNe/HAZMAT Audit with EMAS	EMAS to complete an on-site audit of the Trust's CBRNe/HAZMAT preparedness at both DPOWH and SGH	**Yearly**	**Ongoing**	2021 audit completed Feb 2022 and next audit booked for October 2022
COMAH Site information	Review COMAH Site information held on the Hub	**01/12/2022**	**In Progress**	To carry out review of COMAH Site information held within NLAG and on site visits.
EPRR Steering Group				
Terms of Reference **DCT083**	Review TOR	**01/03/2022**	**Completed**	Reviewed and updated March 2022. Next due for review Feb 2025
Emergency Planning Hub Site				
Emergency Planning	All documents linked to EPRR Avaliable on the Hub	**Ongoing**	**In Progress**	Full review of Hub site to be completed
Fuel Plan				
Fuel Plan	National Fuel Plan utilised and available on the Hub	**08/08/2022**	**TBC**	V4.0 March 2017 on hub - to review updated National Plan

Heatwave Plan				
Heatwave Plan **DCM066**	Review and update plan	**01/06/2022**	**Completed**	16/06/2022 - Reviewed with minor changes to Action Card 5. Due for review June 2023
Incident Coordination Centre				
Incident Coordination Centre Manual **DCM178**	Review and update plan	**01/04/2023**	**Completed**	2020 - Has been updated January 2020 and not due for review until April 2021 2021- Full review and updates as required completed with review date of April 2023 incorporating new framework
DPOW Major Incident Cupboard	Review and ensure sufficiently stocked	**TBC**	**Ongoing**	Review completed. Required maps and stationary ordered and awaiting delivery
SGH Major Incident Cupboard	Review and ensure sufficiently stocked	**TBC**	**Ongoing**	Review completed. Required maps and stationary ordered and awaiting delivery
On-Call Director and Senior Manager Training	Create and deliver major incident training session to On-Call Directors and Senior Managers	**Ongoing Rolling Programme**	**To do**	Sessions delivered at DPOWH and SGH 2020 - sessions being held virtually 2021 - sessions being held virtually 2022 - Principles of Health Command Training sessions arranged to align compliance with new national mandatory training
Neighbouring Hospitals Info Pack	Create info pack on neighbouring hospitals for the ICC	**TBC**	**To do**	Created and on website for easy access, to be reviewed and updated 2020
Loggist Training Refresher Sessions	Relaunch Loggist role and deliver training sessions for loggists	**Ongoing Rolling Programme**	**To do**	New system for loggists introduced which moves away from volunteers in favour of nominated inidivudals from non-operational Directorates. Several training days completed and more arranged for new loggists on both sites 2020 - Different approach taken due to the Covid-19 Pandemic 2021 - to look at sessions 2022 – New approach to loggists needed with relaunch
Switchboard Cascade Test	To test Switchboards Major Incident Response	**Ongoing**	**6 monthly**	2020 - Live incident Nov 2020 2021- March 2021 Tests completed at DPOW and SGH
Switchboard Major Incident Familiarisation Session	To familiarise Switchboard staff during a Major Incident	**TBC**	**yearly**	2021 - to create a training session utilising the loggist training sessions 2022 to be arranged

Investigations, Action Plans, Assurance Frameworks and Submissions				
NHS England Core Standards for EPRR Self-Assessment and Submission	Completed 2020-21 self-assessment, Trust Board approved and submitted to NHS England before deadline. Awaiting release of 2022/23 self-assessment (expected July 2022)	**Nov 2022**	**Future Development**	Awaiting release of 2022/23 core standards
Lockdown Policy				
Policy & Procedure Lockdown **(DCP195)**	Review and update plan	**01/03/2022**	**Completed**	For Security (LSMS) to review and update with support from EPRR Team
Major Incident Plan				
Major Incident Plan **DCM176**	Review and update plan	**01/12/2022**	**To do**	Due for review December 2022 – Will need to incorporate latest EPRR framework
Critical Incident Plan	Review plan	**01/12/2022**	**To do**	Due for review December 2022
Major Incident Plan Table Top Exercises	Create an MIP table top exercise and organise a date for delivery at both DPOWH and SGH	**TBC**	**To do**	**Nov 2019** - Multiple MIP table tops have been delivered on both sites and others arranged - Completed **2021** - to arrange MIP table top exercises at both SGH and DPOW Looking at producing a set number of table top exercises once commanders have completed their training
Major Incident Plan Trust Wide Table Top	Trust wide table top to cover all Directorates	**01/11/2023**	**To do**	**17 Sep 2020** - Implementation of plan during live incidents means a Trust wide exercise is not yet required - Completed **6 Oct 2020** - NLAG Concurrant Exercise - Completed - superseded by Live incident Nov 2020
Mass Vaccination / Treatment				
NLAG Plan to Supprt Mass Vaccination/Treatment **DCM156**	Review and update plan	**01/07/2022**	**In Progress**	2022- Updated with minor changes – Awaiting approval

NLAG Plan to Support Evacuation in Community (inc. Rest Centre Support and Identification of Vulnerable Patients) (DCM007)				
NLAG Plan to Support Evacuation in Community (inc. Rest Centre Support and Identification of Vulnerable Patients) **DCM007**	Review and update plan	**01/06/2024**	**Completed**	18/07/2018 - Changes completed and new review due 2021 10/05/2021 - Plan updated awaiting on SystemOne for update on DCM007A prior to submission to Document Control 04/06/2021 - Submitted to Doc Control **Next review due June 2024**
Pandemic Flu Plan				
Pandemic Flu Plan **DCM147**	Review plan	**01/09/2022**	**To Do**	01/02/2020 - Reviewed and updated. **Next review due September 2022**
Yorkshire and Humber LRFs and LHRPs Pandemic Influenza Framework	Review plan	**01/11/2022**	**In Progress**	**03/10/2017 V0.3 on hub. Reviewing**
Partial or Total Site Evacuation				
Hospital Full and Partial Site Evacuation Plan **DCM171**	Review and update plan	**01/09/2022**	**In Progress**	01/09/2019 - Reviewed and updated**. Next review due September 2022.** To be reviewed sooner due to new ED building works
Site Evacuation Exercise	Organise and conduct a Site Evacuation Tabletop Exercise	**01/06/2023**	**To Do**	
Resilience Direct				
Trust Access to Resilience Direct	Gain relevant accesses to RD	**Completed**	**Completed**	EPRR Advisor roles have access to Resilience Direct during an incident
Trust Emergency Plans on Resilience Direct	Upload relevant plans to RD	**TBC**	**To Do**	Latest plans uploaded to Resilience Direct 2021 - To be reviewed **2022 to be reviewed**
Surge and Escalation Management				

Patient Flow, Escalation and Surge Policy (including Full Capacity Protocol) **DCP301**	Review policy	**01/08/2022**	**To Do**	**Next review due in August 2022**
EMAS Ambulance Divert Request Form	Available on the Hub	**N/A**	**To Do**	V02 from 2013 on hub.
YAS Ambulance Divert Request Form	Available on the Hub	**N/A**	**To Do**	Version from 2020 currently on hub
NEY FINAL Major Trauma Regional Escalation Framework V1.0 19012021		**01/02/2023**	**Completed**	April 2020 - **review in April 2023**
Training Needs Analysis				
Training Needs Analysis	Review TNAs	**TBC**	**To Do**	To be reviewed to align with new national occupational standards for EPRR guidance released
Trust EPRR Risk Register				
Procedure for EPRR Risk Assessments	Review procedure	**TBC**	**To Do**	2022 to be reviewed
EPRR Risk Assessments	Complete additional risk assessments	**TBC**	**To Do**	2022 to be reviewed
EPRR Risk Assessment Annual Summary Report	Provide summary report to EPRRSG	**TBC**	**To Do**	2022 to be reviewed

Emergency Preparedness, Resilience and Response Training Programme – 2021-2023

Key:	Completed	Planned	Cancelled due to lack of attendees	Cancelled Due to Covid-19 Pandemic

Date	Training	Training Type	Provided By	NLAG Attendance	Multi-Agency
Year 2021					
10/02/2021	Manager On Call	Training	NLAG	NLAG Staff	NLAG
23/02/2021	Structured Debrief	Training	UKHSA	Ashley Leggott	Multi Agencies
28/04/2021	Defensible Decision Making	Training	UKHSA	Ashley Leggott	Multi Agencies
10/05/2021	In Action Review	Training	UKHSA	Ashley Leggott	Multi Agencies
24/06/2021	Winter/Covid Learning Event	Learning Event	NHSE/I	NLAG Staff	Multi Agencies
06/07/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
09/07/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
12/07/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
28/07/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
03/08/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
04/08/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
09/08/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
19/08/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
20/08/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
25/08/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
26/08/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
17/09/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
20/09/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
08/10/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
13/10/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
01/11/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
03/11/2021	Manager On Call	Training	NLAG	NLAG Staff	NLAG
04/11/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
11/11/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
16/11/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG

18/11/2021	Goole Dock Gates	Exercise	Humber LRF/EA	Ashley Leggott	Multi Agencies
26/11/2021	NEL Health/Care Flooding Exercise	Exercise	EPARG	Ashley Leggott	Multi Agencies
01/12/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
14/12/2021	Manager On Call	Training	NLAG	NLAG Staff	NLAG
21/12/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
22/12/2021	Omicron Table Top	Exercise	NLAG	NLAG Staff	NLAG
Year 2022					
22/02/2022	PRPS NARU Train the Trainer Course	Training	EMAS NARU	NLAG Staff	NLAG
09/03/2022	Met Office Services to Civil Contingencies	Training	Met Office	Ashley Leggott	Multi Agencies
05/04/2022	Climate Change	Training	Met Office	Ashley Leggott	Multi Agencies
11/04/2022	Manager On Call	Training	NLAG	NLAG Staff	NLAG
28/04/2022	Meteorology for Resonders	Training	Met Office	Ashley Leggott	Multi Agencies
03/05/2022	Summer Weather Hazards	Training	Met Office	Ashley Leggott	Multi Agencies
09/05/2022	Space Weather	Training	Met Office	Ashley Leggott	Multi Agencies
18/05/2022	Atmospheric Dispersion	Training	Met Office	Ashley Leggott	Multi Agencies
28/06/2022	Cyber Exercise	Exercise	Humber LRF/EA	Matt Overton/ Tonya Fredrickson	Multi Agencies
08/07/2022	Major Incident Cascade	Test	NLAG	Switchboard	NLAG
08/07/2022	Principles of Health Command Train the Trainer	Training	NHSE/I	Ashley Leggott/Matt Overton	Multi Agencies
20/07/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi Agencies
22/07/2022	Principles of Health Comman	Training	NHSE/I	NLAG Staff	Multi Agencies
25/07/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi Agencies
15-17/08/2022	CBRNe/HAZMAT	Training	NLAG	ED DPOW	NLAG
16/08/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi Agencies
12/09/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi Agencies
13/09/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi Agencies
18/09/2022	Flood EX	Exercise	Humber LRF/EA	NLAG Staff	Multi Agencies
21/09/2022	Emergency Services Show	Talks	Multi Agencies	Ashley Leggott/Matt Overton	Multi Agencies
22/09/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi Agencies
28/09/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi Agencies
30/09/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi Agencies
10/10/2022	Winter Weather Hazards	Training	Met Office	Ashley Leggott	Multi Agencies
TBC	National Power Outage TT	Exercise	NLAG	NLAG Staff	NLAG
2023					
January	Major Incident TT	Exercise	NLAG	NLAG Staff	NLAG

January	Loggist	Training	NLAG	NLAG Staff	NLAG
January	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
February	Loggist	Training	NLAG	NLAG Staff	NLAG
February	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
March	Major Incident TT	Exercise	NLAG	NLAG Staff	NLAG
March	Loggist	Training	NLAG	NLAG Staff	NLAG
March	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
April	Loggist	Training	NLAG	NLAG Staff	NLAG
April	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
May	Major Incident TT	Exercise	NLAG	NLAG Staff	NLAG
May	Loggist	Training	NLAG	NLAG Staff	NLAG
May	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
June	Loggist	Training	NLAG	NLAG Staff	NLAG
June	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
June	Live CBRNe/HAZMAT Exercise	Exercise	NLAG	NLAG Staff	NLAG
July	Major Incident TT	Exercise	NLAG	NLAG Staff	NLAG
July	Loggist	Training	NLAG	NLAG Staff	NLAG
July	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
August	Loggist	Training	NLAG	NLAG Staff	NLAG
August	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
September	Major Incident TT	Exercise	NLAG	NLAG Staff	NLAG
September	Loggist	Training	NLAG	NLAG Staff	NLAG
September	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
October	Loggist	Training	NLAG	NLAG Staff	NLAG
October	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
November	Major Incident TT	Exercise	NLAG	NLAG Staff	NLAG
November	Loggist	Training	NLAG	NLAG Staff	NLAG
November	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
December	Loggist	Training	NLAG	NLAG Staff	NLAG
December	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG

Agenda Number: NLG(22)184

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	4th October 2022	
Director Lead	Gill Ponder, Non-Executive Director / Chair of F&P Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance and Performance Committee – Minutes of the meetings held on 24th August 2022, 20th July 2022 and 22nd June 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Finance and Performance Committee Meeting held on 24th August 2022 and approved on 21st September 2022, Meeting held on 20th July 2022 and approved on 24th August 2022 and Meeting held on 22nd June 2022 and approved on 20th July 2022.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Finance & Performance Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ☒ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

MINUTES

FINANCE & PERFORMANCE COMMITTEE

Meeting: Wednesday 24 August 2022, Executive Boardroom, DPOW

Present:	Gillian Ponder	Non Executive Director (Chair)
	Fiona Osborne	Non Executive Director
	Ian Reekie	Lead Governor
	Lee Bond	Chief Financial Officer
	Brian Shipley	Deputy Director of Finance
	Shaun Stacey	Chief Operating Officer
	Richard Peasgood	Executive Assistant to COO
	Simon Tighe (rep)	Deputy Director of Estates & Facilities
In Attendance:	Anne Marie Hall (for item 7.2)	Ass Director of UC & Discharge Imp
	Angie Legge (for item 6.1)	Associate Director of Quality & Governance
	Keith Fowler (for item 9.1)	Ass Director of Estates/Sustainability
	Lynn Arefi (Minute Taker)	Executive Assistant

ITEM

Gillian Ponder welcomed everyone to the Finance and Performance Committee which was being held face to face for the first time since the beginning of Covid. Gillian Ponder suggested that the Committee continue with holding the meeting via TEAMS with a face to face meeting taking place quarterly.

1. Apologies

Apologies for absence were received from Dr Peter Reading, Manesh Singh, Jug Johal, Helen Harris.

2. Quoracy

It was noted that the Committee was quorate.

3. Declarations of Interest

There were no Declarations of Interest declared.

4. To Approve the Minutes of the Meeting held on 20 July 2022

The minutes were reviewed with the following amendments requested:

- Item 9, first bullet point should read £2.34**m** and £0.99**m**.

Subject to these amendments the minutes were approved.

5. Matters Arising / Action Log

5.1 The action log was reviewed and updated as follows:

8.2 (20/4/22) Planned Care – action plan circulated – **Item closed**
8.1 (22/6/22) E&F BAF Risk – amended reporting structure – **Item closed**

9.3 (22/6/22) Risk Stratification – Deep dive on data will be presented
10.1 (27/7/22) BAF Q1 – ongoing

5.2 F&P Committee Workplan

The workplan was reviewed and it was noted that the sequence had slipped and therefore 1.6 would be discussed at the September meeting which would then bring the workplan back on to normal cycle.

5.3 Terms of Reference

The Terms of Reference and in particular the membership of the Executive Directors was highlighted. Lee Bond went on to note that Executive Directors are not members of the Audit Committee or Remuneration Committees, but he suggested that they would ordinarily be members of a Trust Finance Committee or Workforce Committee. Lee Bond agreed to discuss this with Helen Harris for clarification.

ACTION: Lee Bond to discuss with Helen Harris

Also queried was section 5.3.2 – should this read "between £1mil and £15mil and 6.2 – query if it should be Director of Estates, Facilities and *Sustainability*. Gill Ponder would discuss with Helen Harris.

ACTION: Gill Ponder to discuss with Helen Harris

5.4 Action Plan

Following on from the Committee's Self-Assessment this Action Plan was put together. This will be reviewed and updated for each meeting.

The following item was taken out of sequence on the agenda

7. Review of NLaG Monthly Performance & Activity (IPR)

7.3 Planned Care

Shaun Stacey took the report as read and went on to note that the waiting list is reducing for both admitted and non-admitted. He added that the 52week wait had increased slightly but this was in accordance with the transfers from HUTH and York. With regards to Diagnostics(DM01) there was a problem with performance due to demand and capacity, although there was slight improvement.

Shaun Stacey went on to add that there continued to be issues with cancer performance with real challenges around the 62day performance. On a positive note, Shaun Stacey added that the 104 position had stabilised and the 2week wait position continued to be managed.

The Joint Lung MDT across HUTH and NLag would commence shortly which is very positive.

Fiona Osborne asked whether there was any issue with data intergrity following the presentation given last month where the Committee were assured that the information would be more up to date?. Shaun Stacey confirmed there was no integrity issue and it was related to the national data validation for cancer which can be as much as 30 to 60 days behind.

Fiona Osborne queried the incomplete RTT pathway increases month on month, and questioned whether the mitigations and action plans are going to have an impact. Shaun Stacey confirmed he was not overly concerned and went on to briefly outline that although this aspect of the waiting list is growing, the overall size of the waiting list is reducing.

Gillian Ponder went on to note that a deep dive on cancer took place at last month's Committee meeting but from an assurance perspective there did not seem to be any improvement made which was concerning. Gillian Ponder added that although there was lots of activity, there was reference within the IPR of targets not being achieved for two years and suggested that the lack of assurance on the cancer standards should be reported to the Trust Board. Shaun Stacey responded that there was an unacceptable volume of patients waiting for diagnosis especially in colorectal. This was escalated to the Quality & Safety Committee for a deep dive into the individual specialties and the feedback was that "it was ok". Fiona Osborne stated this was not her recollection of the meeting. Gillian Ponder agreed to write to the Chair of the Quality & Safety Committee highlighting that this was a concern.

ACTION: Gillian Ponder to write to Chair of Q&S re the impact of excessive waits for diagnostics on the cancer pathways

6. Presentations for Assurance

6.1 CQC Progress Report

Gillian Ponder welcomed Angie Legge to the meeting. Angie Legge took the previously circulated CQC Progress report as read noting that there had been a little less progress than expected due to the team being involved in the recent CQC visit and subsequent data requests. Angie Legge went on to highlight the following key issues from the report:

- One action has improved from green to blue due to submission to the CQC: 27WC (Independent registered scrub nurse able to supervise in theatres at all times, joint Surgery and Family Services division)
- Compliance data has been included in section 7 (Actions Rated Green) for mandatory training and appraisals actions in order to provide assurance that these actions can remain rated green or need the rating amending
- Concerns were raised in the ED at DPOW during the recent CQC Inspection, details contained within the full report. Immediate actions have already taken place, a robust improvement plan has been shared with the CQC, regular monitoring is in place and communication of progress with the CQC continues.
- Divisions have continued to engage with the compliance team to work through their plans and remain motivated to maintain momentum progressing actions
- There remain no actions rated as red
- External oversight of progress continues to be provided through the NHSEI and Quality Board
- Monthly relationship meetings continue with the CQC

The risks to the delivery of CQC Improvement Plans were noted as follows:

- Lack of capacity within corporate teams and divisions to do the work with competing priorities, however the compliance team continue to support plans and actions where possible
- Identifying recurrent funding for the financial cost of implementation for some funded actions
- Delays in some actions due to the requirement for system wide collaboration which despite the best efforts of the Trust has delayed progress (specifically for end of life care).

Gillian Ponder queried the reference at the top of page 10 and the need to use the independent sector – Ophthalmology and the delays in finalising the contracts for 2022/23. What has been done to expedite these contracts. Shaun Stacey confirmed that this had been reported through the planned care route, it had taken quite a long time to get the contracts and activity levels in place. Shaun Stacey noted however, that the private sector had continued to work through and had exceeded planned expectations. He added that contracts were now in place.

Gillian Ponder then went on to refer to the bottom of page 22 and queried the sentence "… does not support the ERF for the Trust it supports the ICB ERF". Shaun Stacey went on to briefly explain this and added that maybe the narrative contained within the report may not accurately reflect the position. Angie Legg would look to have this amended.

ACTION: Angie Legge to ask Jennifer Moverley to liaise with Richard Peasgood

Gillian Ponder then went on to highlight the CQC observations at DPOW ED and the improvement plan and asked what would be different this time to ensure these concerns are removed. Shaun Stacey confirmed that the CQC did raise concerns around a change in practice related to the staff on duty at that particular time, he added that this was an educational/training issue for the organisation. The main concern raised was around the use of SDEC and UCS and the operating hours and length of waiting times for patients. Shaun added that he and Lee Bond were working with local Place Directors to review existing GP out of hours services with a view to potentially re-aligning the workforce with the SDEC and UCS service.

Lee Bond added that the opening hours of SDEC are in line with the AAU Business Case and the UTC opening hours are in line with the financial plan. He was not aware that the Trust had committed anything to the CQC to say it was extending these. Shaun Stacey confirmed that it had been agreed to look at the opportunity to extend the hours to midnight but within the existing funding available.

Angie Legge added that CQC have recognised that no patients had come to harm. As part of the action plan there was an oversight mechanism as a level of assurance which was working.

The CQC Progress Report was received and noted by the Committee. Angie Legge was thanked for attending the meeting and it was noted that Angie Legge would be leaving the Trust shortly. The Committee wished her all the best.

7. Review of NLaG Monthly Performance & Activity Delivery (IPR)

7.1 Unplanned Care
7.2 Integrated Urgent & Emergency Care & Patient Flow – *Ann Marie Hall joined for this item*.

Shaun Stacey was invited to update the Committee on Unplanned Care. Shaun Stacey took the circulated report as read and went on to note that, from an ED perspective there had been very little change and we continued to struggle with ambulance waits. The UCS showed a continued improvement in the overall performance and target. Same day emergency care also continued to show improvement. Actions go through the Patient Flow Improvement group which links into the wider system of the A&E Delivery Board.

Shaun Stacey welcomed Ann Marie Hall to the meeting. Anne Marie Hall spoke to the presentation which detailed the current position of the Urgent and Emergency Care sector for NLaG. Ann-Marie Hall went on to highlight ambulance handovers had decreased in numbers from Sept 2021 to July 2022; although this is a success for partner working the volume of patients for walk in patients are increasing. It was noted that approximately 900 patients a month are being pulled from the acute hospitals through SPA. A lot more work around ambulance handovers was required with the current deadline for tasks being September 2022. Anne-Marie Hall went on to highlight that, currently across the 3 sites of NLaG there were 86 patients waiting to be discharged with the majority of these patients being "stranded patients" as we had nowhere to move them to. Fiona Osborne asked what more could be done to tackle this issue. Shaun Stacey added that a common health community approach earlier in the process was being taken with North and North East Lincs. Ian Reekie questioned if the Community Services teams across North and North East Lincs could cope with a significant expansion of D2A enhanced support and expansion of virtual ward provision. Shaun Stacey noted that there was a plan for short-term investment into the community teams so the recruitment plan for the virtual ward is significantly higher to demonstrate that this approach will work. This was part of the Home First Team within North Lincs.

Moving on to ED Anne-Marie Hall went on to note that, on occasions, the ED was overwhelmed by the volume of patients and lack of flow. On a positive note 84% of discharges at NLaG were directly from ED with a percentage of ED admitted attendances seeing an improvement from 23.6% in August 2021 down to 15.5% in July 2022. The Ambulance handover task and finish group continue to work to improve performance.

In relation to SDEC and IAAU it was noted that there had been a steady increase in the number of non-elective admissions discharged within 24 hours with 43% of ED admissions going through SDEC.

Referring to discharges Anne-Marie Hall noted that the Discharge Team had been nominated for the HSJ award in the Integrated Care Pathway category. This was due to excellent collaborative working with community partners in North East Lincs. The Trust is the second best performing in the region for LLOS reporting which was 10.06% for over 21 days. Anne-Marie Hall added that more does still need to be done.

Fiona Osborne asked what impact will the new ED/AAU have. Anne-Marie Hall went on to note that the new facility was approximately double the capacity and it was estimated that the establishment would increase to meet demand; the department is completely fit for purpose with cross flow between departments would show significant improvement. It was noted that there was a delay in the opening of the new ED/AAU which had proved challenging for the Estates teams.

Lee Bond questioned the relationship between our very impressive length of stay performance and our apparent problems with exit block and the resulting “flow” issues across the two main hospitals. It was agreed that more work is needed to fully understand just how these factors are inter-relating, however it was suspected that a small number of long stay patients were materially impacting “flow”.

Gillian Ponder asked if we had considered “off loading” patients from ambulances or would this create further risks. Anne-Marie confirmed that this had been considered but due to the facilities we were unable to do this. The Trust did have an agreement with the Ambulance Service that enables a patient to be handed over if the crew are required to attend to another emergency. The ability for SPA to take lower category ambulance patients is really important to prevent patients being left for hours with no intervention.

Gillian Ponder asked when would we start to see the 75% for the 4-hour standard. Anne-Marie Hall answered that although there were lots of multi-factorial issues but hoped it to be November.

As a closing remark Shaun Stacey asked for his thanks to be noted to Anne-Marie Hall and her team for the hard work over the last 18 months and it is to their credit that the Trust had been recognised.

The Committee thanked Anne-Marie Hall for her presentation which was received and noted.

7.4 Mutual Aid

Shaun Stacey took the paper as read and asked the Committee for their questions. Ian Reekie went on to note that he had three concerns:

- Original Governor concern was the potential of North Lincs patients were suffering
- Clinician competence of clincians from the North Bank
- Long term future viability for Goole

Shaun Stacey went on to respond to the queries posed, regarding the first two issues actions had been taken and are working to get to a solution which is more productive. Shaun Stacey added that surgeons were brought in who were unfamiliar with the operating procedures; these surgeons have now been trained.

Referring to the last issue Shaun Stacey confirmed that the intention with Goole was for it to be a single specialty facility in partnership with HUTH, York and Scarborough; this is part of the bigger ICS picture. Fiona Osborne asked that as part of the wider HASR there have been some issues identified with the north/south divide, staff and patient transport. It looks like the mutual aid have crystalised these problems and will we see a positive advantage from HASR. Shaun Stacey confirmed that he would hope that this is the right direction to deliver an Orthopaedic service across the Humber, but it was still early days.

Fiona Osborne then raised her concern over the section in the paper which referred to Urology and read "Clinical body at HUTH were not supportive of sending a number of patients at the top of the PTL", was this specific to Urology. Shaun Stacey confirmed that this was the case at the time of writing the report and is similar in other specialties but through process we are already beginning to open up to referrals but added this does take time.

8. Review of NLaG Monthly Financial Position – (SO3.1 / SO3.2b)

8.1 Finance Report Month 04

Brian Shipley presented the finance report for M03 and went on to highlight key areas to note:

- The Trust had £1.18mil deficit in July which was £1.34mil worse than plan
- The Trust has a £2.43mil year-to-date deficit which was £3.6mil worse than plan
- Income was £0.8mil below plan in month
- Pay was £1.25mil overspend in month
- Medical staff was £1.2mil overspent with increased non-elective and emergency activity driving overspends across Medicine acute care and ED.
- Nursing was £0.12mil overspent in month.
- Other pay was in line with the planned spend
- Non pay was £0.12mil overspent in month
- Post EBITDA items were £0.5mil underspent in month
- COVID 19 expenditure was £2.28mil year-to-date

Brian Shipley went on to draw the Committee's attention to the fact that the Trust is currently £3.68mil behind plan at the end of month 4. If no mitigating actions are taken, then the initial forecast assessments project a potential risk of a £10.6mil end of year deficit risk.

Brian Shipley noted that, although not referred to in the report, the pay award impact is currently being assessed and the potential funding that has being earmarked with a risk estimated at £1.3mil to £1.8mil.

The capital funding for 2022/23 is £36.32mil. The Trust had reviewed a list of additional priorities and allocated funding to disabled access, fire doors, mortuary works, SGH Max Fax refurbishments and SGH fire alarm.

In conclusion, Brian Shipley highlighted the material issues for the Trust over the coming months which included:

- Maximising planned care activity delivery with a requirement to return to 2019/20 productivity and activity levels within its core capacity. Delivering additional activity to achieve 104% of the 2019/20 activity values and securing the Elective Recovery Funding received for 2022/23
- Delivering a challenging CIP programme and mitigating risks to delivery and conversion of non-recurrent savings into recurrent delivery schemes and identifying new schemes
- Reducing additional COVID19 expenditure as soon as possible
- Reducing material cost pressures which included additional beds and additional duties in both medical and nursing staffing.

Fiona Osborne referred to item 5.1.3 within the Terms of Reference which stated " *oversee the development and delivery of any corrective action plans and advise the Trust Board accordingly*" and asked how, with forecast risks totalling £10.6mil will we see a monthly presentation of the corrective action plans. Lee Bond confirmed that he will be working closely with colleagues with actions being reported back through to the Finance Committee. Lee Bond noted his concern over the medical staffing position and added that at this moment in time he did not have a solution. Alongside this, another concern was productivity; from the 1 October, our core capcity needs to be back at 2019/20 activity levels in order to secure ERF in the second half of the year. Shaun Stacey confirmed that from 1 October to the end of November there was an intention to book exactly what has been committed to (in the plan) and more by using a process called "HIT". This would be done without using excess hours but use current DCC capacity. Challenge would be the Independent Sector related to Ophthalmology and there is a risk.

8.2 Recovery Support Programme Letter

The attached Recovery Support Programme for Finance letter was received and noted.

8.3 Business Case Assurance

Lee Bond noted that the IS and ICB had approved the £5mil for the refurbishment of 3 operating theatres. All that remains is approval from DOH which is expected to be confirmed within the next few weeks which would be very good news.

8.4 SO3 – 3.1Deep Dive BAF

Gillian Ponder referred to 3.1 the target risk for the end of the year is 20 with a risk appetite of 8 to 12; the narrative says that we are on track to exit special measures. Given the current position is there a risk that we may not. Lee Bond responded and noted that there was an increasing risk. Lee Bond added he would like to think that the target risk rating would be reduced. When the report is updated mitigations will be put in place around the savings programme being insufficient and the deteriorating run rate.

Gillian Ponder requested site of the highly scored risks relevant to the BAF deep dives for that specific month.

9. Estates & Facilities (SO1.4)

9.1 Gillian Ponder welcomed Keith Fowler, Associate Director of Facilities & Sustainability to the meeting. Gillian Ponder went on to note that, due to the lateness of the circulation of the attached report the Committee had not had sufficient time to read the report and the embedded papers so the Committee would not be in a position to approve the Trust's Green & Travel Plan which was contained within the paper. Keith Fowler took the Committee briefly through the report which outlined the key core service models within the Facilities Services.

Ian Reekie referred to a previous meeting Jug Johal had indicated that the new national food standards may need the Trust to move away from the current cook/chilled system which raised concerns with the governors as to the very high scores that the food gets from patients. Keith Fowler was unsure at this moment in time of the full details, but the impact could be huge. Fiona Osborne asked that, given the price increase of food how can the Trust continue to maintain the quality with this price increase and what actions are being taken. Keith Fowler confirmed that this would be difficult to mitigate but we will work closely with finance and procurement and look at sustainable menus.

Given that the Committee had not had the chance to thoroughly read and digest the Green & Travel Plan section of the paper the Committee agreed to defer this item until the September meeting.

ACTION: Green & Travel Plan to be on September agenda

10. Finance & Performance Committee Governance Documents

10.1 Board Assurance Framework

Discussed earlier on the agenda

11. Items for Information

11.1 Performance Letters to Divisions

Received and noted.

12. Any Other Urgent Business

None raised.

13. Matters to Highlight to other Trust Board Assurance Committees

See Section 7.3 above regarding the action for Gill Ponder to raise concerns with the Quality Committee regarding excessive diagnostic waiting times for cancer pathwayts, especially colorectal.

Review of Meeting

As it was the first face to face meeting in a while everyone thought it went very well with good discussion.

DATE & TIME OF NEXT MEETING: Wednesday 21 September 2022 – 1.30pm TEAMS

MINUTES

MEETING:	**Finance & Performance Committee**	
DATE:	**20 July 2022 – via Teams Meeting**	
PRESENT:	Fiona Osborne	Associate Non-Executive Director / Chair
	Maneesh Singh	Associate Non-Executive Director
IN ATTENDANCE:	Shaun Stacey	Chief Operating Officer
	Jug Johal	Director of Estates & Facilities
	Brian Shipley	Deputy Director of Finance
	Ian Reekie	Lead Governor
	Jennifer Moverley	Head of Compliance and Assurance (For item 6.1)
	Bill Parkinson	Associate Director of Safety & Statutory Compliance (For Item 7.1)
	Ab Abdi	Deputy Chief Operating Officer (For item 8.3)
	Mr Mathew Thomas	Consultant (For item 8.3)
	Debbie Bagley	Associate Chief Nurse (For item 8.3)
	Richard Peasgood	Executive Assistant – Operations Directorate
	Anne Sprason	Finance Admin Manager/PA to CFO (Minutes)

Item 2 07/22 **Quoracy**

Due to IT issues Shaun Stacey and Brian Shipley were unable to join the meeting until item 7 and therefore the meeting was inquorate until item 8 was presented. It was agreed that until one or both could join the meeting, items that did not require any decisions to be made would be dealt with first.

Item 7 07/22 **Estates & Facilities**

7.1 Monthly Deep Dive – Fire Report

Jug Johal introduced the report and explained that this was the first time that it had been brought to F&P as it had previously been to ARG Committee. There was still some statutory oversight required by ARG and would need to ensure communication links between the two Committees.

Bill Parkinson joined the meeting to present the report and highlight areas to note as follows:

- Grenfell enquiries still ongoing and updates to policies likely in 2023 which is likely to include high risk residential buildings and high-risk buildings, including hospitals. Once received a complete review of Trust policies would be undertaken.
- Fire risk was included on the risk register and had been slightly changed due to the risk of failure to the fire alarms at SGH and Goole which needed replacement. The number of false alarms had now dropped significantly at DPOW following the recent replacement of the alarm system.
- Fire door maintenance and training had insufficient resource and was currently looking at bidding for funding to address.
- Fire Ring main work was ongoing due to the identification of additional connections in place, specifically water supply connections.
- BAF – a number of mitigating actions had been put in place including the fire alarm system replaced at DPOW; a new Alarm Servicing Contracting commenced in April 2022 and was making significant inroads; and a review of cause and effect was ongoing at SGH.

- An Authorising Engineer (AE) for Fire Safety was to be appointed and whilst it was not a current requirement was expected to change the following year.
- A peer review was undertaken by safety officers at Hull who highlighted generally the requirements of the HTM and FSO were being met and made several recommendations to improve fire safety within NLAG which were now being taken forward.
- Face to face Fire Warden training had lapsed due to the pandemic but was now steadily increasing. The training was being reviewed and updated due to Grenfell technical inquiries and new guidance in relation to duties of a fire warden
- Operational incidents including fire door issues remained an issue although 97% of the work on the doors at SGH had now been completed.
- Unwanted fire signals had reduced with the replacement of the alarm system at DPOW but SGH was seeing an increase which indicated a deterioration in the performance of the system.
- It was confirmed that the annual Fire Report would be presented to the next Trust Board in August following its approval at ARG Committee.

Maneesh Singh acknowledged that fire safety was a massive challenge and asked if patients were safe or if any regulations were being broken. Jug Johal stated that if a catastrophic incident happened then that could be close to breaking regulations.

2.30pm *Shaun Stacey was able to join the meeting making it quorate.*

Fiona Osborne asked about the number of connections to the fire ring main and Bill Parkinson explained that at DPOW it was under 20 connections.

Fiona Osborne queried the risk rating of 20 on the Risk Register in light of the replacement of the system in DPoW and the increase in false alarms in SGH. Bill Parkinson stated that the SGH system was the system that is currently driving therisk rating and this is under regular review.

2.35pm Bill Parkinson was thanked for the thorough report, and he left the meeting.

Item 6 07/22 **Presentations for Assurance**

6.1 CQC Progress Report

Jennifer Moverley presented the report and highlighted that two actions had improved from amber to green since the last update. The current position was 85% of 145 actions rated as blue or green with no red actions of those assigned to the F&P Committee. Following the recent inspection, the CQC would be returning the following week to undertake the Well Led Review.

Fiona Osborne asked if the evidence was available of the waiting list figures without mutual aid so that we could evidence the underlying NLaG trend potentially allowing a move from amber to green. Jennifer Moverley explained that she had asked for the trajectories and from conversations understood that most would have achieved green. Shaun Stacey explained that the mutual aid was for different modalities and services and therefore some would have achieved the green rating e.g., Orthopaedics was down to 28 weeks but now taking 600 patients, so the picture looked worse. The waiting times would increase, and the 52-week position would not be closed until October from the original date of September.

The original reason for the mutual aid was to clear the 104 week waits but had only received a few of those, the majority were from other waits.

Jennifer Moverley was thanked for the report, and she left the meeting.

The Committee then returned to the order of the agenda.

Item 1 07/22 **Apologies for absence**

Apologies for absence had been received from Gill Ponder, Lee Bond and Peter Reading.

Item 2 07/22 **Quoracy**

Shaun Stacey had joined the meeting earlier making the Committee quorate.

Item 3 07/22 **Declarations of Interest**

Fiona Osborne noted that no declarations had been received prior to the meeting. There were no new declarations of interest made.

Item 4 07/22 **To approve the minutes from the previous meeting held on 22 June 2022**

The minutes from the meeting held on 22 June 2022 were reviewed and Shaun Stacey referred to page 5 (item 7.2, 3rd paragraph) which stated the … "*reimplementation of the recovery board meetings".* This should be the *…." Implementation of planned care and productivity meetings".*

With this amendment the minutes were agreed as an accurate record of the meeting.

Item 5 07/22 **Matters Arising**

5.1 Action Log

The action log was reviewed as follows:

8.1 (26 06 22) – E&F BAF Review – Medical Gases – Jug Johal confirmed that the amendment to the reporting structure would be corrected before the report was due back to the Committee. **Item Closed.**

9.3 (26 06 22) – Risk Stratification – Jackie France to advise on the mix of weeks overdue of the 16000 patients. Shaun Stacey advised that Jackie France was currently on holiday, and he would check on her return. **Action**: Shaun Stacey

Following review, the action log was noted.

5.2 F&P Committee Workplan V7

The updated workplan was reviewed and agreed.

5.4 Action Plan following Self-Assessment Exercise

The action plan was reviewed and agreed.

Item 8 07/22 **Review of NLAG Monthly Performance and Activity Delivery (IPR)**

9.2 Unplanned Care

Shaun Stacey presented the report and highlighted that overall, there were no signs of improvement to the emergency care and access and was included on the workplan to be the subject of a deep dive at the next meeting. The pressure remained due to inability to discharge patients back into the community, resulting in significant use of beds. Shaun Stacey explained that SDEC stopped at 10.00pm with referrals ending around 7.00pm which resulted in a build up in ED and a slight increase in the Out of Hours service.

General issues included staffing, high level of agency and medical spend and 60 unfunded beds combined with vacancies across the Trust. Recruitment actions were being addressed and improvements should be seen around October 2022.

Emergency care was in a good position until 10.00pm with 90+% managed within 4hours. SDEC remained a positive solution with 40% streamed to services and discharged the same day. Further development of board rounds and training being undertaken with Consultants to be less risk averse but would be the end of year before noticeable improvement would be seen. The Trust remained ahead of the region in 7+; 14+ and 21-day LOS and working to sustain that position. A combined healthcare solution had been agreed for winter planning and additional funding was being sought to support that solution.

Bed occupancy was above 90% but the report did not reflect the 60 additional beds generating significant agency and nursing costs.

3.00pm Ab Abdi and Brian Shipley joined the meeting.

Maneesh Singh queried SDEC and asked if there was sufficient demand to warrant 24/7 opening and asked how easy it was to discharge patients when admitted overnight.

Shaun Stacey explained that the same staffing needs were not required for the whole 24/7 so costs much better. In terms of discharging patients, it was easier as they were not true admissions although any confused, elderly patients with no-one at home would not be able to be discharged to come back to clinic.

Maneesh Singh acknowledged the challenge was outside of the hospital and Shaun Stacey explained that there was still some in-house work to do to ensure a consistent approach to discharge.

Fiona Osborne queried ambulance handovers, noting that good results had been seen over the last two months and within tolerance levels over the last few months and asked what neighbouring Trusts were doing and whether ambulances were choosing to use NLAG because of the measures in place. Shaun Stacey stated that he did not think that ambulances would bypass other A&Es to come specifically to NLAG but it was probably more down to geography.

8.2 Planned Care

Shaun Stacey highlighted the continued sustained improvement being seen, noting the unvalidated data within the report.

Inpatients overdue risk stratification which needed to be reviewed against theatre productivity; theatre capacity in May had been lost which had resulted in lower performance level.

DM01 was coping with demand; DNAs had seen an improvement since text messaging had been resumed; and the non-face to face position was being held.

Cancer – concern with the 104-day waiters testing which had increased; the 38-day referrals to Hull numbers were low; and 2-week waits were directly affected by workforce issues.

8.3 Deep Dive: Elective Care, Cancer, Diagnostics, and Waiting List Recovery

Ab Abdi attended the meeting, with support from Mr Mathew Thomas and Debbie Bagley, to present the report. Ab Abdi spoke to the presentation, which had been provided.

Maneesh Singh noted that performance was severely affected by the mutual aid work and asked how long that would continue and what impact that would have on the longer-term waiting list position. Mr Mathew Thomas stated that the position would deteriorate and would need a more productive model to be used of taking patients that could be treated by Trust Doctors.

Ian Reekie referred to the patients being transferred to be 104 week but when reassessed were under 52 weeks and asked if patients were given a false impression that they would be treated quicker. Mr Thomas explained that reliance was on the validation undertaken by Hull.

Maneesh Singh referred to the impact of mutual aid increasing the Trust's 40 week waits and asked how that was to be addressed. Mr Mathew Thomas explained that there were several bottlenecks in pathways which required more work and numbers had increased in a short timeframe as longer waits from Hull were seen.

Maneesh Singh queried diagnostics waits and how that affected pathways. Mr. Mathew Thomas explained that pathology was done through Path Links and it was a national issue due to a shortage of pathologists in reporting slides. He stated that a one-stop clinic to do MRI reporting on same day and having upper GI straight to test route would help.

Fiona Osborne referred to the worsening position of MRI and noted a plan was in place to resolve in July and asked what the current position was. Ab Abdi stated that it was still a risk and working with IS on a medium to long term plan to resolve.

Fiona Osborne referred to the ERF funding which as per the Finance report for M03 was not being achieved, and Ab Abdi referred to slide 12 and the fact that the case mix was not sufficient to achieve 104% of the 2019 activity to achieve ERF funding, with Surgery and Family services requiring more work. Fiona Osborne stated that the Committee understood the reasons and complexities of why the 104% were not being achieved. However at this stage the Committee are not assured that the standard to gain the ERF funding would be met and given the presentation had quoted ERF funding being assigned to fund IS improvements another plan would be needed either for alternative funding or to ensure ERF funding could be achieved.

Fiona Osborne also referred to the 62-day backlog which had increased since April 2022 and when cross referenced to the IPR was seeing that May and June were outside of acceptable tolerances and asked which was correct and what the plan was to bring back to acceptable levels. Ab Abdi explained that the report presented was real time whereas the IPR was a retrospective view and the IPR would show improvement to 62-day backlogs in July.

4.08pm Following the presentation and questions Ab Abdi, Mr Thomas and Debbie Bagley were thanked for attending and they left the meeting.

Item 9 07/22 **Finance Report**

9.1 Finance Report M03

Brian Shipley presented the finance report for M03 and highlighted key areas to note:

- The Trust had a £0.60m deficit, £0.99m worse than plan. The year-to-date deficit was £1.26m, £2.34m worse than plan.
- The number of beds open was 60, which had reduced to 40 in June but still a cost pressure. This was driving some of the medical staffing spend. Delivering additional capacity was a key pressure with ERF at 94% and having to rely on outsourced capacity.
- There was circa £7.5m at risk which had been highlighted to ICB although the forecast had not been formally changed. Conversations were ongoing with NHSI regarding mitigation actions required.
- Medical staffing was overspent in month and a series of meetings were to be arranged to undertake deep dives to understand the drivers and reviewed through PRIMs.
- The Trust was in the process of submitting additional capacity funds for beds. Operational pressures and risks being faced with new Covid increases.
- Underspend in midwifery and community services assumption that it would continue due to recruitment.
- Slippage of £1m in CIP primarily driven by Medical staff and nursing vacancy projections expected to be behind plan. New savings programme needed to be identified to replace failing schemes, noting continued over-delivery in back-office functions to support some slippage of other schemes.

Maneesh Singh referred to outpatient follow up and asked if there was a way of engaging clinicians to reduce the requirements or if patients should be going back to primary care. Shaun Stacey explained that Connect Health was looking at that but historically follow-ups were undertaken by clinicians. Jim Mackie's team had provided guidance on how to work with clinicians to change that culture and had engaged with Connect Health partners to assist with that. Shaun Stacey acknowledged that it was not a quick process to avoid disengaging clinicians as need to recognise associated safety concerns.

Fiona Osborne asked if the Committee could be assured that if all the actions were taken the forecast position would be achieved. Fiona Osborne also asked if the Finance Business Partners had been able and successful in supporting and advising Divisions how to get back on track whilst maintaining patient quality and safety particularly given the high level of medical staffing spend.

Brian Shipley stated that risks were not interdependent with some elements out of the organisation's control, but some were within its control and must be taken. The Finance Business Partners are working closely with the Divisions to help them achieve the forecast. The forecast position assumes delivery but there was so much uncertainty and waiting for guidance in M04.

9.2 Recovery Support Programme for finance (RSPf) letter

Due to timing of the meeting with NHSI, no letter had been received.

9.3 Cost Efficiency – National Cost Collection Submission

Brian Shipley presented the report and explained that the Committee had received and approved the pre-submission report in May 2022 and the current report updated the actions and identified any areas where the Trust was still working to complete the return.

Fiona Osborne referred to the Internal Audit report embedded within the Costing report which was very positive placing less emphasis on the issues in the report submitted to the Committee. Brian Shipley explained that the audit was undertaken to ensure that the team followed costing standards and not on the quality of the submission. There were recognised gaps in data quality and how that was mitigated but the audit was more about following standards.

Fiona Osborne referred to the actions which appeared to pass responsibility for resolution to other teams rather than presenting them as a collaboration with those other teams and asked if this was the case. Brian Shipley did not agree that responsibility was being passed elsewhere as the teams had been honest about their limitations. They were working closely in collaboration with other teams if they were unable to address those issues entirely by themselves.

Following review, the report was approved for submission.

9.4 Business Case Review

Ashy Shanker attended the meeting to present the report which was an update to the annual business process that had taken place for 2022/23 and provide a summary list of the business cases submitted and those that had been agreed to take forward.

Ashy Shanker explained the changes to the previous process which included more intensive Executive involvement and a methodology of prioritisation. Ashy Shanker explained that following a “wish list” submission, the Divisions were then asked to shortlist to three-five per division. The initial cost was £17m which was reduced to £15m and following prioritisation with the Executive Team was shortlisted further.

Brian Shipley explained that it was not an easy process and was a balance to ensure the Divisions were engaged but not disheartened. Initially there was £32m of business cases reduced to £15m and then further reduced to £7m. Ashy Shanker highlighted that if an issue arises in-year that affects patient safety, it would be reviewed.

There was a lot of challenge from ICB for new business cases and Brian Shipley explained that there was to be no new investments and had to really push to get to the agreed cases and required some learning that not all investments were finance focussed.

Ashy Shanker highlighted that improvement quality related funding from NHSI was also considered.

Fiona Osborne praised the process used as a real step forward in the business planning cycle from the previous year. She asked about further improvements for the next business planning cycle. Fiona Osborne highlighted as an example the top three-five proposals from the Divisions and asked how assured the Committee could be that those brought forward in one Division was of higher priority than those from another Division that did not get through. Ashy Shanker explained that they were considered at divisional level but would look at all the following year to compare if one was more important than another that did not achieve the top three-five.

Shaun Stacey explained that a planning concept paper was being prepared for Executive/TMB to sign-off which would include that part of the process and could come back to F&P for assurance.

9.5 Capital Investment Board Minutes

The minutes had been provided and it was noted the further slippage on completion of the ED may need the capital plan to be re-phased.

Item 10 07/22 **F&P Committee Governance Documents**

10.1 Board Assurance Framework (BAF) – Q1

The BAF – Q1 had been provided to the Committee. Fiona Osborne queried strategic threats and asked if the wider economic climate should be included – which was agreed.

Fiona Osborne highlighted that the Fire Strategic risk was not under planned actions and given the Deep Dive report presented earlier in the meeting could this be included. Jug Johal agreed to address.

Action: Jug Johal

Item 11 07/22 **Items for Information**

11.1 Performance Letters to Divisions following PRIMs meetings

There were no letters available for this meeting.

11.2 Mutual Aid Report

A mutual aid report was provided for information. Shaun Stacey highlighted that the report would be updated and brought back to the Committee at a future meeting.

Item 12 07/22 **Any Other Urgent Business**

There were no matters raised.

Item 13 07/22 **Matters to highlight to other Trust Board Sub-Committees**

There were no issues raised during the meeting.

Item 14 07/22 **Matters for Escalation to the Trust Board**

There were several issues to be included on the Highlight Report which Richard Peasgood would draft and circulate to members of the Committee for agreement.

Action: Richard Peasgood

Item 15 07/22 **Review of Meeting**

Shaun Stacey stated that given the number of technical issues at the start, the meeting had gone well. Shaun Stacey highlighted that the team who attended the meeting from Ops had felt positive with the questions asked.

Fiona Osborne thanked Shaun Stacey and Brian Shipley for dialling in on their telephones given the difficulties with internet access.

Item 16 07/22 **Date and Time of next meeting**

The next meeting was due to take place on 24 August 2022 – Executive Board, DPOW – 1.30pm-4.30pm.

Attendance Record 2022/23

Name	Apr 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23
Gill Ponder	✓	✓	✓	Apols								
Linda Jackson	-	-	-	-								
Fiona Osborne	✓	✓	✓	✓								
Michael Whitworth	-	-	-	-								
Maneesh Singh	✓	✓	✓	✓								
Lee Bond	Apols	✓	✓	Apols								
Peter Reading	-	✓	Apols	Apols								
Shaun Stacey	✓	✓	✓	✓								
Jug Johal	✓	✓	✓	✓								
Helen Harris	Apols	Apols	Apols	-								
Brian Shipley	✓	✓	✓	✓								
Simon Tighe	-	-	-	-								
Ab Abdi	-	-	-	-								
Richard Peasgood	✓	✓	✓	✓								
Ian Reekie	✓	✓	✓	✓								
TOTAL ATTENDEES	**8**	**10**	**9**	**7**								

MINUTES

MEETING:	**Finance & Performance Committee**	
DATE:	**22 June 2022 – via Teams Meeting**	
PRESENT:	Gill Ponder	Non-Executive Director / Chair of F&P Committee
	Fiona Osborne	Associate Non-Executive Director
	Maneesh Singh	Associate Non-Executive Director
	Lee Bond	Chief Financial Officer
	Shaun Stacey	Chief Operating Officer
	Jug Johal	Director of Estates & Facilities
	Brian Shipley	Deputy Director of Finance
	Ian Reekie	Lead Governor
IN ATTENDANCE:	Richard Peasgood	Executive Assistant – Operations Directorate
	Jennifer Moverley	Head of Compliance and Assurance (For item 6.1)
	Jackie France	Associate Director of Patient Services (For items 9.3 & 9.4)
	Ann-Marie Hall	Associate Director for Urgent & Emergency Care & Discharge Implementation (For item 9.5)
	Anne Sprason	Finance Admin Manager/PA to CFO (Minutes)

Item 1 06/22 Apologies for absence

Apologies for absence had been received from Peter Reading. It was noted that Jug Johal would be late to the meeting due to an urgent call.

Item 2 06/22 **Quoracy**

There were enough of both Executive Directors and Non-Executive Directors in attendance for the meeting to be quorate.

Item 3 06/22 **Declarations of Interest**

Gill Ponder noted that no declarations had been received prior to the meeting. There were no new declarations of interest made.

Item 4 06/22 **To approve the minutes from the previous meeting held on 25 May 2022**

The minutes from the meeting held on 25 May 2022 were reviewed and Shaun Stacey referred to Page 4 (3rd paragraph), which stated that … *improvements would be seen in flow from June/July onwards in SGH …..* and explained that this would be September. It was agreed to add as a post meeting note to the minutes.

The minutes were agreed as an accurate record of the meeting.

Item 5 06/22 **Matters Arising**

5.1 Action Log

The action log was reviewed as follows

11 (18 02 22) – BAF - Removal of risks from F&P Committee's remit. Gill Ponder confirmed that the risks had now been removed from the TOR. **Item Closed.**

8.2 (20 04 22) – Planned Care – A small group from the Committee to discuss areas of focus for areas underperforming took place on 10 June. An action plan would be circulated in advance of the July meeting for comments and implementation from July. **Action**: Gill Ponder.

11.1 (20 04 22) – Terms of Reference – To add that Richard Peasgood would be the Senior Administrative Support to the meeting. These had been included in the TOR and agreed at Trust Board. Meeting took place on 9 June to agree on the remit of the role**. Item Closed**.

Following review, the action log was noted.

5.2 F&P Committee Workplan V7

Shaun Stacey noted the monthly deep dives which required cross reference to the Transformation Projects listed on the workplan. It was agreed that Shaun Stacey and Richard Peasgood would review and amend accordingly.

Gill Ponder noted that there was nothing included on the workplan on the financial plan within business planning. It was agreed to add to the workplan for February. A retrospective and prospective position could be included within the monthly finance report.

Business Continuity had been suggested by Peter Reading at the last meeting to move to the ARG Committee. Gill Ponder noted that a review of all sub-committee remits was to be undertaken and she would be speaking with Linda Jackson and Sean Lyons as part of that process.

Lee Bond noted that under Finance (c) should now read "*achieving the HNY ICS control total".*

1.45pm Jug Johal joined the meeting.

Fiona Osborne noted in the TOR the Committee had responsibility for investment decisions and asked if any business cases would be seen by the Committee. Shaun Stacey noted that a summary position would be available in-year and suggested a high-level summary could be brought to the Committee by way of assurance. It was agreed to include a line to reference business cases within the capital section.

Fiona Osborne stated that it would be useful to have sight of the scoring table used during the business planning cycle for the next year.

It was agreed that Shaun Stacey and Richard Peasgood would tweak the workplan following the suggestions made and circulate for agreement with implementation from July 2022.

Action: Shaun Stacey / Richard Peasgood

5.4 Action Plan following Self-Assessment Exercise

Gill Ponder highlighted that the action plan was still to be finalised for circulation and agreement at the July meeting. The main comment from the self-assessment was the amount of business making the agenda quite long. Gill Ponder noted that now Strategy and Digital have moved to the Strategic Development Committee this had made the agenda much shorter.

As the meeting was running slightly early the next item was taken out of sequence.

Item 11 06/22 **Items for Information**

11.1 Performance Letters to Divisions following PRIMs meetings

The letters from May 2022 had been provided for information and were noted.

Item 6 06/22 **Presentations for Assurance**

6.1 CQC Progress Report

Jennifer Moverley presented the paper and advised that there were no Trust-wide red actions. She explained that an end of year report would be prepared for the Committee for assurance purposes. The current position was 83% of 145 actions rates as blue or green. There were 27 actions aligned to F&P Committee and Jennifer Moverley briefly highlighted the seven amber actions as listed in the summary document.

Shaun Stacey referred to the 52 week waiting list which stated in the report that the Trust trajectory was to have zero patients at the end of Q1 and advised that it had been agreed by the organisation that this would be September 2022 due to the mutual aid work being undertaken.

Shaun Stacey also highlighted that Clinical Support no longer existed as a division and was now Surgery & Critical Care and Diagnostics. Jennifer Moverley confirmed that a plan was in place on how to monitor the two areas once the CQC visit had taken place and would be able to align the two.

Fiona Osborne stated that as always it was a very clear report and referred to a previous request for a report of completed actions to ensure sustainable, which Jennifer Moverley advised would be added on as an Appendix.

Gill Ponder highlighted reference in the report that once a finance strategy was available the Trust would be able to emerge from special measures which she thought relied on an inspection and being on track to deliver the plan this financial year and suggested the report ought to reflect those changes. Lee Bond agreed and explained that the financial strategy was still emerging, and the clinical strategy needed to reflect the changes due to the Humber provision of acute care.

Gill Ponder suggested that it may be better to do a high level strategy due to the emerging picture and public consultation and outline that the plan was to break even then the clinical strategy to be finalised then consultation which could close the action. Lee Bond was not clear on the added value of producing that and suggested that the CQC could be asked if happy with what had already been done. Jennifer Moverley suggested a completion paper to the CQC if required, which was agreed.

There were no further questions raised and Jennifer Moverley was thanked for the helpful report and she left the meeting.

Item 7 06/22 **Finance Report**

7.1 Finance Report M02

Brian Shipley presented the finance report for M02 and highlighted key areas to note:

- YTD was £600k adverse to plan. In M02 claw back of ERF assumption for M01 had been reversed to align with the wider ICS assumptions.
- The main pressures were in medical staffing with a number of material overspends across the board. Surgery had the biggest challenges with vacancies and additional costs in the Medicine Division with ED and acute care amounting to £1.4m overspend.
- Nursing was in line with the plan with continued pressures due to escalation beds which were circa 60 above the funded position.
- Other pay was £0.66m underspent with over-delivery of non-recurrent CIP within corporate functions.
- Non-pay – one off expenditure linked to buying equipment for mutual aid work so should realign. Pressures with high cost drugs would have been passed to commissioners previously so currently undertaking analysis.
- Real pressure was medical staffing and non-delivery of activity and escalation beds in nursing.
- Covid expenditure had reduced from last month but still need to be sighted on it although living within envelope.
- Temporary staffing increased with the main pressures in medical staffing spending more than in previous year with the majority in Surgery. A deep dive was being undertaken across all specialties and revisiting the work undertaken by Ernst and Young previously. Escalation beds were also affecting medical staffing.
- CIP delivery was slightly behind plan on its core programme of £1.78m delivering £1.77m. Covid spend reduction savings had improved which provided mitigation against the core position.
- The Trust had been allocated £8.0m of Elective Recovery Funding (ERF) to deliver the 104% activity requirement which was currently at 96% in-month which was a slight improvement on April but still behind. Capacity reserve was being spent but not delivering activity.
- Capital Funding key variances included Ward 25 reconfiguration delays of approximately two weeks with the ED expected handover early/late August which would affect the start of the AAU works. It was noted that this had the potential of slipping into the next financial year and resources would need to be managed across two financial years.
- The general underlying position was circa £26m.

Fiona Osborne noted the challenges highlighted with medical and nursing staffing costs, escalation beds, substantive posts expected to be filled, and delays with equipment which were risks very early in the financial year and asked if reforecasting was being undertaken to understand the level of risk. Brian Shipley stated that he was looking at the forward projection and linking with recruitment to understand the position.

Fiona Osborne asked if the issues within Surgery in terms of CIP, medical costs etc. were picked up with the finance business partner. Brian Shipley explained that monthly divisional team meetings were undertaken and the PRIMs meeting where the issues were discussed.

Shaun Stacey highlighted that in medical staffing several bids had been put in to support workforce redesign which for certain activities came with a cost; BAME risks assessments were still in place and prevented some clinicians in undertaking routine work as well as short and medium term sickness all contributed to the challenges being faced. A productivity group was now in place looking at all areas of activity which was starting to take effect but would need time. The independent sector was only being used on an ad hoc rather than planned basis which again came at a cost.

Lee Bond commented that he had attended PRIMs with Surgery and they were aware of the drivers on their spend position, including Ward 19, medical outliers, additional clinics adjacent to ED which had been introduced as part of Covid but not funded in the current year's plan; 22 WTE admin staff in Surgery with some non-recurrent due to issues with transfer of rota co-ordinators and need a degree of granularity to understand what needs to be put in the forecast.

Maneesh Singh asked if money was being spent to chase the 104% level to clawback the ERF and asked what the 4% looked like. Shaun Stacey stated that it depended on several variables and highlighted the different areas but were focussing on the activity to get to 100%.

Gill Ponder referred to the £600k adrift of plan at the early part of the financial year and asked if additional grip and control and recovery actions would need to be applied. Lee Bond explained that work was ongoing with each Division to understand what could safely be cut noting that there was no particular problem with the CIP programme which could offer opportunities.

7.2 Financial Plan Update

Brian Shipley presented the report which provided an update of the Trust's 2022/23 financial plan and built on the planned £6m deficit plan submitted in April. Brian Shipley highlighted key areas to note including the national tariff uplift of 0.7% to support inflationary pressures resulting in an increase of funding of £2.73m. This had been agreed by CCGs except for Lincolnshire CCG.

The proposed investment programme had been adjusted by £1.45m for anticipated slippage in the ED expansions and AAU recruitment but need to get back to 100% activity within existing resources. Brian Shipley highlighted that as part of the April plan no ERF was included for Lincolnshire ICB which was estimated to be £1.18m. This had been disputed by the Lincolnshire ICS and negotiations were being held with the support of the ICS but could be a risk to the plan if not resolved.

Fiona Osborne asked Shaun Stacey if he was comfortable of delivery given all that had been discussed in the meeting. Shaun Stacey confirmed that the clinicians were aware of the need for delivery which was the reason for the implementation of planned care and productivity meetings and highlighted that the monthly GIRFT reports highlighted where the gaps and focus needed to be.

7.3 Recovery Support Programme for finance (RSPf) letter

Brian Shipley advised that the last meeting covered an update on the M01 position and a verbal update on the plan position. The main focus for them was on medical staffing drivers of pay and work was being done internally with RSPf team on that.

The RSPf letter was noted.

7.4 Capital Investment Board Minutes

Due to the timing of the CIB meeting, the minutes were not available.

Item 8 06/22 **Estates & Facilities**

8.1 BAF Risk Review – Medical Gases

Jug Johal presented the paper which had already been discussed at Trust Board and highlighted that the final phase of the Oxygen upgrade at DPOW was commencing noting that the challenge would be at SGH as no funding had been allocated.

Jug Johal advised that an update on the enforcement notices would be included within the reports each month.

Fiona Osborne queried the medical gas wall point terminals (Risk ID 1620) which would be replaced in line with ward upgrades and asked what the timescales were. Jug Johal explained that there was no long-term plan but were being done based on the capital received. The medium-term capital plan would feature in discussions at the next joint Board.
Gill Ponder noted that the flow diagram in the reporting structure (2.2) missed out F&P which Jug Johal agreed to action.

Action: Jug Johal

Gill Ponder also referred to the Serious Incidents (page 13) and asked when the residual actions would be completed. Jug Johal explained that the key action related to training and an update would be provided to Trust Board in August. It was hoped that all actions would be closed by the end of August 2022.

Following the update, the report was noted.

8.2 BAF Risk Review – SO1.4

It was noted that NEDs could raise questions around risks, risk score and mitigations. Jug Johal asked if there was anything missing or not understood.

Gill Ponder referred to BLM which had been discussed many times and it was acknowledged that the situation would get worse unless there was additional funding and asked if there were any plans to seek further funding for those more worrying issues. Jug Johal commented that there was no more emergency capital because of the cash position and Lee Bond added that there was only £70m across the ICS. At the joint trust board discussions could be held to ensure awareness but was not going to be the solution. Jug Johal stated that the majority of risks were behind walls or above ceilings so not transformational noting however, that if an enforcement notice were to be served then that would have to be dealt with adding that it was about pre-empting the risks which is what was done with the £2m pot from the budget.

It was agreed that the scores on the BAF were an accurate reflection of the position.

Item 9 06/22 **Review of NLAG Monthly Performance and Activity Delivery (IPR)**

9.1 Unplanned Care

Shaun Stacey presented the report and highlighted key issues to note including there were now no specific Covid wards in place; workforce issues continued to be a challenge; there had been an increase in patients through emergency care model; and the 4 hour waiting times was 65.5% for May. There had been an increase in patients waiting for 12 hours. Shaun Stacey also advised that an audit had been undertaken on patient flow and could share the report for reference.

Action: Shaun Stacey

Shaun Stacey advised that working with system commissioners to address the flow out of ED and/or the hospital and whilst the conversations were proving fruitful the issues still needed to be addressed. There were several beds open supporting patients with no right to reside. Work had been done with the Community team in North Lincs but required investment and still negotiating with others. The number of patients at +7 and +14-days LOS continued to be high.

Fiona Osborne referred to the escalation beds and asked what the trajectory was to reduce. Shaun Stacey stated that a downward trend would usually be seen now until October but still seeing a demand for beds. It was not possible to put a trajectory or time frame on it until concluded work with the PLACE and Community Teams.

Maneesh Singh referred to Cardiology patients and 30+ days LOS and asked if there was a way to ease the pressure to get them home sooner. Shaun Stacey explained that whilst they did not need to reside in hospital, they needed to be monitored which could not be done outside of hospital. This was a similar situation in other specialties and working through a plan looking through pathways, but it required funding to support a risk-based decision.

9.2 Planned Care

Shaun Stacey highlighted that the percentage of inpatient waiting list stratification was at 100% in May and there had been a reduction of over-due follow-ups. A deterioration in 104-day cancer backlog and 2ww in-month. Breast pain clinics were still to be up and running but it was hoped there would be improvement over the next six months. A deep dive was being undertaken on the 104-day backlog from a quality perspective and engaging clinicians.

Fiona Osborne referred to the cancer waiting list and levelling up and asked if the numbers coming through from HUTH pathway rather than NLAG could be identified. Shaun Stacey advised that work continued with the cancer teams and Hull diagnostic and treatment pathways. There had been 590 referrals from HUTH and York brought into the organisation which varied between 2 weeks and 64 weeks; a breakdown would be attached to the IPR. There had been over 100 patients treated with plans for a further 86; there had been 36 transferred who had received their treatment elsewhere.

Maneesh Singh asked if Shaun Stacey thought the peak of the challenge had been reached. Shaun Stacey commented that he did not think it was at the peak of planned care recovery as there was more work to do and across the ICS significant problem in planned care. A recovery director had been appointed as part of the collaborative board and was beginning to understand the issues.

Jackie France joined the meeting to present the following two items.

9.3 Risk Stratification

Jackie France presented the report and highlighted that significant progress could be seen since the last report. An automated process had been introduced, where it was safe to do so, with an option for clinicians to update manually. The biggest challenge was overdue patients as there was no automated process as could be a patient safety risk and needed to be reviewed by a clinician. The focus remained on high priority overdue patients. The BI report had up to date data which showed long waiters who were managed through weekly PTL and flagged through to the operational management group for patients classed as high risk.

Fiona Osborne referred to outpatient review appointments specifically Ophthalmology and Jackie France stated that Ophthalmology work differently as they have safety officers in place who keep an eye on waiting lists and were risk stratifying their own patients as they need regular review. Work was ongoing to find a better way to do that but still work in progress including working on a blended hybrid but confirmed that Ophthalmology did keep on top of them.

Ian Reekie queried the stage at which automation was considered. Jackie France explained that where manual risk stratification was done clinicians were encouraged to remove the patient if low risk and consider putting on PIFU both for when a patient was seen or reviewing their notes. Shaun Stacey added that it was about clinician preference and was a difficult balance to ensure patients comply and the risk for the clinician if under their care.

Gill Ponder queried the review appointments and overdues as there were a substantial number of people unstratified and asked what the plans were for those and the timescales. Jackie France explained the process and that there would always be a few patients not risk stratified as they go through the system; there was a two or three week grace period as they became overdue. Jackie France agreed to check for Gill Ponder the mix of weeks overdue of the 16,000 patients.

Action: Jackie France

Maneesh Singh queried how a patient on a PIFU got back into the system. Jackie France explained that there was a process in place, and it was explained to the patient at the time the PIFU was put in place, and if there had been no interaction in 12 months then the patient would be contacted.

9.4 OPD Transformation Project

Jackie France presented the report and highlighted that the Connected Health Network (CHN) had received national awards and recognition for its innovative approach. The funding used was pilot funding and NHSE/I were keen to work with the Trust to ensure the model was sustainable in the long term. There was excellent clinical engagement and more specialities were keen to join and patients felt confident in using the service.

Patient initiated follow-ups (PIFU) had reduced over the last few months but to meet the 5% target a different approach was required and work was ongoing to see if PIFU could be the default position.

Jackie France highlighted digital communications which had delivered savings, particularly in terms of outpatient letters. The postage costs had recently increased and work with Jug Johal's team was ongoing to understand the reasons. The Patient Knows Best (PKB), patient portal had been successful in its TIF bid to fund 2-years licence fee. Conversations had taken place about the Trust being a beacon site on the NHS App.

The DNA Rates had seen a significant sustained reduction which had been helped with the use of text messaging but there were still opportunities to improve. The outpatient follow-up activity needed to be reduced by 25% from the 2019/20 baseline activity so that would be a focus, noting the need for transformation change so an ambitious ask and not a quick fix.

Jackie France drew the Committee's attention to the Risks and highlighted that a Clinical Lead was due to be appointed which would help change clinician culture.

Gill Ponder thanked Jackie France for the presentation and asked for the next update in three months' time that any changes were highlighted specifically, as the Committee were keen to see the progress being made.

9.5 Transformation Projects – Urgent & Emergency Care

Ann-Marie Hall attended the meeting to present the report and highlighted specifically that the UCS continued to be a success with good engagement with GPs to ensure cover although the CCGs discussed duplication of some services and a review of those was being undertaken.

The same day emergency care was off-track due to in-reaching for some specialities and work was ongoing with Divisions.

Ann-Marie Hall noted the patient flow and discharge which in the report stated that the Trust was the third best performing in the region for LLOS reporting with the current position being second best and holding that position.

Ann-Marie Hall also highlighted several areas where work was ongoing including, working with system partners on exit blocks; ward rounds particularly deep ward rounds at Grimsby; and process mapping with phlebotomy.

Fiona Osborne acknowledged the good work that was being undertaken and specifically asked about the urgent care service from 8.00am-10.00pm which Ann-Marie explained had a “pinch point” around tea-time but then increased again.

Gill Ponder also agreed on the amount of good work but queried the lack of improvement in the 4-hour performance. Ann-Marie stated that it would be much worse if not used the model and explained how some of the processes had been streamlined.

Gill Ponder asked for the next update that any changes were highlighted specifically and for some indication to the Committee of when they would translate into improvement to the constitutional standards performance.

Item 10 06/22 **F&P Committee Governance Documents**

10.1 Board Assurance Framework (BAF) – Q4

There was no update due this month.

Item 11 06/22 **Items for Information**

11.1 Performance Letters to Divisions following PRIMs meetings

The letters from May 2022 had been provided for information and were noted.

Item 12 06/22 **Any Other Urgent Business**

There were no matters raised.

Item 14 06/22 **Matters to highlight to other Trust Board Sub-Committees**

There were no issues raised during the meeting.

Item 15 06/22 **Matters for Escalation to the Trust Board**

Richard Peasgood would draft the highlight report for the Trust Board and circulate to members of the Committee for agreement.

Action: Richard Peasgood

Item 16 06/22 **Review of Meeting**

It was agreed there had been good debate and good discussion during the meeting. Fiona Osborne agreed that the shorter agenda helped, and the meeting flowed well.

Item 17 06/22 **Date and Time of next meeting**

The next meeting was due to take place on 20 July 2022 – 2.00pm-5.00pm in **The Boardroom, New Beacon House, Scunthorpe.**

Attendance Record 2022/23

Name	Apr 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23
Gill Ponder	✓	✓	✓									
Linda Jackson	-	-	-									
Fiona Osborne	✓	✓	✓									
Michael Whitworth	-	-	-									
Maneesh Singh	✓	✓	✓									
Lee Bond	Apols	✓	✓									
Peter Reading	-	✓	Apols									
Shaun Stacey	✓	✓	✓									
Jug Johal	✓	✓	✓									
Helen Harris	Apols	Apols	Apols									
Brian Shipley	✓	✓	✓									
Simon Tighe	-	-	-									
Ab Abdi	-	-	-									
Richard Peasgood	✓	✓	✓									
Ian Reekie	✓	✓	✓									
TOTAL ATTENDEES	8	10	9									

NLG(22)185

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	4th October 2022	
Director Lead	Kate Wood, Medical Director Ellie Monkhouse, Chief Nurse Mike Proctor, Non-Executive Director	
Contact Officer/Author	Fiona Osborne, Chair of Quality & Safety Committee	
Title of the Report	Quality and Safety Committee (QSC) minutes from July and August 2022 meetings	
Purpose of the Report and Executive Summary (to include recommendations)	The paper includes the minutes of the Quality and Safety Committee (QSC) meeting for July and August.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Monday 25 July 2022 from 10.30am to 1pm
Via MS Teams

Present:

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

In attendance:

Abdi Abolfazi	Deputy Chief Operating Officer
Peter Reading	Chief Executive
Angie Legge	Associate Director of Quality Governance
Melanie Sharp	Deputy Chief Nurse
Ian Reekie	Governor
Simon Buckley (item 168/22)	Associate Chief Nurse, Medicine
Debbie Bray (item 168/22)	Associate Chief Nurse, Neonates Children & Young People
Dr Vijaya Hebbar (item 168/22)	Clinical Lead for Paediatrics & Consultant Paediatrician
Antony Roseveare (item 170/22)	Associate Chief Operating Officer Family Services, Community & Therapies
Donna Smith (item 170/22)	Associate Chief Nurse, Community & Therapies
Jane Warner (item 171/22)	Associate Chief Nurse, Midwifery, Gynae & Breast Services
Jo Loughborough (item 172/22)	Senior Nurse, Patient Experience
Vicky Thersby (item 175/22)	Head of Safeguarding
Jennifer Moverley (item 179/22)	Head of Compliance & Assurance
Laura Coo	PA to the Medical Director **(minute taker)**

164/22 Welcome and Apologies for Absence

Apologies for absence were received from: *Dr Kate Wood, Kishore Sasapu, Shaun Stacey (Abdi Abolfazi to rep), Ellie Monkhouse (Mel Sharp to rep),*

165/22 Opening remarks

There were no opening remarks.

166/22 Declaration of Interests

The Quality and Safety Committee was quorate and there were no declarations of interest related to any agenda item.

167/22 To Approve the Minutes of the Previous Meeting held on 21 June 2022

A typo was pointed out on page 5 should be a closed bracket rather than a zero.

The attendance table had been updated and all agreed it was now an accurate reflection of this year's meeting attendance.

The minutes were accepted as an accurate reflection of the previous meeting.

Ant Roseveare, Simon Buckley, Vijaya Hebbar and Debbie Bray joined the meeting.

Matters Arising

168/22 The Royal College & Diabetes Management update

Following the meeting in May, Mike Proctor explained that he had asked for the letter from the Royal College of Paediatricians in relation to diabetes to be included in the paper to be discussed as he wanted to understand where the Trust was with the recommendations and monitoring for Diabetes given that the standards identified for improvement had an impact on the safety and training related to Diabetes care.

Debbie Bray referred to the paper distributed which was taken as read.

In relation to the immediate action identified around the nursing element, an advert for additional staff had gone out which closed on Friday and they had four applicants. As an interim measure there was support in DPoW from the SGH team which was not causing any problems. The administration support to the teams had been increased and the national team had requested a further meeting to discuss the actions around the immediate risk.

There had been two meetings with the team to discuss the seven serious concerns around dietetic workforce, CPD, training and education. A robust action plan had been completed which would be sent off by 26th July. Debbie advised that there would need to be some additional funding to be able to support the action plan.

Mike asked how surprised the team were by the report as reduced staffing seemed to have become a theme, he wanted to know if the team had become desensitised and whether this had been escalated. Debbie responded to say that there was not a lot in the feedback that came as surprise to the team, but noted that the situation had a sensitive HR element to it which is why it hadn't previously been fully addressed, but noted that this had already been discussed with the engagement group from a nursing point of view.

Peter Reading thanked everybody for responding so quickly and Debbie had answered the question Peter was going to raise about whether the Patient Experience Group had been involved as often parents of children with long term conditions were experts in their own right with regards to the care. Debbie added

that going forward there would be a senior member of the team at all the parent forums to ensure issues raised by families were taken into account.

Mike asked if Vijaya Hebbar, as Clinical Lead, was happy with this action plan and if she felt it would cover all elements to improve the service.

In response Vijaya felt it would cover all the elements, noting they had a Consultant who was leading the service previously but they had left to work in Hull and that additional lack of leadership at one point had magnified the issues. Going forward with the revised staffing levels they looked to be ok and would be able to provide a good service.

Fiona Osborne noticed that the parent's concerns identified on page seven said that they raised concerns outside of the PALs process and queried what that was. Debbie replied that on that occasion, letters of complaint were handed to a clinician, so the correct process for raising complaints had been reinforced through the Parent Forums and with clinical team.

Fiona was impressed with the response to the situation although was concerned that even though this Committee had received regular reports on diabetes, that members were not aware of this situation and wondered how we could prevent that from happening again. Debbie added that it had been escalated within the Division and was on the risk register but on reflection it needed to broadcast more widely so took Fiona's comments on board going forward.

Maneesh Singh asked if people felt they could not raise concerns and queried if the two months was enough. Debbie said they could, but that there had been a lack of senior presence at some meetings, and they recognised this was important to enable concerns to be brought through for action.

Angie Legge followed up on Fiona's point as it did raise an important issue about how operational teams were supported to give the right level of assurance, and noted that guidance in future would be to include the need to mention the risks, this was a little bit of a failsafe aspect to avoid being in this position in the future.

In terms of ongoing monitoring Mike agreed with Angie's suggestion. It had been previously agreed that this would be the last time this Committee received a report on this topic however Mike asked that it came to this Committee for review on progress again in three months' time.

Jane Warner joined the meeting at 10.50am

The Committee agreed to the three month time scale for the next report.

Mike added that this Committee was here to support, not out to criticise and thanked Debbie Bagley, Vijaya Hebbar and Simon Buckley for the update.

169/22 Review of action log

All actions were up to date.

Regular Reports

170/22 End of Life Update

Donna Smith referred to the document distributed which was taken as read and highlighted the key points.

The team had used this report as an opportunity to consolidate the work that had been undertaken for the CQC inspection, it gave them the opportunity to look back, to see where they were now and what they had achieved. There was still work to do but there had been some improvements. The Bluebell model had been vital in making this work albeit there was more to do there.

Fiona Osborne thought the work was moving along nicely and knew some aspects had been a real challenge but asked in terms of resource if they had enough to facilitate that. Donna stated that the funding for the Respect training from Health Tree had now ceased so that was a risk. Clinical capacity was stretched and they recognised that was a risk and were putting together a business case for funding to try to mitigate that risk.

Peter Reading thanked everybody for all their work in moving this forward. The CQC had come back with queries on this but Donna felt they were moving in the right direction and felt the questions they were asking indicated they were looking for the evidence to improve the rating on the service.

Abdi referred to page five of the update but could not see any obvious themes. Donna commented that it was usually around communication and family and relatives not being aware of the care plan but other than that there did not seem to be any obvious themes.

Ian Reekie stated that he had participated in a 15 steps visit to DPoW ED on Thursday and asked staff if they had access to EPAC, which they did not and wondered when they were likely to get access. Donna agreed it was fundamental for them but was unsure of the timescales.

Mike Proctor summarised that there had been good progress in this area and he hoped the CQC recognised that, but there was still a lot of work to do. Regardless of feedback from CQC it would continue to a priority area for improvement in the Trust.

Mike thanked Donna and Ant for the update and the report was noted.

171/22 CNST & Ockenden update

Jane Warner referred to the update distributed which was taken as read and highlighted the key points.

The detail being the current position with regards to CNST was included in the first few pages of the report. They were doing well and Jane was confident that they would meet CNST again this year.

No.1 National Perinatal Mortality Review - There was still a lot of work to do, with regards to the ten safety actions for the National Perinatal Mortality Review, but Jane thought they were meeting every aspect and had no concerns.

No.2 – Submitting data to the Maternity Services – the paper contained Julys data but Jane did anticipate that would be met.

No.3 - Avoiding admissions – there had been a lot of work around ensuring staff were trained ensuring babies were not cold and doing everything to ensure term babies were not having to go the Neonatal Unit.

No.4 – Clinical workforce - everything was as we would expect and they were collating compliance for the Paediatricians. There was also a guideline re: roles and responsibilities.

No.5 – Effective system of midwifery workforce planning - had Birthrate Plus, which showed the team did not need to be looking for additional midwives and it did look like staffing was as it should be. Ellie Monkhouse had undertaken an establishment review as well.

No.6 – to demonstrate compliance with four elements of saving Babies Lives - looking at whether women were being encouraged to stop smoking, were we training our midwives etc Jane noted that this was in hand.

No.7 – Linked to premature babies – this was about ensuring those who were extremely premature were delivered in a tertiary unit but we are compliant. Ruth Prentice, from the maternity voices partnership, worked closely with NLaG but would be stepping down which was a loss to the Trust.

No.8 – Training compliance – This assessed how those who would work together train together particularly on PROMPT training. Figures were included in the report on page 23 but had been updated since and were looking much better i.e. anaesthetics had been at 5% but were now at 40%.

No.9 – Safety of the service – Jane and Mike Proctor were safety champions and were ensuring voices of staff from the bottom to the board were being heard.

No.10 - Reporting - this was about ensuring we reported into NHS resolution which being undertaken.

Page 28 of the report was focussed on Ockenden and gave the current position were well on our way to completing the first action plan and were working on 17 actions.

The Division had acquired some monies for an Audit Facilitator who would support the evidence to show they were complying. There were 15 immediate and essential actions within the final report. The regular fortnightly meetings and the action plan had not started although they had done a baseline review of services but were awaiting the report from East Kent.

Jane invited any comments or questions.

Fiona Osborne referred to safety element six, CO testing. She asked whether it was the extraction of data causing challenges or the number of women being tested. Jane explained that it was around extracting the data. Jane was confident it

was happening but the Community Midwives had been putting that information in different places i.e. in free text which meant analysis was more challenging. It was only when they investigated they realised what was happening so Jane expected that would increase dramatically for the next report.

Angie Legge asked about no.7 and the mechanism for gathering feedback, Angie was aware that there had been some noise about how good the maternity voices partnership was and therefore expected it would be rated as green. Jane agreed and was perhaps being over cautious so would look at this.

The Committee were assured by Jane's confidence in subsequent achievement of all standards and thanked Jane for the update.

172/22 Complaints Annual report

Jo Loughborough referred to the report distributed which was taken as read and highlighted the key points.

The report was a good reflection of what had gone on in the year. The number of PALS received had doubled in the year, which Jo believed had been brought about by the changes in visiting.

Complaints were seeing a year on year increase and the report was reflective of that. Complaints were being closed within the timescale which was a dramatic improvement. Learning lessons was still the big piece of work to do, there were challenges with being able to evidence that at Divisional levels.

Compliments were an underutilised piece of work which the team were going to focus on for next year but it was difficult data to collect.

Peter Reading complimented Jo supported by Mel Sharp and the Complaints and PALs teams as he thought they had anchored a revolution for dealing with complaints and PALS and to drive that down to the response times and re-opened complaints was revolutionary and really very powerful really.

Peter thought Jo's explanation of PALs was highly credible but in terms of complaints Peter thought it was a modest number but he was always of the belief that to have a high number of complaints was healthy rather than unhealthy as it gave the opportunity to address issues and make changes. Peter asked if there was any bench marking as it would be helpful to put things into context of we were.

Jo replied to say that the Trust tended to sit within the range of between 250 to 450 and there had been a lot of work around addressing claims at source. Our PALS process dealt with a lot of concerns that perhaps should go down the formal route.

Fiona Osborne referred to page 8, where it mentioned the 19% increase in complaints on the previous year but looking at pre pandemic statistics it was still less.

In addition, Fiona mentioned that the themes from PALS/complaints were appointments and the patient line launch had been mentioned and Fiona asked if we would we see an immediate impact on the back of the launches. Jo responded to say that

the patient helpline had been launched in November 2020 however the PALS numbers had been consistently high but since the visiting had re-opened Jo hoped that would go down. There had been some work on this but probably not enough to make the significant impacts so communication issues were likely to remain as a prominent issue and tended to be an ongoing theme in most Trusts.

From a point of view of transparency, it was agreed these reports should at least go on the Public Board agenda for information.

173/22 National Inpatient 2021 Update

Jo Loughborough referred to the update distributed which was taken as read and highlighted the key points.

Overall, it was a positive report and was by far one of NLaG's best survey results particularly considering that in 2020 we were an outlier Trust.

Jo noted that NLAG had been reported positively on eight out of the nine actions from the surveys.

She outlined that the survey was monitored through the Patient Experience Group (PEG) which improved oversight into beds, family and homes, sleep (rated as a low response) moves at night and impact on sleep were an issue but there were some positive comments from patients too.

Maneesh Singh commented that communication seemed to be a running theme in both reports. Jo agreed it was a consistent theme which they were looking into.

Fiona Osborne was curious about the number of respondents and asked why there were no respondents from the BAME community. Jo thought there was some work to do with regards to that as it was noticed that the report lacked diversity. There were facilities to feedback in different languages etc but it was a random sample and it could have simply been that there were not any BAME people in that sample.

Mike Proctor asked if this would progress to Board, and it was confirmed after the meeting that it would.

174/22 Nursing Assurance Report & Patient Experience

Mel Sharp referred to the report distributed which was taken as read and highlighted the key points.

Mel highlighted the continued number of vacancies, the QI team were undertaking a rapid recruitment event, which would be quite an intensive day and were hopeful and positive they could dramatically reduce the number of HCA vacancies.

There had been a reduction in falls and were still undertaking MDTs.

Mel highlighted that the data identified a noticeable red rating in pressure ulcers in the Community and Ward C2 had some concerns. They had a summit planned for this week with a lot of intensive support and it remained a focus from an assurance point of view.

Mel noted that the vacancies were skewed by the increase in establishment however there were vacancies before the establishment increase. He mentioned that with regards to the recruitment event, job offers would be made on the day.

Angie Legge commented about the falls, noting that they were seeing a lot of them being delogged as serious incidents as the huddle process was identifying that although there was a fall, all the processes were being followed and nothing more could have been to be done to avoid them. She stated that this was a positive as it indicated staff were doing everything possible to maintain safety.

Fiona Osborne referred to page 29 and the statement regarding midwifery staffing and the possibility of having to close one of the two units temporarily to maintain safe staffing levels, Fiona thought that sounded very serious in terms of patient safety. Mel advised that they had not shut any of the units in July but yes they remained concerned about staffing in maternity but that was going to be part of the recruitment exercise.

Fiona asked about the apprenticeships and the nurse apprenticeships commencing in January 2023 and if everything had been agreed. Mel replied that she was still waiting for that business case to be approved.

Mike Proctor added that if the unit was ever closed it was a safety measure not a safety risk.

Ian Reekie commented that during the 15 steps visit to DPoW ED, it had revealed that the unit required intensive support and asked if that had been addressed. Mel responded that immediate actions had been taken and that Simon Buckley was regularly visiting the department. Mel added that she was due to take CQC around ED on Tuesday 26th July. She said that a lot of the issues raised were around documentation but the CQC were aware that they were moving into a new build and all concerns were escalated straight to Medicine.

Manesh Singh commented that the CNST report from Jane Warner stated there was enough staff for midwifery yet this report said we were dangerously close to closing the unit and queried which was accurate.

Action: Mel Sharp would have a look into that and provide a post meeting note.

The Committee noted the report.

Post meeting note: Mel Sharp clarified that Jane Warner had talked about the staffing report and that the Birthrate Plus report was not showing that we would need any more Midwives than we had in the establishment currently. They do however have a large number of vacancies and do not have enough staff due to vacancies.

175/22 DoLS & Safeguarding

Vicky Thersby referred to the report distributed which was taken as read and highlighted the key points.

Several business cases were proposed but not all had been approved.

The Complex Transition and Learning Disability business case was approved and the post was out to advert. The business cases for the Paediatric Liaison Practioner and for the Implementation of the Liberty Protection Safeguards (LPS) were not approved. LPS was a bit of a moving target but from an adult safeguarding perspective both adult nurses were now full time so this was mitigated at present.

An Ofsted inspection of Special Educational Needs and Disability in North Lincolnshire was carried out in December and the findings published in March 2022.

Vicky outlined that they were looking at an options paper in relations to MARAC as the time commitment had increased threefold in the past two years and this level of commitment was difficult to maintain. Vicky went on to highlight that the safeguarding activity data and processes had all been streamlined since the 2019 CQC inspection and that the methodology was more robust. She added that they were proposing to develop a Safeguarding Supervision Policy.

In terms of the business cases, Mike Proctor knew that Vicky was aware that the Trust could not meet all requests but asked in terms of a wish list and priorities were the decisions right. Vicky responded that overall, she thought they were but would have liked to have the Paediatric Liaison post too as this would have strengthened the team.

Fiona Osborne referred to the Paediatric Liaison and wondered what the risk rating was and what mitigations were in place. Vicky replied that there was a Paediatric Liaison already in place, in that they did 20 hours, not every day and not on weekends. This had been monitored on a weekly process and they were feeding that back. This service took up any gaps and that role was a quality service and was a wish to continue to have that as they did not want a delay in any referrals. This meant that although there was a risk, it was not significant.

Action: Vicky Thersby to get back to Fiona Osborne about the details of the risk .

Mike Thanked Vicky for providing the Safeguarding update and the Committee noted the report.

176/22 IPR

Mel Sharp referred to the report distributed which was taken as read and highlighted the key points.

In terms of the PEWs and the NEWS recording they had put a lot of work in but they needed to record weights on our EPMA. They were looking to ensure they had the right level of equipment required to undertake this, but teams did need to ensure they had the weights (more information included on page 22). Mel thought we needed to remind staff of the importance of taking weights on admission

Angie Legge added that this piece of work had commenced following an investigation into an inadvertent overdose of paracetamol; she noted that there were three places where weight could be recorded, there had been a lot of

discussion as to whether one could be the primary source and others dropped. This was because the audits indicated that people were often completing the weight, just not in all three locations. There had been a discussion as to whether something could be done to link the sources, so weight entered into one would automatically populate in the other two however this was not currently feasible.

Angie highlighted the SHMI, as NLaG were now the lowest they had ever been despite the continued high out of hospital SHMI in N E Lincs.

She also highlighted that VTE was going in the right direction and had now met the target.

Fiona Osborne asked about the care hours mentioned on page 15, and the three 3 differing statistic points. Mel thought it was an error but would look into it.

Post Meeting note: Mel Sharp updated that the point raised by Fiona about the CHPPD where it read Mar, April, May 2022 (in the box on the chart on page 15) that was incorrect information and should read Mar, April, May 2020

177/22 Key SI Update including Maternity

Angie Legge referred to the report distributed which was taken as read and highlighted the key points.

Angie highlighted the positive that one of the maternity reports had been closed and HSIB, who were investigating, came back to say they found all good practice with no recommendations or actions required. To get that from HSIB was good. Angie clarified that this was relating to a maternal death not neonatal death.

Fiona Osborne was interested in appendix B and the timing particularly about the scrub nurse having the time to undertake the swab count and asked what kind of impact that was having on the patient, whether that was that fully enacted. Angie advised that it was fully enacted but only took a couple of minutes so in reality it was not a big impact on the timings of the operation list and was safer for the patient.

Mike Proctor would note the HSIB report to the Board

178/22

Potential Deviations from National Documentation

None to discuss.

179/22

CQC Improvement plan

Jennifer Moverley referred to the report distributed which was taken as read and highlighted the key points.

There were no red actions now and five amber actions.

Community and Therapies had seen significant progress in waiting times for continence patients.

All training had increased for Respect with regards to EoL clinical care.

Oxygen prescription combined action for Medicine and ED was now a mandatory element and a clinician identified at each site.

Study days had commenced for Family services and Medicine combined RCNS training.

Ian Reekie noted that the Governor Group had praised this report and commented on how helpful it had been and they got the clear impression that the CQC were equally impressed with this report. On the back of Ian's comments Angie Legge added that what was unique about this report was the process behind the report, this was an action plan owned by the Divisions and that was what would help the organisation move forward in the future.

Mike thanked Jennifer for providing the update and the Committee noted the report.

Peter Reading left the meeting at 12.05pm

180/22 Patient Safety Specialists

Angie Legge referred to the report distributed which was taken as read.

Mike Proctor explained that this was about nominating people in existing safety roles rather than recruiting. Currently Angie was the only Patient Safety Specialist for the Trust and a lot of other organisations had more than one.

The Committee approved the suggestion to add a further four patient safety specialists to support the Trusts' work on improving patient safety and agreed there was no financial implications to the organisation in doing so.

181/22 Board Assurance Framework (BAF)

Mike Proctor referred to the report distributed which was taken as read and highlighted the key points.

Fiona Osborne noted that there were some gaps in assurance that she wanted to discuss. Fiona asked if it would be reasonable to remove cancer from the gaps in assurance if we were at that point yet. Mike thought there was still a gap, Angie Legge thought as there had been a change the Committee could agree to take this one out and add another on cancer pathways which would clarify the gap. Abdi Abolfazi thought that linked to this would be to look at tumour sites one by one, do a deep dive into those and close them one at a time. Abdi thought that should appear in the assurance part and until we had evidence the gap had been closed. Discussions were needed with Helen Harris and the Team about the BAF.

Under strategic threats Fiona asked if the Trust really had a widespread threat to patient safety. There was some confusion to the text and it was suggested that perhaps the Non-Executive Director should be part of those conversations before the report came to this Committee.

Fiona thought the planned actions should be rolled into the next quarter from a practical point of view.

182/22 Quality Priorities

Angie Legge referred to the report distributed which was taken as read and highlighted the key points. This report was the start of our discussion about quality priorities and Angie would look to take this to as many places as possible to get good engagement in the process and take account of all stakeholder views.

Mike Proctor thought the key thing was whether the Governors were being involved in this process. Ian Reekie would like to have a say in the list and final recommendations before it goes to the Trust Board. Angie apologised that she had kept the timetable the same but was all for engagement and would be happy to take it to the Governors meeting. In terms of the March and February dates that was something they would be working on to finalise.

183/22 Review of workplan

Angie Legge referred to the workplan distributed which was taken as read. The Committee approved the revised schedule.

Highlight reports

184/22 Quality Governance Group (QGG)

Angie Legge referred to the highlight report distributed which was taken as read. The Ergonomist report was discussed and a working group had been set up so that would be monitored.

The Learning group had held a Sepsis Event and Angie highlighted that there had been good progress to date on CQUINS, they were not all being met yet but Angie was confident they would be.

Items for information

185/22 Quality Governance Group (QGG) minutes

Attached for information

186/22 Radiotherapy update / Briefing note

Mike Proctor highlighted this update which although had been included under items for information, Mike wanted to ensure people had chance to read it. There were significant problems at HUTH , nothing NLAG could do anything about but it had a significant impact on our patients. Abdi thought it would have a detrimental impact on NLaG and the challenge for him was to measure that impact, the report did not give tangible perspective and would be a detrimental impact to us. In terms of harm it would be difficult to measure too.

187/22 Any Other Business

Nothing raised

188/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

Mike Proctor to put the highlight report together after the meeting.

189/22 Meeting review

Already discussed earlier (under review of workplan).

190/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 23 August 2022
Time: 1.30pm – 3pm
Venue: Via MS Teams

The meeting closed at 12.18pm

Annual Attendance Details:

Name	Oct 2021	Nov 2021	Dec 2021	Jan 22	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022
Michael Proctor	x	✓	✓	✓	x	✓	✓	✓	✓	✓		
Michael Whitworth	✓	✓										
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Maneesh Singh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Dr Kate Wood	✓	✓	✓	✓	✓	✓	✓	✓	✓	x		
Ellie Monkhouse	✓	✓	x	✓	✓	✓	✓	✓	✓	x		
Dr Peter Reading	✓	✓	✓	✓	✓	✓	x	✓	✓	✓		
Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Helen Harris	x	✓	x	x	x	x	x	x	x	x		
Jan Haxby	✓	x	x	x	✓	✓	✓	✓	x	x		
Shaun Stacey	x	x	✓	x	x	x	✓	x	x	x		

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 23 August 2022 from 1.30pm to 4pm
Via MS Teams

Present:	
Mike Proctor	Non-Executive Director **(Chair of the meeting)**
Fiona Osborne	Associate Non-Executive Director
In attendance:	
Dr Kate Wood	Medical Director
Ellie Monkhouse	Chief Nurse
Angie Legge	Associate Director of Quality Governance
Ian Reekie	Governor
Jan Haxby	Director of Nursing, NE Lincs CCG
Ashy Shanker	Deputy Director of Planning and Performance.
Jane Warner (item 200/22)	Associate Chief Nurse, Midwifery, Gynae & Breast Services
Elaine Graham (item 201/22)	Pathology Site Manager
Simon Priestley (item 197/22)	Chief Pharmacist
Karen Smith (item 199/22)	Lead Chemotherapy Nurse
Jill Mill (item 199/22)	General Manager, Medicine
Laura Coo	PA to the Medical Director **(minute taker)**

191/22 Welcome and Apologies for Absence

Apologies for absence were received from: *Maneesh Singh, Peter Reading, Shaun Stacey (Ashy Shanker to rep), Jennifer Granger, Mick Chomyn (Elaine Graham to rep)*

192/22 Opening remarks

Mike Proctor had received a letter from the CEO about the Oxygen supply and which subcommittee it should be discussed at. The letter advised that three Committees were being asked to consider and assure themselves of specific aspects in relation to this Serious Incident including this one but there would only be one single report required for the Board.

Action: Laura Coo to add to the workplan for 2023

193/22 Declaration of Interests

The Quality and Safety Committee was quorate and there were no declarations of interest related to any agenda item.

194/22 To Approve the Minutes of the Previous Meeting held on 25 July 2022

Ellie Monkhouse suggested for a reference to the fact that the day of the meeting was changed which was why the Chief Nurse and Medical Director were both not there.

The minutes were accepted as an accurate reflection of the previous meeting.

195/22 Matters Arising

There were no matters arising for discussion.

196/22 Review of action log

174/22 – Nursing Assurance, there was a query about an anomaly between the CNST report from Jane Warner and the Nursing update provided by Mel Sharp. A post meeting note was provided to clarify and was included in the July minutes.

175/22 – DOLS, Fiona Osborne had asked for clarification on the details of the Paediatric Liaison risk rating and what mitigations were in place but had not heard back from Vicky Thersby yet.

Ellie Monkhouse queried what Fiona wanted assurance on. Fiona explained it was about the Paediatric Liaison business case not being approved and Fiona had requested information on the risk assessment to patients.

Action: Ellie Monkhouse will have a discussion with Vicky Thersby and feedback at the next meeting.

Simon Priestley joined the meeting at 1.40pm

Regular Reports

197/22 Pharmacy Update

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

One of the main pressures was workforce, although they had some Pharmacist recruitment there were still a number of vacancies particularly at the Scunthorpe site.

The success with the Safe and Secure audit had broadly been sustained and the team were looking at the number of audits to pick up in other areas as well as picking up concerns that had been coming in from Primary Care.

Simon invited any comments or questions.

Fiona Osborne thought the report was clear; she asked about about services at Scunthorpe working on prioritisation outlined on page one and how priorities for dispensing were assessed. In response Simon stated that as a service their main aspect was medicines reconciliation and the ward based Pharmacists had been ensuring they worked with the nurses and medics on the wards to ensure they were focused on the appropriate cases for reconciliation or discharge.
Fiona asked how NLaG was differentiating to make it a more inviting place for Pharmacists to work. Simon advised that we offered training for a diploma followed by the offer of non-medical prescribing training at the end of that, there was a clear progression route as well as progression from a band six to band seven.

Mike Proctor asked if Simon felt they had done everything possible in terms of the skill mix. Simon thought there was still more that could be done around education and training although benchmarking historically had shown NLaG were a lean workforce anyway. They had invested in non-qualified staff to support the Pharmacists but there was still a little bit more they have a look at. Whilst they had the vacancies to an extent they had the budget to explore other supporting roles.

Fiona wondered whether the Pharmacist workforce position should be referred over the Workforce Committee to get more focus. All agreed that would be useful. Kate Wood offered her support for that discussion, noting that Simon had displayed in both reports the quality matrix and how the Pharmacy, Nursing and Medical teams were working together. It was about looking to get the appropriate medicines to the appropriate people in a timely manner and the risk was that we would not achieve that. It was agreed that would be highlighted to the Board.

A new procedure agreed amongst the NEDs was that the action would stay on the action log until the Committee got a new Chair. Therefore, it would be added to the action log so the Committee did not lose sight of it.

Action: Mike Proctor to write to the Chair of the Workforce Committee to request information on plans for Pharmacist recruitment and staffing

198/22 Annual Medication Report

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

The risks identified carried forward were around improving transfer of care between settings, improving communications when the patients go back to the GP and expanding the safe and secure work.

Fiona Osborne thought the report was very informative and thorough but asked if it would be possible for next year to include some KPIs and progress as that would be useful. Kate Wood agreed that was a good idea but noted that one of our quality priorities was improving discharges and Simon was pulling together a task and finish group around how we communicate medicines on discharge and thought that was a really brilliant piece of work he was pulling together and would really help the quality of care and the continuity of care for our patients. This wasn't articulated as clearly as she would have liked in the report and therefore was drawing the committee's attention to that work. Kate was happy to approve the report.

Karen Smith and Jill Mill joined the meeting at 1.50pm

Ian Reekie asked about the extent of Pharmacists employed in community practices. Simon explained that Pharmacy was quite disparate and had strong links across Acute providers, it was the GP Primary Care Network that needed developing. There were some discussions when PCNs first started about how we could have collaborative working which Simon was trying to move forward. The team did have links to community Pharmacists but that did need strengthening.

Mike summarised that everybody was looking towards Community Pharmacy to reduce the workload of GPs which added a further challenge to pharmacy recruitment but in terms of the report the Committee was happy to approve and there seemed to be significant progress on a number of things.

Simon Priestley left the meeting at 1.56pm

199/22 Oncology Pathway

Karen Smith referred to the report distributed which was taken as read and highlighted the key points.

There was huge concern for Oncology and our partners in Hull. The biggest problem over the last few years was a shortage of Clinical and Medical Oncologists so the Trust had looked at how the Oncology services were run across the sites. Clinics were moved to Grimsby and they were now able to escalate issues quite freely. Had appointed two new Clinical Directors who were Consultant Oncologists, one used to work at NLaG so was familiar with the organisation. A Humber Lead Chemotherapy Nurse had been appointed and there were lots of improvements overall.

Fiona Osborne asked about the digital aspect as noticed one of the key aims was to bring the digital services closer together but Fiona asked what had been the biggest issue.

The Oncology Prescribing System had been a shared system, they were already used to using the shared systems and used to using a centralised system which was where most of the information was kept.

Kate Wood could not see the benefits to the patients from the paper and asked where the articulation was of the better flows as she could not see them written down. Karen added that it had been a very difficult time and patients had been affected by this and felt it continued to be work in progress for that. Patients were having to go to Hull for their first appointments but were then hopefully able to get their treatment closer to home. There were ongoing challenges and they had developed significantly; things had improved as far as treatment went. Delivering Radiotherapy had been a challenge over the last few weeks and they were working with Lincoln but they continued to support patients and their families as best they could.

Ian Reekie asked how confident Karen was that the care on the south bank was as good as on the north bank. Karen felt we were in a position to speak up and ensure we had an equitable service for all our patients with what we had got.

Fiona asked about the arrangements for mutual aid through Lincoln and what that entailed. Karen advised that they were looking at patients who lived on the South coast where actually Lincoln could be closer to them and looking at what might be more suitable for patients. Kate added that we were very clear as an organisation that we used Hull for our patients and Hull had the responsibility for communication with Lincoln in this regard so ensured patients went go through a central area and all patients would be followed through appropriately.

Mike thanked Karen and Jill for the update and noted there were significant improvements since the last update to this Committee.

Jill Mill and Karen Smith left the meeting at 2.07pm

200/22 Ockenden update

Jane Warner gave a verbal update and highlighted the key points.

There was not a lot to update since the last meeting, they now had fortnightly meetings with an MDT approach to ensure they successfully completed the first action plan from the first report and then would work on the second report. At this stage the Division had not been asked to supply any compliance data for the second report but were waiting for the East Kent report and expected to have to supply something after that.

In terms of training, the team were taking the approach of 'we work together we train together'. The PROMPT training was going extremely well training alongside our Anaesthetic colleagues as they worked so closely together.

Midwifery staffing continued to be a challenge. Regionally they were looking for a regional escalation policy and started to feed into that. Recruitment work continued, after this meeting Jane was meeting with an Afghanistan refugee who was a very experienced Midwife, this was an example of how they were looking at all options available to them.
The student Midwives were starting with the team shortly and they had recruited a Pastoral Midwife to provide support to new Midwives which would hopefully support them in staying with us. As part of staffing they did utilise the NICE red flags, staff were very good at completing incident forms and red flag incidents although an error had been noted recently and the process tweaked to resolve the issue.

Jane was happy to take any questions.

Fiona Osborne felt that report suggested there was a little bit of a holding pattern in terms of midwifery staffing, we had an increase in red flags and staffing but questioned if the recruited staff had actually started their employment. Jane confirmed that new staff would start in the Trust in October. Jane expected the improvements would be seen in October / November time.

Fiona asked about the red flags. Jane explained the error was raised by the analyst at the weekly meetings. Ellie Monkhouse concurred with what Jane had said the data came in very late this month and the anomaly was spotted. Fiona asked if there had been an increase in births in July. Jane noted that the numbers had not

increased but the complexity had increased. She gave an example whereby they had delivered a set of triplets at Scunthorpe. Jane noted that approx. 30% to 40% of women were induced and when there was reduced staffing they could not start that process as timely as optimum and may need to divert care between the sites. Jane noted that there was mutual aid between organisations.

Jane Warner left the meeting at 2.18pm

201/22 Pathlinks update

Elaine Graham referred to the report distributed and highlighted the key points

A KPI report was provided and there were no real identified trends other than their ability to meet the document control KPI. Elaine felt they had set the bar too high for example they had set for documents to be reviewed every year which was not necessary and would look at a staggered review process.

There was a national wax shortage used to process histopathology tissue samples which was impacting on histopathology there was a critical shortage which would potentially result in at least a 50% reduction in service capacity to process surgical samples. They had since received some stock and were working through the backlog, Elaine thought there was approx. six weeks of backlog to work through.

DartOCM, the electronic requesting system was use in Primary Care which was old and a recent failure had presented the risk of potential patient ID error, the true numbers of that was probably very small but the risk existed and they were hoping to move over to WebV which was now in test phase and was likely to go live in the next three months. They did a virtual server run on 25th July which was successful.

Some of the equipment would fail in temperatures above 30 degrees but had support of portable air condition units. There were potential sanctions to the Trusts HTA with the regards to the mortuary, a task and finish group had been set up and meeting on weekly basis and estates had been working on the pipes, flooring and storage capacity.

The Trust had failed the assessment several times by UKAS in relation to seven day working. They had warned us that if that was still a problem they could potentially suspend the accreditation.

In terms of the NLaG and ULHT contract, an SLA was now in place but the Pathology programme Board had recently met and there were going to be monthly meetings to start working through some of the ongoing issues
Fiona Osborne asked if two portable air conditioning units were enough, particularly with the temperatures being as high as they had been recently.

Elaine did not think two were enough but they were working with what they had and would mitigate the risk of equipment failure due to high temperatures by reducing the equipment in use, as the equipment itself produced heat adding to the high temperatures.

Kate Wood asked about the wax shortage, and whether that meant the Trust would not be able to process some of the samples and that some of our samples might

degrade. Elaine advised that would not be the case because they were in formalin so were fixed and safe and had catalogued them all in case there were cancer samples in there.

Kate asked about the HTA, Elaine had described about the task and finish group and monitoring, but Kate asked where that group fed into so as the Board were not sighted on it. The Task and Finish Group was chaired by the Pathology Quality Manager but Elaine was unsure how that fed back but would find out.

Angie Legge advised that the Task and Finish Group fed into the Pathology Board which reported into QGG. She noted that the work of the Task and Finish group had also been discussed at QGG but it thought it may be beneficial to report directly into QGG for assurance.

Referring to the wax issue Mike Proctor commented that obviously some specimens had been delayed but this Committee would be interested in understanding if there were any issues or harms in terms of those delays.

Ian Reekie asked Kate about the report that appeared in the HSJ today that says *'hundreds of items and consumables ranging from dressings to tracheotomy tubes are under strict demand management by NHS supply chain*' and asked if there were any other areas that Kate was aware of that were suffering shortages at the present time.

Kate had not had anything personally escalated through to her but would expect those types of things would go through Ivan Pannell in Procurement and would expect that to be then escalated through routes in the Finance Team.

Fiona referred to the funding for seven day working and asked for clarification there was a comment in the report saying that Lincolnshire ULT were proposing to support funding and asked if that had been agreed and if we did not get that funding what was the plan B. Elaine would have to speak to Mick Chomyn to see if there was a further update as at the moment it was a proposal.

Mike thanked Elaine Graham for the report he thought it was interesting and informative.

202/22 Nursing Assurance Report

Ellie Monkhouse referred to the report distributed which was taken as read and highlighted the key points.

She noted that they had identified anomalies in the maternity dashboard and red flags which was being addressed. C2 were in an intensive support regime, the next summit would be next week and there would be further summits. They were a complex demographic and Ellie was looking to see if that demographic could be dispersed into other areas.

Ellie was happy to take any questions.

Fiona Osborne mentioned the HCA side and vacancies, and knew the recruitment events were planned for September, but asked if that was something the Trust had

done before or was that brand new. Ellie noted that since she had started with the Trust she had done a one stop shop for Registered Nurses and had the highest Registered Nurse recruitment for the Trust. They had linked into the local colleges and for younger volunteers as well and were trying all they could.

Kate Wood asked about section 5.2 nursing apprenticeships and the difference in recruitment with our neighbouring Trusts and wondered if this Committee could support with anything to help. Ellie thought this organisation was quite behind compared to others in terms of nursing apprenticeships and felt we needed some significant investment, when you look at the age profile for nursing staff, it was clear the Trust needed a strong pathway for career profession. Ellie also pointed out that when we refer to nurses, they do not just work on wards, we need to recognise that people choose their pathway and work in specialised areas.

With regards to the unqualified workforce, Ellie was working through the background work and how to make the money flexible to have a cohort in January. Mike Proctor felt quite strongly that although some people did not get the grades to qualify as a nurse they were very suited for that role and nursing was not just about the academic side.

Fiona asked about the organisation cultural transformation plan that included new pathways into the profession and if Ellie was comfortable with the pathways and would they deal with the issues described. Ellie responded that NLaG had an odd age profile in this area, very young and then those who return to the area in their mid-forties and then those in their fifties with nothing in between.
The nursing and medical apprentices were discussed and that needed to be sustained and that monitoring of nursing in each age profile is key to a sustainable nursing staff

Fiona thought the referral to Workforce should be key KPIs for age group and it would help to have some feedback and scrutiny on that to support Ellie.

Action: Mike Proctor to write to the Chair of Workforce to request age profiled Nursing KPIs in the Cultural Development Programme

203/22 IPR

Kate Wood referred to the report distributed which was taken as read and highlighted the key points.

Kate drew focus to the VTE performance which had been transformed with the work on the wards and the multi-disciplinary aspect.

The SHMI was a sustained improvement which had come about through a number of different routes. Part of it was around the fact patients who were on their end of life were being identified and we were able to get them out to their preferred place, which affected the out of hospital SHMI. Work was ongoing to try to reduce these patients needing to come into hospital in the first place.

Learning through mortality, the structured judgement reviews were not being completed in month, part of that was operation pressures, but we had increased the number of ways and routes into our structured judgement review; through the

medical examiner route, coding and screening route. Then it was getting the SJR's completed and getting them recorded. There was always a nosedive with he figures because the SJR process allowed 6 weeks for completion, so these are caught up later. Kate wanted to discuss with Shauna and her team the possibility of stopping the monthly reports otherwise we were going to get challenged on that dip every month when we know why that is happening and it was not an issue as it resolves itself. It is more important that we get the learning rather than just tick a box.

Ellie Monkhouse talked about the continued risk to the *C.Diff* target due to the high use of antibiotics during the Covid pandemic, btu did not think we were alone with that and NLaG were doing well in comparison to other organisations.

In terms of complaints Ellie thought that although we were not hitting the target we were still in a good position, complaints had increased considerably and had become very complex, that could be linked to various factors such as Opel 4.

204/22 Key SI Update including Maternity

Angie Legge referred to the report distributed which was taken as read and highlighted the key points.

There had been one new maternity SI where a pregnant lady had not been referred to a new clinic. That was the only omission in the ladies journey, and it was highly unlikely to have impacted on the outcome, however, it was declared due to the potential for learning about introducing new clinics and the need to ensure these were fully embedded from the outset.

Angie noted that the two Never events had both just been signed off and the learning would be available in the next report.

205/22 Potential Deviations from National Documentation

Angie Legge referred to the paper distributed and advised that there were three deviations in place based around capacity in MRI.

The Committee was asked to support the removal of two deviations;

- NG38 – Fractures (non-complex) assessment and management. Due to the limited MRI capacity at the time, the division were unable to meet this recommendation but that was no longer the case.
- NG98 - Hearing loss in adults: assessment and management. MRI did not have the capacity support the increase in referrals at that time however there was now sufficient capacity in MRI so that was no longer the case.

In regards to NG128 - Stroke and transient ischaemic attack in over 16s: diagnosis and initial management, this needed a clear pathway in place which the team were working on, once in place it would be brought back through this Committee for removal.

206/22 CQC Framework

Angie Legge referred to the report distributed which was taken as read and highlighted the key points.

Angie advised that the team had now got back onto working on the action plan following the CQC visit. One action was moved from green to blue and they were going through the templates to increase this.

As part of the well led, unannounced visit they found a difference between practice in ED at SGH and DPoW in relation to streaming and paediatrics. There was a robust action plan that was being updated and sent to Ellie Monkhouse, Shaun Stacey and Angie on a weekly basis and a summit had been held to discuss that process, there would be another one in a few weeks' time. Ellie Monkhouse added that there were a number of failsafe actions that were put in place.

Ian Reekie asked whether the action plan included making a more determined effort to extend the service ideally to 24/7. Ellie confirmed it did.

For the purposes of the minutes Kate Wood noted she had not been involved in those discussions and actions because she was on annual leave but has since picked that up and was part of the conversations and work now.

Angie added that we now needed to wait for the CQC report to come through before we could move forward with a refreshed plan.

207/22 Quality Priorities

Angie Legge referred to the report distributed which was taken as read and highlighted the key points.

This was an ongoing process that would continue until mid-autumn, Angie asked if anybody had anything that was a concern and thought it should go on the long list to please let Angie know. Governors would be involved in the process, the timetable include attending Governor meetings, Angie would be attending the meeting on 8th September. Ellie Monkhouse queried nutrition on the long list as they had done quite an extensive review and thought some things were removed. Angie explained that the process was to add things to the list as raised, and then in the Autumn these would be whittled down to those which were a priority. In that process, items which were no longer a concern could be removed.

Kate Wood thought there needed to be a continued focus on Sepsis and thanked Angie for going to the Governors meetings early in the process.

With regards to process from an operational point of view Ashy Shanker explained that they needed to make sure all our business cases aligned and Jan Haxby wondered how this would fit into the new PLACE structures going forward, how that flowed and where does that fitted into the ICS priorities and equally how did the Trust reflect that in part of the health care planning. Angie agreed that with the move from CCGs to the ICS, this needed to be factored in and she would welcome the opportunity to discuss how this could be best achieved.

Ashy commented that was around the alignment between the quality trust priorities and systems priorities and then leading that through the business process. It was

important to do drafts as we go along to be able to tweak so it fitted into the divisional and corporate business plans throughout the year.

Highlight reports

208/22 Quality Governance Group (QGG)

Angie Legge referred to the highlight report distributed which was taken as read and pulled out the key points.

She highlighted that the Trust had altered the way we dealt with CCG incidents in North East Lincolnshire, rather than an investigation on each, these were themed with an overarching action plan which was beginning to have impact.

She noted that at the time of QGG an issue had been flagged with EPMA and maternity however, this had since been resolved.

209/22 Mortality Improvement Group (MIG)

210/22 Patient Safety Champions

211/22 Serious Incident Review Group

One of the things that came out this time was the wider learning about the lens box itself and how it was labelled became a risk therefore Angie Legge had written to the manufacturers to see if that could be changed to have the word ‘minus’ on instead of just a small sign.

Items for information

212/22 Quality Governance Group (QGG) minutes

To follow

213/22 Mortality Improvement Group (MIG) minutes

To follow

214/22 Patient Safety Champions minutes

215/22 Serious Incident Review Group (SIRG)

216/22 Any Other Business

PSERF – Kate Wood advised that this had now been released, there were a number of things the Trust needed to be doing and some key things to work through as an organisation but it did not need to be implemented in the next year. Angie Legge thought this would take a bit of time to implement, there was a training requirement it was quite a different way of looking at things and the focus was where there was benefit and learning for the level of harm. It did seem to indicate the level for maternity would remain where they are.

Action: Angie Legge to bring a plan and proposed time scale to the next meeting.

Ian Reekie asked if the removal of the SI label cause a problem in identifying those that needed to be focused on. Angie did not think it was a concern and was more than happy to give an update to the Governors but it might be beneficial to firstly bring a paper that was more in depth.

Ellie Monkhouse thought it seemed an appropriate moment to thank Mike Proctor for all his support as this was his last Quality and Safety Committee, he had been a great support to Ellie and Kate in their Executive roles and a support to the board.

Mike Proctor thanked everybody for their contribution to the Committee over the years, particularly to Kate and Ellie for their openness and honesty and his fellow NEDS. Fiona Osborne would be taking over as Chair of this committee and he was sure she would do a great job. Angie had kept Mike on the straight and narrow and the Trust would miss her probably a lot more.

Fiona thought both Mike and Angie would be sorely missed and wished them well for the future.

217/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

Mike Proctor to put the highlight report together after the meeting.

218/22 Meeting review

219/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 27 September 2022
Time: 1.30pm – 4pm
Venue: Via MS Teams

The meeting closed at 3.35pm

Annual Attendance Details:

Name	Oct 2021	Nov 2021	Dec 2021	Jan 22	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022
Michael Proctor	x	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	
Michael Whitworth	✓	✓										
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Maneesh Singh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	
Dr Kate Wood	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	
Ellie Monkhouse	✓	✓	x	✓	✓	✓	✓	✓	✓	x	✓	
Dr Peter Reading	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	x	
Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Helen Harris	x	✓	x	x	x	x	x	x	x	x	x	
Jan Haxby	✓	x	x	x	✓	✓	✓	✓	x	x	✓	
Shaun Stacey	x	x	✓	x	x	x	✓	x	x	x	x	

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 4 October 2022
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jenny Hinchliffe, Deputy Chief Nurse Melanie Sharp, Deputy Chief Nurse
Title of the Report	**Nursing Assurance Report**
Purpose of the Report and Executive Summary (to include recommendations)	The Board is asked to note the content of the report. The overall CHPPD remains at 7.9 in July compared to the model hospital recommended peer median of 8.2. The Midwifery to Birth Ratio was 1:26.2 which is below the acceptable ratio of 1:28. Vacancies remain high across our hospitals and in the community, including in our midwifery services. Recruitment and retention work remain a priority and the corporate nursing team are working collaboratively with workforce colleagues and the QI team. The total number of falls reported in July has increased significantly with an increase in the number or single and repeats falls. The low fill rate and high activity across sites may have been contributing factors and this will be kept under review. The number of hospital acquired pressure ulcer incidents reported in July 2022 decreased, however there has been an increase in the number of pressure ulcers reported in the community and a deep dive is underway to understand themes and actions required. New formal complaint numbers have decreased by 34%. The Trust declared 22 mix sex breaches, this involved 6 patients. The Trust had declared OPEL 4 on all occasions and there was a lack of step-down beds for patients no longer requiring level 3 care. The Trust is now seeing low numbers of patients with COVID-19 and there is a pause to asymptomatic testing in both patients and staff. The winter is predicted to be very challenging in the hospital setting regarding isolation / cohorting of patients. A QI collaborative on safe storage of medications commenced in November 2021. In 2022 the annual audit showed a large improvement with a trust average of 87% compliance compared to 73% in 2020.
Background Information and/or Supporting Document(s) (if applicable)	NA
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Quality & Safety Committee

Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	NA	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	NA	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Nursing Assurance Report – September 2022 (July data)

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 and utilise escalation beds across the Trust, any data should be viewed with caution and for this reason we continue to review individual metrics and apply professional judgement. In line with the Deployment and Assurance of Clinical Nursing Workforce during Covid 19 emergency guidance (February 2021), Quality impact assessments are undertaken with final sing-off by the Chief Nurse prior to additional wards being opened.

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.

2.0 Safe Staffing

2.1 Shift Fill Rates and Care Hours per Patient Day (CHPPD)

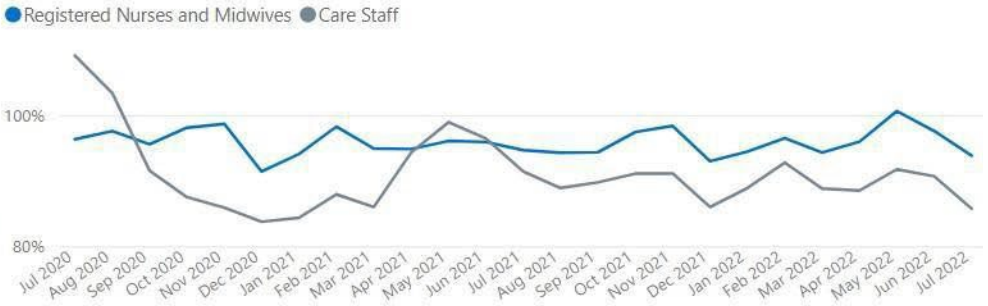
The information presented shows data on inpatient wards only.

Shift Fill Rates Summary Jul 2022

Overall	Registered Nurses and ...	Care Staff	Nursing Associates
90.7% ▼ -4.3%	93.8% ▼ -3.8%	85.7% ▼ -4.9%	

Overall Fill Rate

Fill Rate by Staff Group



Overall Fill Rate by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jul 2022	DPoW	90.3%	-7.2%	97.5%	
Jul 2022	GDH	104.0%	2.6%	101.4%	
Jul 2022	SGH	89.7%	-1.6%	91.3%	

Overall Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jul 2022	Medicine	93.1%	-2.5%	95.6%	
Jul 2022	Surgery & Critical Care	90.6%	-7.6%	98.1%	
Jul 2022	Women & Children's	84.4%	-4.9%	89.3%	

Shift fill rates are reported against ward establishments. Nurse staffing reviews take place at intervals throughout the day, including a trust wide review of SafeCare Live information at 10am in a meeting chaired by the Deputy Chief Nurse or one of the Associate Chief Nurses.

The Chief Nurse undertook an establishment review in 2021 with collection of the Safer Nursing Care Tool (SNCT) data during April and May once the bed base was reset. Meetings were held with ward and department managers so that recommendations could be made. The report was presented to the Trust Board in December 2021. The Board agreed to fund the very high/ immediate risk recommendations and funding has been allocated through the 2022/23 Business Planning Process with the exception of the recommendations for staffing for the surgical HOBS beds where there is ongoing discussion, however temporary staffing continues to be booked to maintain patient and staff safety.

The graphs above show the fill rate trends from the Nursing Assurance Dashboard. The combined fill rate shows some variance from month to month and in July was 90.7% which is below the target of 95%.

Safer Nursing Care Tool (SNCT) data was collected in June and will be repeated in October in preparation for the 2022 safe staffing establishment review. The full establishment review will be undertaken in the autumn to align with the business planning process.

A mix split of 60:40 is aimed for, with a higher skill mix for midwifery. Registered Nurse and Midwife to HCSW ratio for the Trust has been above 60% for the last year. Medicine remains the lowest RN ratio in July at 57.3%. Surgery & Critical Care has the highest RN ratio and is reflective of the number of level 2 and 3 beds within the division.

RNMW Ratio Summary Jul 2022

RNMW Ratio

63.1% ▼ -0.3%

RNMW Ratio

RNMW Ratio by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jul 2022	DPoW	60.6%	-0.2%	60.8%	
Jul 2022	GDH	55.8%	-1.5%	57.4%	
Jul 2022	SGH	67.0%	-0.2%	67.2%	

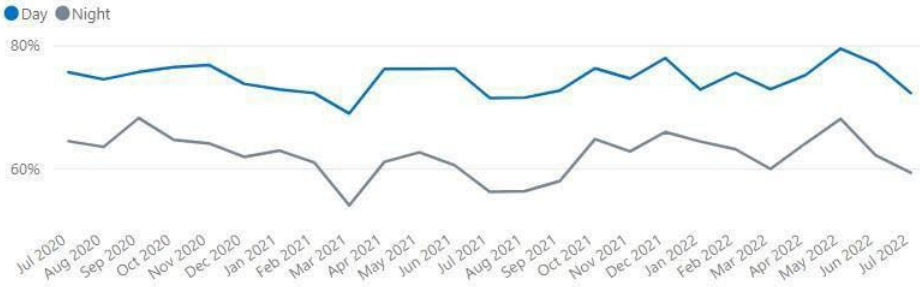
RNMW Ratio by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jul 2022	Medicine	57.3%	-0.2%	57.5%	
Jul 2022	Surgery & Critical Care	72.8%	-0.9%	73.7%	
Jul 2022	Women & Children's	66.8%	-0.4%	67.2%	

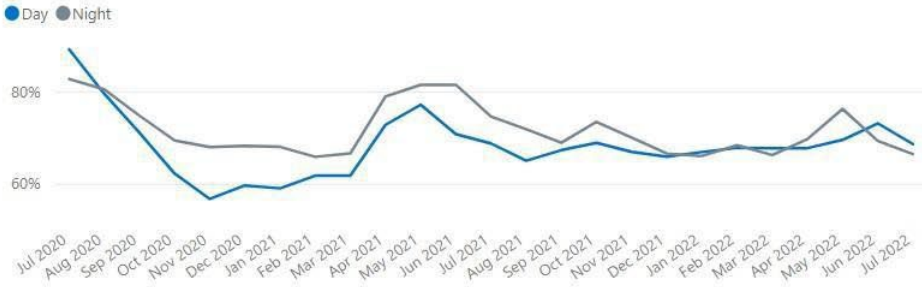
Substantive Fill Rates Summary Jul 2022

RNMW - Day	RNMW - Night	Care Staff - Day	Care Staff - Night
72.2% ▼ -4.8%	59.3% ▼ -2.8%	68.6% ▼ -4.5%	66.4% ▼ -2.9%

Registered Nurses and Midwives Substantive Fill Rate %



Care Staff Substantive Fill Rate %



RNMW - Day Substantive Fill Rate by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jul 2022	DPoW	75.3%	-5.0%	80.2%	
Jul 2022	GDH	80.1%	-2.2%	82.2%	
Jul 2022	SGH	68.0%	-4.8%	72.9%	

RNMW - Day Substantive Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jul 2022	Medicine	70.2%	-2.7%	72.9%	
Jul 2022	Surgery & Critical Care	80.5%	-7.4%	88.0%	
Jul 2022	Women & Children's	66.1%	-7.3%	73.4%	

Wards with Substantive Fill Rate Below 50% Jul 2022

Staff	Registered Nurses and Midwives	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
Disney SGH	44.9%	▼ -19.5%
Amethyst	32.7%	▼ -35.0%

Staff	Registered Nurses and Midwives	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
Ward C3	49.8%	▲ 3.4%
WARD 24 SGH	48.4%	▼ -2.9%
Ward A1	48.4%	▲ 3.0%
Amethyst	47.6%	▲ 0.9%
Ward 26 SGH	45.5%	▼ -9.6%
NRC Nursing Team GDH	45.2%	▼ -16.4%
Rainforest DPoW	43.1%	▼ -34.7%
Gynae Assessment Unit	41.9%	▼ -14.7%
WARD 3 GDH	39.3%	▼ -12.4%
Disney SGH	36.6%	▼ -11.0%
WARD C5 DPoW	35.5%	▼ -8.0%
WARD 17 SGH	25.8%	▼ -0.3%

Staff	Care Staff	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
Amethyst	47.9%	▼ -24.7%
Ward 26 SGH	44.8%	▼ -4.9%
LAUREL WARD DPoW	40.3%	▼ -13.4%
Clinical Decisions Unit	38.8%	▼ -5.9%

Staff	Care Staff	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD B6 DPoW	44.8%	▼ -16.2%
Ward 19	36.7%	▼ -53.3%
WARD 28 SGH	36.6%	▼ -16.6%
WARD 23 SGH	20.4%	▼ -13.3%
HDU DPoW	2.6%	▲ 2.6%

Substantive versus temporary staff fill rate is monitored and a decrease in substantive staff fill rate is seen for days and nights for RNs and HCAs.

Two wards had a substantive RN/RM fill rate below 50% on day shift. Work is underway to review data for Disney ward and the impact of PAU as this substantive fill rate does not appear accurate. Night shifts continue to be the shift with the lowest substantive fill rate for RNs with12 wards less than 50%.

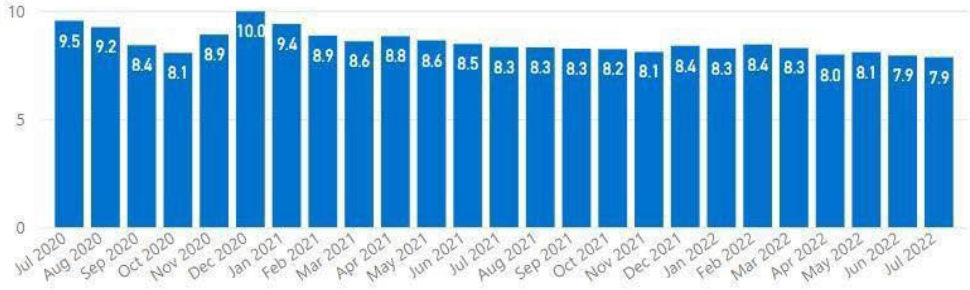
The information below demonstrates the level of sickness and vacancy in the areas with the lowest substantive fill rate. All wards except neuro rehab unit and gynae assessment have high sickness levels.

Ward	Sickness	RN vacancy wte	HCA vacancy wte
Neuro rehab unit Goole	2.55%	3.3	10.19
Ward 26	17.82%	8.04	0.53
Ward 24	5.40%	8.11	5.65
Gynae assessment unit SGH	4.31%	2.06	0.61
Rainforest	7.67%	2.62	-0.28
Disney	5.07%	4.75	0.10
Amethyst	6.29%	9.80	7.0
C3	6.28%	-4.76	1.72
A1	6.15%	6.20	5.07
C5	6.15%	6.78	4.23
Ward 3	6.83%	3.22	1.13
Ward 17	7.76%	6.45	3.04

CHPPD Summary Jul 2022

Overall	Registered Nurse...	Care Staff	Nursing Associates
7.9 ▼ -0.08	5.0 ▼ -0.07	2.9 ▼ -0.01	

Overall CHPPD



CHPPD by Staff Group

CHPPD by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jul 2022	DPoW	7.9	! -0.1	8.0	
Jul 2022	GDH	7.4	✓ 0.6	6.8	
Jul 2022	SGH	7.9	! -0.1	8.0	

CHPPD by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jul 2022	Medicine	6.7	! -0.2	6.9	
Jul 2022	Surgery & Critical Care	9.3	✓ 0.5	8.8	
Jul 2022	Women & Children's	11.4	! 0.0	11.4	

Wards with CHPPD Below 6.0 **Jul 2022**

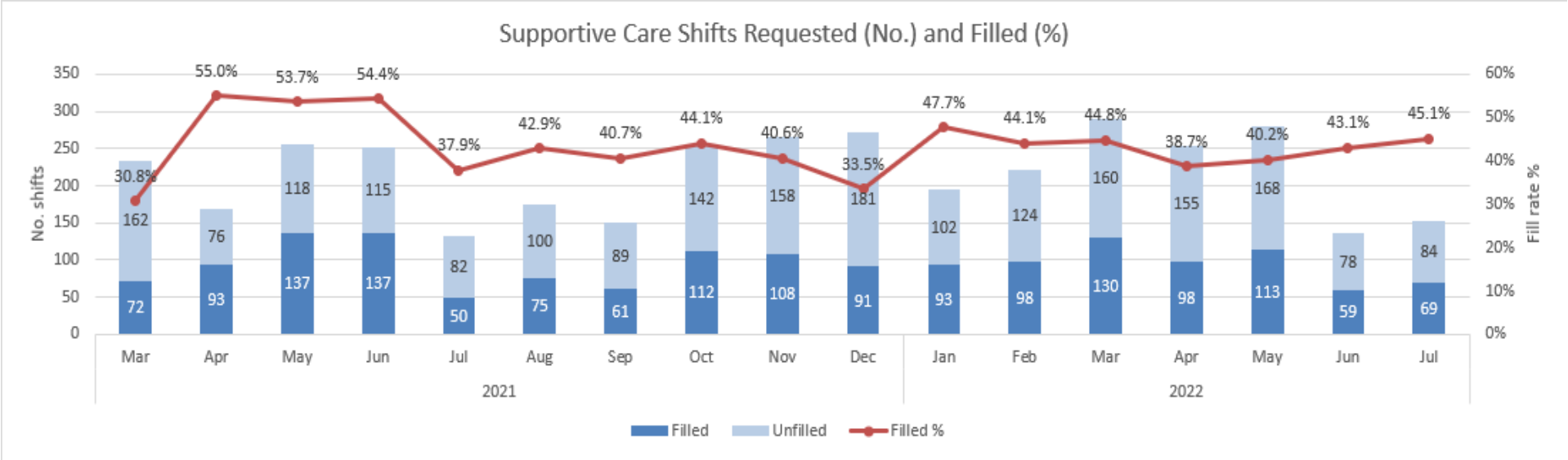
Staff	Registered Nurses and Midwives		Care Staff		**Total**	
Ward name	CHPPD	Change	CHPPD	Change	**CHPPD**	**Change**
STROKE UNIT DPoW	2.7	▼ -0.18	3.3	▼ -0.57	**6.0**	**▼ -0.75**
Rainforest DPoW	2.9	▼ -4.25	2.9	▼ -0.65	**5.8**	**▼ -4.90**
WARD 22 SGH	3.1	▲ 0.06	2.6	▼ -0.16	**5.7**	**▼ -0.10**
WARD C2	2.8	▼ -0.09	2.7	▼ -0.42	**5.5**	**▼ -0.51**
Amethyst	3.0	▼ -0.51	2.4	▼ -0.54	**5.4**	**▼ -1.05**
Clinical Decisions Unit	2.4	▼ -2.67	1.8	▼ -0.70	**4.2**	**▼ -3.37**

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 the trend for the CHPPD which has seen no significant change since the increase 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.

The overall CHPPD remains at 7.9 in July. The latest model hospital data for April 2022 indicates a national median of 8.1 and recommended peer median of 8.2. It remains difficult to benchmark using this data due to changes in ward demographic and acuity over the past 2 years.

2.2 Supportive Care



The wards are seeing an increase in number dependent patients, several which require 1:1 supportive care. These shifts are not part of the ward establishment. Shifts are sent to the temporary staffing team to source unregistered cover. The above chart demonstrates that of the requested shifts, less than 50% are filled. This has at times been a concern across all areas of the Trust and risks are identified and reviewed in safety huddles, staffing meetings and on operational calls.

Additional processes have been put in place for risk assessing our patients with tools such as AFLOAT to support prioritisation and decision-making regarding options available. All areas where 1:1 care need is identified have permission to access additional duties to try and cover this need. Additional allocate on arrival shifts are also booked centrally to help with providing a staff resource outside of the ward establishments to support 1:1 supportive care need. Matrons have a daily presence on the wards and can review patients and risk assessments and provide support and oversight of high-risk patients. This low fill rate impacts on the ward with core ward staff supporting. SafeCare Live supports deployment decisions which are based on the acuity and dependency of patients and available staff.

The number supportive care shifts requested has remined low resulting in an increase in the percentage filled in July for the second month. Recruitment onto the bank continues and fill rate will continue to be monitored.

2.3 Escalation Beds

It is still not possible to obtain accurate escalation bed data against established beds from WebV or the Sitrep reports. Escalation beds which are not established are open on C3 (n4), B2 (n5), ward 24 (n6), IAAU (n12), Laurel (n5 D2A), SGH gynae (n2 D2A) – total 34 beds. This has an impact on staffing across all areas.

2.3.1 Maternity Staffing

The Chief Nurse undertook a desktop maternity staffing establishment review in early March 2021 and the increases in establishments identified were included in the Trust's Ockenden Immediate and Essential Actions submission. A further desktop review was undertaken in May 2022 and an establishment review using Birthrate Plus workforce planning tool has been undertaken and the final report is expected soon.

2.3.2 Maternity Fill Rates and CHPPD

Maternity Wards Fill Rates and CHPPD Jul 2022

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**95.6%**	**▲ 7.1%**	**88.2%**	**▲ 11.3%**	**13.7**	**▲ 2.85**
Registered Nurses and Midwives	95.2%	▲ 11.2%	86.9%	▲ 17.9%	8.5	▲ 1.96
Care Staff	96.3%	▼ -0.2%	90.3%	▼ -0.3%	5.2	▲ 0.89
Central Delivery Suite	**75.8%**	**▲ 2.2%**	**59.2%**	**▼ -1.4%**	**33.5**	**▲ 1.15**
Registered Nurses and Midwives	73.1%	▼ -0.4%	54.6%	▼ -4.2%	27.1	▲ 0.38
Care Staff	89.5%	▲ 15.4%	83.0%	▲ 13.9%	6.4	▲ 0.76
Jasmine & Honeysuckle	**88.4%**	**▼ -6.8%**	**70.3%**	**▼ -9.4%**	**11.8**	**▼ -1.63**
Registered Nurses and Midwives	84.8%	▼ -8.8%	68.4%	▼ -8.4%	7.6	▼ -1.26
Care Staff	95.8%	▼ -2.7%	74.2%	▼ -11.3%	4.2	▼ -0.37
Ward 26 SGH	**76.1%**	**▲ 3.4%**	**53.8%**	**▲ 2.2%**	**6.3**	**▲ 0.73**
Registered Nurses and Midwives	74.7%	▼ -2.3%	49.8%	▼ -5.6%	4.5	▲ 0.20
Care Staff	80.0%	▲ 19.0%	64.6%	▲ 23.5%	1.8	▲ 0.53
Total	**84.5%**	**▲ 1.2%**	**68.8%**	**▲ 0.5%**	**12.2**	**▲ 1.00**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	62.3%	▲ 1.7%
Central Delivery Suite	80.8%	▼ -1.7%
Jasmine & Honeysuckle	64.6%	▼ -1.5%
Ward 26 SGH	71.7%	▼ -5.9%
Total	**69.0%**	**▼ -1.1%**

For the eighth month all the maternity wards, except Blueberry/Holly have fill rates <95 %. Staffing shortfalls have been experienced across both sites and in the community due to COVID19 absence, sickness and vacancies. Operational staffing meetings are held three times per day with review of issues and escalation of any risks that can't be mitigated, with senior oversight in the 10.00-hour safe staffing meeting. Proactive requests for bank staff / agency staff are made as required. Escalation processes and plans are in place with daily oversight from the senior midwifery team.

Recruitment is ongoing and vacancies are reviewed regularly and taken to the weekly establishment review meeting. There is a rolling advert for rotational midwifery posts and international recruitment of midwives has commenced with the support of the regional NHS England workforce team.

2.4 Staffing Indicators

2.4.1 Vacancies

The information presented below shows data on **inpatient wards** only.

Vacancies - Unqualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2022	DPOW	62.1	2.9	59.2	
Jul 2022	GDH	8.6	0.0	8.6	
Jul 2022	SGH	57.0	3.3	53.7	

Vacancies - Unqualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2022	Community & Therapies	10.2	0.0	10.2	
Jul 2022	Family Services	5.2	-1.6	6.8	
Jul 2022	Medicine	78.9	7.9	71.0	
Jul 2022	Surgery	33.4	-0.1	33.5	

Vacancies on the inpatient wards in July for both Registered Nurses and Healthcare Assistants showed an increase.

Newly qualified nurses are joining our wards and are starting to receive their NMC registration and international recruitment continues.

Targeted recruitment and retention work are ongoing with colleagues in POE and the QI team and a rapid improvement recruitment process event was held. Mass recruitment events are being held during September at both sites to recruit to fill the HCA vacancies. Career pathways are being developed along with nursing apprenticeships. Retention work continues and as part of this the HCSW induction programme has been refreshed and career clinics have been established.

Funding was secured from NHSE/I to support recruitment of an additional 120 international nurses before December 2022 (£3k per nurse). Risks associated with the ability to continue to support international nurse recruitment at pace include Practice Development team capacity as the business case for substantive recruitment of nurses to support OSCE prep and induction was not approved and temporary funding from NHSE/I ends, and the availability of sufficient training rooms due to the loss of training space in Beacon House. The trust has amended the MOU with NHSE/I to appoint 120 nurses and has advised that this number will now be 90 by December 2022.

A workforce plan and RN forecast has been developed with finance and workforce colleagues to support recruitment initiatives going forward.

There are a total of 264.68 WTE (14.56%) registered and 173.66 WTE (18.49%) unregistered vacancies across the Trust.

2.4.2 Staffing Incidents

The information presented below shows data on inpatient wards only.

Wards with Incidents

Indicator	Staffing Incidents		Red Flags	
Site - Ward	Value	Change	Value	Change
DPOW - Rainforest	0	▼ -1	24	0
SGH - CDS	9	▲ 3	1	▼ -1
SGH - ICU	0	0	9	▲ 3
SGH - Ward 26	4	▲ 2	5	▼ -1
DPOW - C3 Short Stay	0	0	8	▼ -18
DPOW - Maternity	4	▼ -2	2	▲ 2
DPOW - A1	0	▼ -1	5	▼ -10
DPOW - C2	1	0	4	▼ -4
SGH - Disney	2	▼ -1	2	0
DPOW - B2 Assessment Unit	1	▼ -2	2	▼ -5
DPOW - C5	0	0	3	▲ 1
DPOW - NICU DPW	2	▲ 1	0	▼ -1
DPOW - Stroke DPW	0	0	2	▲ 2
GDH - Ward 6	0	0	2	▲ 2
SGH - Stroke SGH	1	▼ -1	1	▼ -3
SGH - Ward 23 Short Stay	0	0	2	▼ -1
SGH - Ward 27	0	▼ -1	2	▼ -1
DPOW - Amethyst	0	0	1	▲ 1
DPOW - B7	0	0	1	▼ -2
DPOW - C1 Glover	1	▲ 1	0	0
DPOW - HDU	0	0	1	▲ 1
SGH - NICU SGH	1	▲ 1	0	0
SGH - Ward 16	0	0	1	▲ 1
SGH - Ward 17	0	▼ -1	1	0
SGH - Ward 18	0	0	1	▼ -3
SGH - Ward 24 Assessment Unit	0	0	1	▲ 1
SGH - Ward 28	0	0	1	▲ 1

26 nurse staffing incidents were reported in July on the Ulysses system compared to 27 in June.

2.4.3 Red Flags

A total of 82 staffing red flags were reported (72 on Safecare Live and 10 red flags on Ulysses) in July. This was a decrease compared to 123 in June but is comparable with previous months and some fluctuation is seen month by month.

Red Flags on SafeCare Live

Red Flag type, Ward	No.
Below Safe Staffing Levels	44
Rainforest	17
C3 Short Stay	6
A1	3
Ward 26	3
C2	2
ICU	2
C5	2
Stroke DPW	2
Ward 16	1
Amethyst	1
Ward 24 Assessment Unit	1
Ward 17	1
Ward 28	1
Ward 18	1
Ward 23 Short Stay	1

Red Flag type, Ward	No.
Less than 50% substantive staff on shift	10
ICU	4
Ward 23 Short Stay	1
B7	1
C2	1
Ward 27	1
C3 Short Stay	1
HDU	1
Less than two trained nurses on a Clinical Area	7
Rainforest	5
Ward 27	1
Maternity	1
Covid-19 +ve pts on Ward	4
Rainforest	2
A1	2

Red Flag type, Ward	No.
Trained Nurse less than 12mths qual left in Charge	2
B2 Assessment Unit	2
Delay of over 30mins to provide Acute pain relief	2
Ward 6	1
C3 Short Stay	1
Co-ordinators Non Supernumerary	2
ICU	2
More than 50% Staff under 12months Qualified	1
C5	1
Area outside of normal Footprint	1
ICU	1
Delay of IV Medication by 1hr x3 Patients	1
Ward 6	1

Red Flags on Ulysses

Red Flag type, Ward	No.
Less than 2 trained nurses on a clinical area	3
Disney	2
ECC SGH	1
Below safe staffing levels following escalation	3
Ward 26	2
CDS	1
Less than 50% substantive staff on a shift	2
ECC DPW	1
C2	1
Trained nurse less than 12 months qualified, or still i	1
Stroke SGH	1
Missed medication during an admission to hospital (	1
Maternity	1

C3 and Rainforest/PAU are the highest reporters of red flags. It is noted that C3 are also showing low substantive fill rate and high sickness levels.

3.0 Community Nursing

Community Nursing Assurance Dashboard Jul 2022

NHS Northern Lincolnshire and Goole NHS Foundation Trust

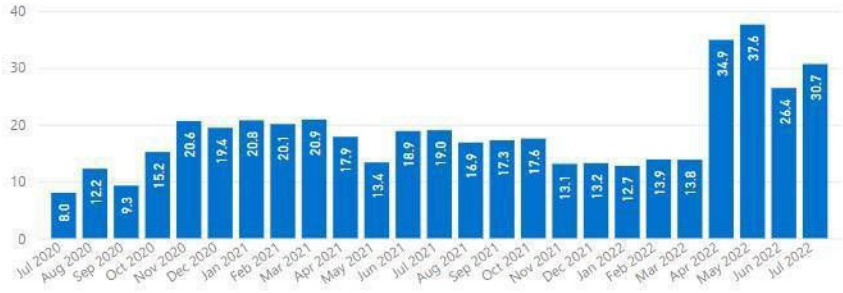
Indicator Category	Activity			Safety & Quality							Staffing	Infection Control	Friends & Family	End of Life Care
Team	Contacts Actual	Contacts Planned	Contacts Telephone	Red Flags	Falls - Total	Community Acquired PU - Total	Complaints	Weekly Assurance Tools	Caseload Reviews	Caseload	Vacancies - Total	Hand Hygiene %	FFT Recommended Rate %	Deaths with Care in Last Days of Life %
West Network	3,375.0 ↘		102.0 ↘	1.0 ↘	1.0 ↗	18.0 ↗	0.0	0.0	0.0		5.3 ↗			
East Network	3,374.0 ↗		100.0 ↘	1.0 ↘	0.0	12.0 ↗	0.0	0.0	0.0		11.2 ↗			
South Network	4,116.0 ↘		132.0 ↘	9.0 ↗	0.0	15.0 ↗	0.0	0.0	0.0		7.0 ↗			
West, East & South Networks		10,244.0 ↗												
Unscheduled Care Team (UCT) (incl rapid response)	393.0 ↗		70.0 ↘	1.0	0.0	1.0 ↗	0.0	0.0			1.7 ↘			
Macmillan Health Care Team	1,371.0 ↗		17.0 ↗	0.0 ↘	0.0	0.0	0.0	4.0 ↗			2.2 ↘			
Specialist Palliative Care Nurses (SPC)				0.0 ↘	0.0	0.0	0.0	0.0			3.0			
Palliative Care				0.0	0.0	0.0	0.0	0.0			1.0			
Palliative Care (incl specialist nurses)	418.0 ↗		287.0 ↗											
Single Point of Access (SPA)				1.0 ↗	0.0	0.0	0.0	0.0			-2.3 ↘			
Continence Team	265.0 ↘		79.0 ↘	0.0	0.0	0.0	0.0	0.0			1.7			
Tissue Viability Team	197.0 ↗		9.0 ↗	0.0	1.0 ↗	1.0	0.0	0.0			0.0			
Long Term Conditions / Complex Care Matrons (Comm Matrons)	290.0 ↘		145.0 ↘	0.0	0.0	0.0	0.0	0.0			-0.6 ↘			
Intermediate Care Services (ICS) + Core Therapy	1,167.0 ↗		26.0 ↗	0.0	0.0 ↘	4.0 ↘	0.0	0.0			1.5			
Discharge Liaison Team				0.0	0.0	0.0	0.0	0.0						
Locality Co-ordinators				0.0	0.0	0.0	0.0	0.0			0.0 ↘			
Evening / Night Service				0.0	0.0	0.0	0.0	0.0			-0.9 ↘			
Chronic Wound Team	406.0 ↗		53.0 ↗	0.0	1.0 ↗	1.0 ↗	0.0	0.0			-0.2 ↘			
DN Students				0.0	0.0	0.0	0.0							
Community Nursing														51.4 ↗

3.1 Community Nursing Workforce – July 2022

Community Nursing Vacancies — Jul 2022

Vacancies - Total	Vacancies - Qualified	Vacancies - Unqualified
30.7 ▲ 4.2	30.9 ▲ 4.9	-0.3 ▼ -0.7

Vacancies - Total



Vacancies by Staff Group

Vacancies by Team Jul 2022

Team	Vacancies - Qualified	Vacancies - Unqualified	Total
East Network	10.7	0.5	**11.2**
South Network	5.4	1.6	**7.0**
West Network	4.6	0.8	**5.3**
Specialist Palliative Care Nurses (SPC)	3.0		**3.0**
Macmillan Health Care Team		2.2	**2.2**
Continence Team	1.2	0.5	**1.7**
Unscheduled Care Team (UCT) (incl rapid response)	1.5	0.2	**1.7**
Intermediate Care Services (ICS) + Core Therapy	1.5	0.0	**1.5**
Palliative Care	1.0		**1.0**
Locality Co-ordinators	0.0		**0.0**
Tissue Viability Team	0.0	0.0	**0.0**
Chronic Wound Team	-0.3	0.1	**-0.2**
Long Term Conditions / Complex Care Matrons (Comm Matrons)	-0.6		**-0.6**
Evening / Night Service	-0.5	-0.5	**-0.9**
Single Point of Access (SPA)	3.3	-5.6	**-2.3**
Total	**30.9**	**-0.3**	**30.7**

Vacancies

A slight increase overall in our nursing vacancies was seen for July 2022 after a significant increase in April/May which reflects the recent nursing establishment uplifts and the posts identified in the community business case which have now been funded. In the community nursing networks the vacancies are split as below:

East network has a vacancy of a band 7 Practice Assessor with one of the District Nurses currently completing the necessary qualification. All band 6 posts are recruited. There are 9.7wte band 5 vacancies with 4 newly qualified nurses due to commence in the autumn, the remaining vacancies will continue to be a focus of ongoing recruitment work. Following successful recruitment, East network now have 6 APs (2 in development) and 3 Healthcare Assistants.

South network has no band 7 vacancies. They have 2wte band 6 District Nurse posts which are out to advert. Three staff members are enrolled on the District Nurse Specialist Qualification. There are 3.4wte band 5 vacancies with 3 newly qualified nurses due to commence in the autumn, the remaining vacancies will continue to be a focus of recruitment work. Following successful recruitment, South network now have 6 APs and 3 Healthcare Assistants.

West network has no vacancy at band 7 or band 6. There are 4.6wte band 5 vacancies with 2 newly qualified nurses due to commence in the autumn, the remaining vacancies will continue to be a focus of recruitment work. Following successful recruitment, West network now have 6 APs and 3 Healthcare Assistants.

Bank Staff - recruitment to the community bank is underway with an open day planned for 1st September 2022 for staff to meet with the Team Leaders to discuss shadow shifts, training and complete the required paperwork.

The vacancy position within the community networks links to risk 2921 on the risk register, this has recently been reduced from high to moderate because of the increase in band 4 and 3 unregistered nurses and is mitigated daily by using bank, staff undertaking extra hours and support from other teams as able.

Recruitment in other teams is also ongoing with progress in unplanned services for the Adult Night and SPA teams. Recruitment to vacancies in the Unscheduled Care team is underway but it is a current challenge to recruit to these posts. The vacancies in the Continence Team and Macmillan Health Care Team have all been appointed to and are in the recruitment pipeline. The 3.0wte MacMillan Specialist Palliative Care Nurses which will enable the movement to a 7-day service in acute care are currently being advertised on NHS jobs.

Community Nursing Network Contacts

ACTIVITY

Activity is slightly down from last month in the nursing networks with a slight increase noted in face-to-face contacts but a decrease in telephone contacts. South network again has had the most face-to-face and telephone contacts, but this is proportionate to the caseload size in comparison with the other 2 networks. A focused deep dive into community nursing data is being undertaken in August 2022 which includes:

- Referrals per month – April 2020 – June 2022
- New v Follow-up contacts per month – April 2020 – June 2022
- Length of stay and average length of stay

The findings will be shared in the next Community Update report for Nursing Metrics.

Community nursing remains challenged. Benchmarking data shows that nationally NLAG receive the second largest number of referrals per 100,00 population and the lowest utilisation of remote consultations indicating the need for service transformation.

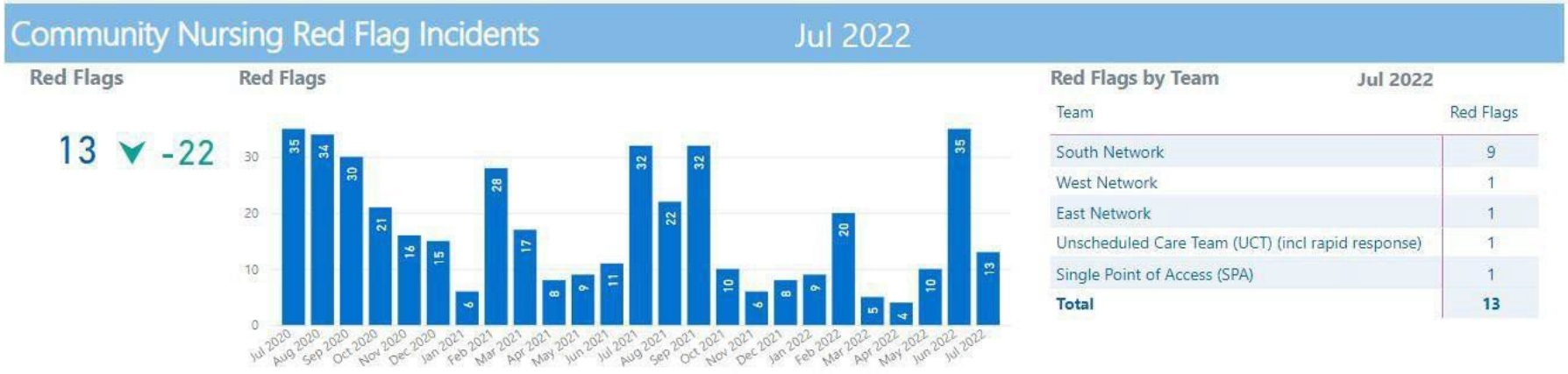
The QI team will undertake an initial process mapping exercise in September focused on:

- Referral in/triage and allocation
- Patient Journey from admission to discharge
- Staff experience/systems and process

Staffing capacity is also an ongoing issue with ongoing work being undertaken to recruit to vacancies and retain existing staff and new starters. Work is ongoing to articulate minimum staffing numbers for community nursing based on capacity and demand methodology which aligns to the national community SNCT due to be released later this year.

Collaborative working is ongoing with Malinko to produce accurate data for the networks. A band 4 Co-ordinator for Malinko has been appointed to oversee the system.

Community Nursing Red Flag incidents



The total nursing red flag incidents for July 2022 is 13 which is a significant decrease from the 35 reported in June 2022. 10 of these relates to a shortfall in nurse/ staffing in the community nursing networks although this is not reflective of the daily workforce challenges. There has been sickness in the nursing networks during July 2022 and we have several vacancies across the teams awaiting staff commencing in post, several which will be filled by the Newly Qualified Nurses commencing in September 2022. Work is underway to articulate minimum staffing numbers for community nursing based on capacity and demand methodology which aligns with the National Community SNCT due to be released later this year.

4.0 Maternity Dashboard and Red Flag Incidents

DPOW Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022
Midwife to Birth Ratio	25.2	25.4	25.2	24.4	24.8	24.6	24.9	24.0	23.9	24.9	24.8	26.5
Red Flags	10.0	28.0	15.0	5.0	17.0	10.0	12.0	8.0	11.0	2.0	2.0	7.0
(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)	1.0	9.0	8.0	2.0	4.0	1.0	3.0	3.0	0.0	1.0	0.0	0.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	3.0	5.0	1.0	1.0	1.0	0.0	0.0	1.0	0.0	0.0	1.0	2.0
(c) Missed medication during an admission to hospital	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
(d) Delay of more than 30 minutes in providing pain relief	1.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	2.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	1.0	0.0	0.0	1.0	1.0	1.0	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) Delay of 2 hours or more between admission for induction and beginning of process	3.0	5.0	4.0	0.0	3.0	2.0	4.0	2.0	2.0	0.0	1.0	2.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	1.0	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	2.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	1.0	8.0	2.0	1.0	8.0	2.0	5.0	2.0	9.0	1.0	0.0	0.0
In Receipt of %	13.0	14.0	15.0	11.0	9.0	10.0	23.0	9.0	14.0	10.0	15.0	13.0
CoC In Receipt of %	55.1	53.7	58.0	60.0	52.0	21.0	83.0	56.0	82.0	79.0	72.0	89.0
Continuity Team Caseload	374.0	347.0	348.0	347.0	326.0	342.0	334.0	319.0	347.0	314.0	314.0	305.0
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	
Actual v Planned Staffing %	91.5	88.9	90.7	92.7	90.1	92.8	91.5	95.1	94.0	91.5	92.2	86.0
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	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	10.6	13.9	13.2	11.5	10.8	12.1	11.8	11.2	19.3	19.4	19.1	23.2
Vacancies - Registered	10.0	13.3	12.0	9.8	8.8	10.3	10.9	10.2	16.4	17.4	17.5	17.7
Vacancies - Unregistered	0.6	0.6	1.1	1.8	2.1	1.9	0.9	0.9	2.9	2.1	1.5	5.5

SGH Maternity Dashboard

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Indicator	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022
Midwife to Birth Ratio	24.0 ↗	23.8 ↘	24.7 ↗	23.6 ↘	24.9 ↗	24.2 ↘	23.9 ↘	23.9 ↗	26.4 ↗	25.3 ↘	25.5 ↗	25.8 ↗
Red Flags	34.0 ↗	22.0 ↘	13.0 ↘	14.0 ↗	43.0 ↗	23.0 ↘	24.0 ↗	18.0 ↘	19.0 ↗	22.0 ↗	15.0 ↘	27.0 ↗
(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)	3.0 ↗	5.0 ↗	0.0 ↘	0.0	9.0 ↗	1.0 ↘	3.0 ↗	0.0 ↘	2.0 ↗	0.0 ↘	1.0 ↗	5.0 ↗
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	6.0 ↗	1.0 ↘	4.0 ↗	1.0 ↘	3.0 ↗	1.0 ↘	2.0 ↗	0.0 ↘	1.0 ↗	2.0 ↗	2.0	0.0 ↘
(c) Missed medication during an admission to hospital	1.0	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0	1.0 ↗
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	2.0 ↗	0.0 ↘	1.0 ↗	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	4.0 ↗	1.0 ↘	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	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	10.0 ↗	9.0 ↘	3.0 ↘	4.0 ↗	11.0 ↗	1.0 ↘	2.0 ↗	3.0 ↗	1.0 ↘	11.0 ↗	5.0 ↘	11.0 ↗
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	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	1.0 ↗	0.0 ↘	0.0	1.0 ↗	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	10.0 ↗	6.0 ↘	2.0 ↘	8.0 ↗	19.0 ↗	19.0	16.0 ↘	14.0 ↘	15.0 ↗	9.0 ↘	7.0 ↘	10.0 ↗
In Receipt of %	6.0 ↗	4.0 ↘	12.0 ↗	12.0	6.0 ↘	8.0 ↗	7.0 ↘	5.0 ↘	6.0 ↗	6.0	5.0 ↘	3.0 ↘
CoC In Receipt of %	39.1 ↗	27.3 ↘	63.0 ↗	65.0 ↗	64.0 ↘	38.0 ↘	38.0	47.0 ↗	44.0 ↘	50.0 ↗	30.0 ↘	33.0 ↗
Continuity Team Caseload	163.0 ↘	157.0 ↘	152.0 ↘	161.0 ↗	161.0	155.0 ↘	151.0 ↘	171.0 ↗	177.0 ↗	174.0 ↘	174.0	0.0 ↘
Divert / Unit Closures	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Actual v Planned Staffing %	90.0 ↗	88.3 ↘	85.6 ↘	88.2 ↗	85.1 ↘	87.4 ↗	88.8 ↗	88.1 ↘	80.2 ↘	83.3 ↗	82.7 ↘	81.4 ↘
Labour Co-ordinator Supernumerary Status %	96.8 ↘	96.7 ↘	96.8 ↗	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	11.3 ↗	14.0 ↗	16.9 ↗	13.6 ↘	18.3 ↗	19.3 ↗	18.3 ↘	20.5 ↗	27.9 ↗	28.5 ↗	25.1 ↘	24.9 ↘
Vacancies - Registered	11.0 ↗	12.9 ↗	15.8 ↗	12.0 ↘	15.7 ↗	16.7 ↗	15.7 ↘	17.3 ↗	22.3 ↗	23.5 ↗	21.9 ↘	22.7 ↗
Vacancies - Unregistered	0.3 ↗	1.1 ↗	1.1	1.6 ↗	2.6 ↗	2.6	2.6 ↘	3.2 ↗	5.6 ↗	5.0 ↘	3.2 ↘	2.2 ↘

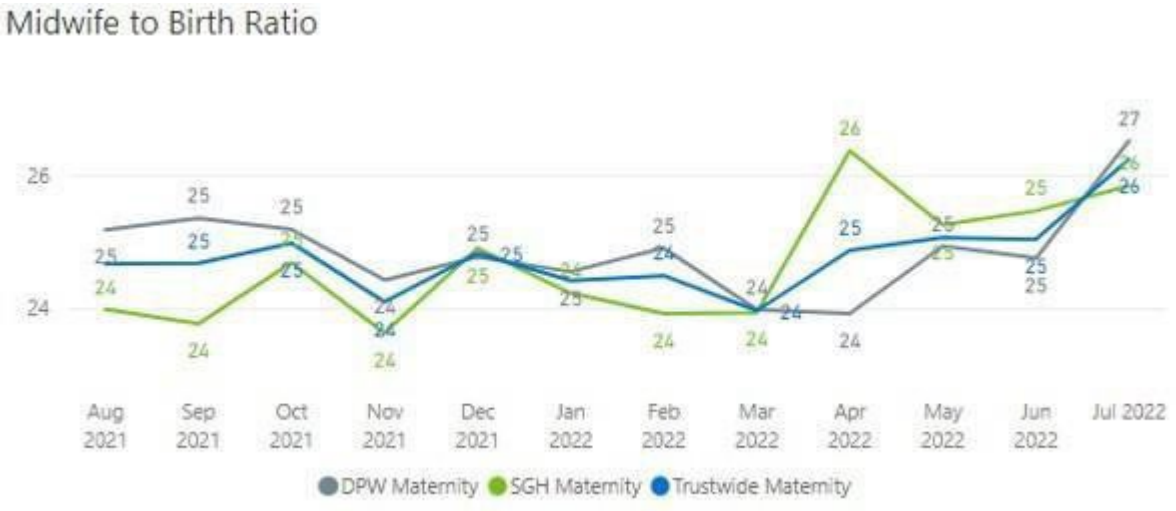
Trustwide Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

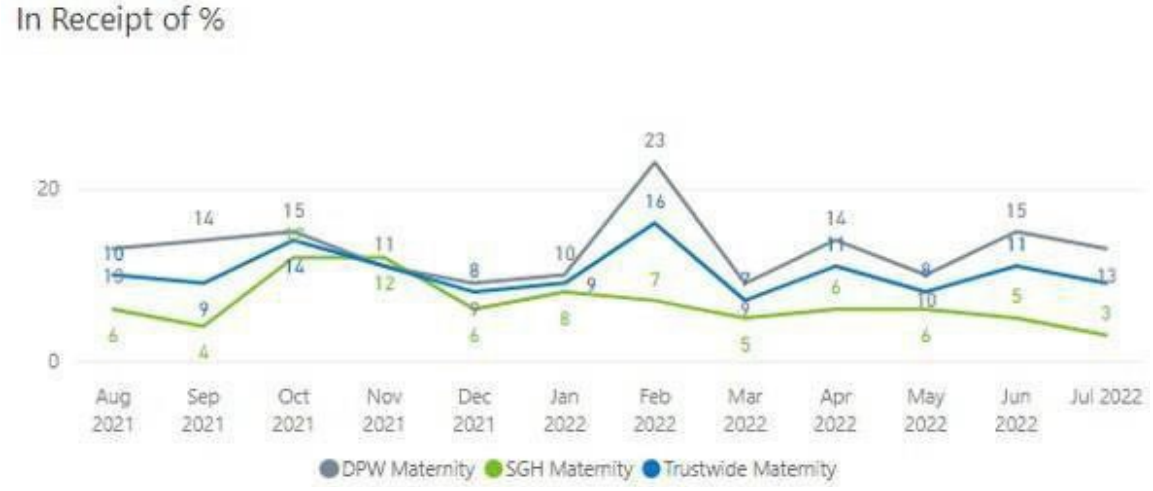
Indicator	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022
Midwife to Birth Ratio	24.7	24.7	25.0	24.1	24.8	24.4	24.5	24.0	24.9	25.1	25.0	26.2
Red Flags	44.0	50.0	28.0	19.0	60.0	33.0	37.0	26.0	30.0	25.0	18.0	34.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or EI LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	4.0	14.0	8.0	2.0	13.0	2.0	6.0	3.0	2.0	1.0	1.0	5.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	9.0	6.0	5.0	2.0	4.0	1.0	2.0	1.0	1.0	2.0	3.0	2.0
(c) Missed medication during an admission to hospital	1.0	1.0	1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	2.0
(d) Delay of more than 30 minutes in providing pain relief	1.0	0.0	2.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	2.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	5.0	1.0	0.0	1.0	1.0	1.0	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	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	13.0	14.0	7.0	4.0	14.0	3.0	6.0	5.0	3.0	11.0	6.0	13.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	1.0	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	1.0	0.0	0.0	3.0	0.0	1.0	0.0	1.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	11.0	14.0	4.0	9.0	27.0	21.0	22.0	16.0	24.0	10.0	8.0	10.0
Continuity of Carer %	22.5	16.0	21.0	19.0	21.0	16.0	20.0	20.0	19.0	20.0	18.0	12.0
In Receipt of %	10.0	9.0	14.0	11.0	8.0	9.0	16.0	7.0	11.0	8.0	11.0	9.0
CoC In Receipt of %	50.0	44.4	60.0	63.0	56.0	47.0	67.0	49.0	69.0	68.0	58.0	70.0
Continuity Team Caseload	537.0	504.0	500.0	508.0	487.0	497.0	485.0	490.0	524.0	488.0	488.0	305.0
Divert / Unit Closures	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Actual v Planned Staffing %	90.8	88.7	88.5	90.8	88.0	90.5	90.3	92.1	88.1	88.0	88.1	84.1
Labour Co-ordinator Supernumerary Status %	98.4	98.3	98.4	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	21.5	28.1	30.3	25.7	29.7	32.0	30.7	32.2	46.6	47.3	43.5	44.5
Vacancies - Registered	20.5	26.4	28.1	22.4	25.1	27.6	27.2	28.2	38.1	40.3	38.8	39.8
Vacancies - Unregistered	0.9	1.7	2.2	3.4	4.7	4.5	3.5	4.1	8.5	7.0	4.7	4.7
Sickness Absence (Division) %	4.8	6.4	6.0	5.8	7.2	8.4	7.2	8.0	8.8	5.9	5.8	
New Complaints (Division)	7.0	4.0	6.0	9.0	3.0	4.0	5.0	2.0	7.0	3.0	4.0	6.0
New PALS (Division)	20.0	26.0	21.0	28.0	16.0	33.0	32.0	30.0	22.0	23.0	20.0	19.0

The concerns related to midwifery staffing continue with July 2022 showing NICE Maternity Red Flag status of 34 in total. There was an error in the reported flags for June with 98 in total for the month. The report had calculated the figure incorrectly and should have read 18 in total, 16 at Scunthorpe and 2 at Grimsby. The report was received very late and there was not an opportunity to audit the figures prior to them being shared and it was only afterwards that it was identified. The majority of these relate to delays from admission to the start of the induction process (13) as well as the need to call in the on-call community midwives as part of the escalation process (10). There is a weekly incident review meeting in which all incidents are discussed in a multi-disciplinary manner, each red flag is specifically discussed to understand the background and the justification for the red flag.

Assurance that safety was maintained within the maternity units with the Midwife to Birth ratio. In July the data for both units is 1:26.2 which is below the acceptable ratio of 1:28. Although the vacancy factor is high, the ability to cover shifts shows positively in the ratios. The Midwife to Birth Ratio has throughout the year been below the expected 1:28 for both sites. During the month of July, the Scunthorpe unit had to close with care being sent to the Grimsby unit. There is a robust escalation policy that is utilised in times of high acuity and there are close links to the Operations team throughout both sites.



With respect to the Continuity of Carer teams, the Poppy and Daisy teams continue at Grimsby with 'in receipt of' care still providing around 9% of all women accessing our maternity services.



Positively, we continue to provide 1:1 in labour 100% consistently as well as the labour co-ordinators being supernumerary.

Midwifery vacancies were at a similar position as the previous month, with registered midwives being 39.8 (June – 38.8wte)) and unregistered being 4.7 wte (June 2022 – 4.7 wte). We have successfully recruited student midwives that are due to commence in post in the autumn (14.0 wte) and are also hoping to welcome some international midwives later in the year. We continue to recruit to the remainder of the posts.

Maternity services received 6 new formal complaints in July 2022, two more than the previous month and PALS saw a further reduction from 20 to 19 new concerns raised with the service. We have a well embedded process for dealing with both PALS and Complaints which is led by the Associate Chief Nurse – Maternity.

5.0 Training & Development

5.1 Student Placement Hours

Work has been completed to ensure student placement hours are accurately recorded to support returns and receipt of the correct income. Work continues to determine where Non-Medical Staff Education and Training tariff income is currently allocated/ spend withing the Trust and where the costs/ spend should sit for training nursing, midwifery and AHP students.

5.2 Apprenticeships

The business case for nursing apprenticeships is going to TMB on 5th September 2022 for approval and will support retention work and dependence on expensive temporary staffing. Due to delays in finalising approval for the business case, the nursing apprenticeship programmes will not commence until January 2023.

5.3 Advanced Clinical Practitioner Programme

High ACP turnover is a concern with qualified and trainee ACPs leaving for posts in primary care or the ambulance service. A survey has been sent to ACPs to obtain their views about their experience of the programme, and work is underway to develop a vision and strategy for ACPs within the trust.

5.4 Learning Needs Analysis (LNA) and CPD funding

The Nursing, Midwifery and AHP Learning Needs Analysis was submitted to HEE with the support of the Trust training team and HEE has confirmed what will be funded across the region. The LNA submission has been used to inform CPD spending plans and spend of the Trust's CPD allocation is progressing against the plan.

6.0 Quality (Falls)

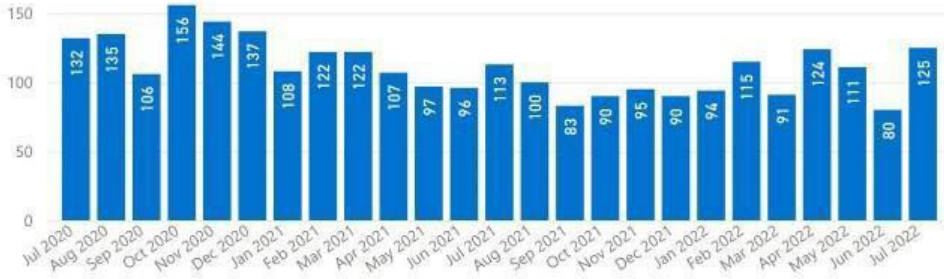
6.1 Reported Falls Incidents

The information presented shows data for inpatient wards only and is the standard throughout the report.

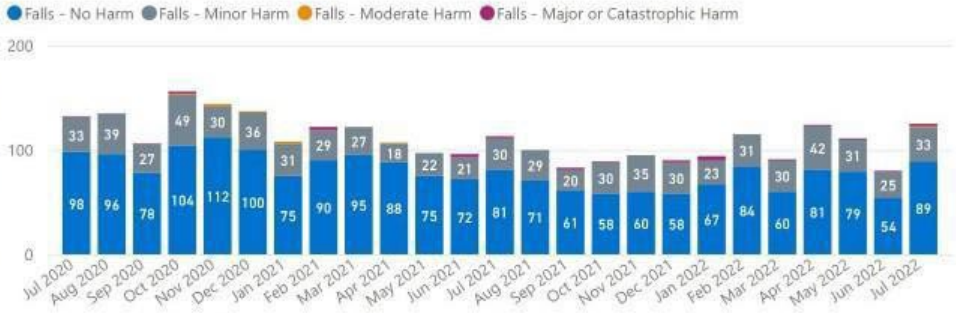
Falls Incidents Summary Jul 2022

Falls - Total	No Harm	Minor Harm	Moderate Harm	Major or Catestrophic
125 ▲ 45	89 ▲ 35	33 ▲ 8	1 ▲ 1	2 ▲ 1

Falls - Total



Falls by Category



Falls - Total by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2022	DPOW	69	! 30	39	
Jul 2022	GDH	4	✓ -3	7	
Jul 2022	SGH	52	! 18	34	

Falls - Total by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2022	Community & Therapies	2	✓ -1	3	
Jul 2022	Family Services	3	◆ 0	3	
Jul 2022	Medicine	104	! 37	67	
Jul 2022	Surgery	16	! 9	7	

The total number of falls reported in July 2022 has increased significantly. There was an increase in the number or single and repeats falls. The low fill rate, heatwave and high activity across the sites may have been potential contributing factors.

One in-patient fall was reported with moderate harm at Grimsby on Ward C2. The patient sustained fractured humerus. No lapses in care were identified at the huddle.

Two in-patient falls were reported with major harm following each patient sustaining a fracture to the femur. One incident occurred on Ward C5 at Grimsby and the other on Ward 16 at Scunthorpe. No lapses in care were identified at each huddle and de-logs for both incidents were agreed by the Integrated Care Board.

6.2 Falls per 1,000 Bed Days

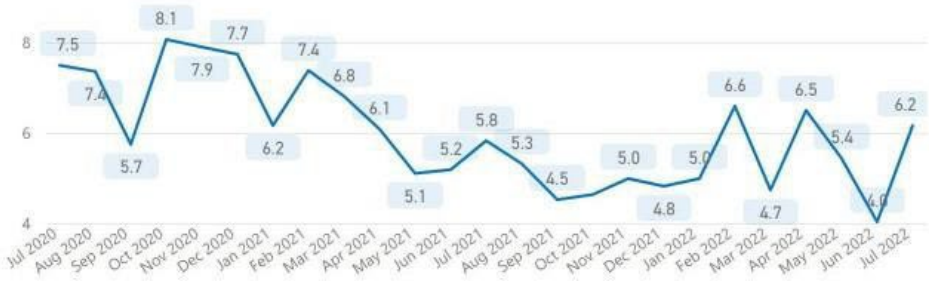
The falls per 1000 bed days across the Trust has increased in July 2022 with the largest increase at the Grimsby site. Caution should be used when interpreting the data as not all escalation beds are included within the 1000 bed days calculation.

Falls per 1,000 Bed Days Summary Jul 2022

Falls per 1,000 bed days

6.2 ▲ 2.1

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 2022	DPOW	6.8	! 2.9	3.9	
Jul 2022	GDH	3.5	✓ -2.6	6.1	
Jul 2022	SGH	5.8	! 1.9	3.9	

Falls per 1,000 Bed Days by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2022	Community & Therapies	4.1	✓ -2.2	6.3	
Jul 2022	Family Services	1.2	✓ 0.0	1.2	
Jul 2022	Medicine	8.2	! 2.7	5.5	
Jul 2022	Surgery	3.4	! 1.9	1.5	

6.3 Wards with Highest Incidence of Falls

Highest Reporting Wards with Falls Incidents Jul 2022

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
DPOW - B2 Assessment Unit	11	▲ 7	1	▼ -1	0	0	0	0	12	▲ 6
DPOW - C3 Short Stay	9	▲ 7	1	0	0	0	0	0	10	▲ 7
SGH - Stroke SGH	5	▲ 4	3	0	0	0	0	0	8	▲ 4
SGH - Ward 16	3	0	4	▲ 4	0	0	1	▲ 1	8	▲ 5
DPOW - Amethyst	2	0	5	▲ 4	0	0	0	0	7	▲ 4

Highest Reporting Wards - Falls per 1,000 Bed Days

Site - Ward	Falls per 1000 Bed Days	Change
DPOW - B2 Assessment Unit	13.9	▲ 6.9
SGH - Stroke SGH	13.2	▲ 6.4
DPOW - A1	12.1	▲ 2.6
SGH - Ward 19	12.0	▲ 3.6
SGH - Ward 16	11.3	▲ 6.9

Ward C3 (Short Stay) at Grimsby reported a significantly higher number of falls in July 2022. These were a combination of repeat falls and single falls. The staffing data for July 2022 shows that the ward had one of the lowest fill rates along with a lower substantive fill rate. This could potentially have affected the ability of staff to provide the appropriate level of observation to patients.

The areas detailed above will be reviewed alongside other metrics at the Nursing Metrics Panel.

7.0 Quality (Pressure Ulcers)

7.1 Hospital Acquired Pressure Ulcer Incidents

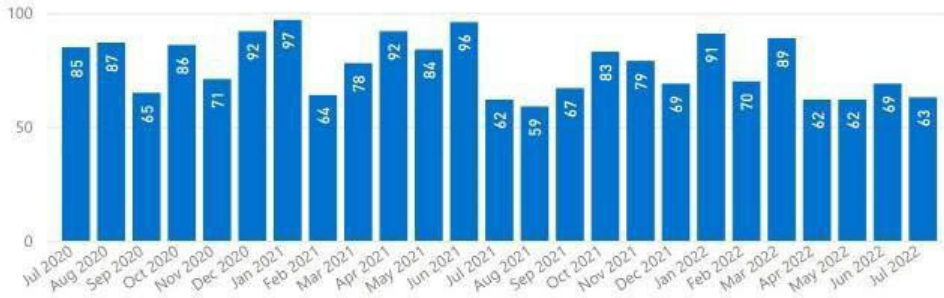
The data includes hospital acquired category 2,3,4 and unstageable pressure ulcers and is the standard throughout the report.

Data changes from month to month due to ongoing validation and these figures may contain un-validated pressure ulcers.

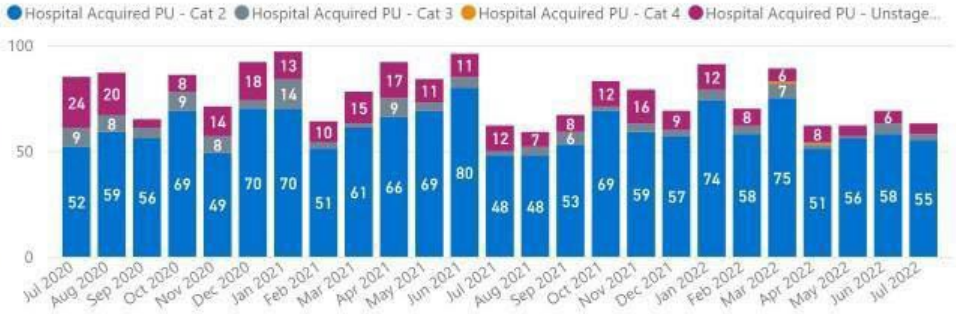
Hospital Acquired PU Incidents Summary Jul 2022

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
63 ▼ -6	55 ▼ -3	3 ▼ -2	0	5 ▼ -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 2022	DPOW	35	▼ -6	41	
Jul 2022	GDH	1	▼ -1	2	
Jul 2022	SGH	27	▲ 1	26	

Hospital Acquired PU - Total by Division

Latest Month	Divison	Result	Variance to Previous	Previous Month	Trend
Jul 2022	Community & Therapies	0	◆ 0		
Jul 2022	Family Services	0	◆ 0		
Jul 2022	Medicine	44	▲ 7	37	
Jul 2022	Surgery	19	▼ -13	32	

There number of pressure ulcer incidents reported in July 2022 has decreased.

Both the Grimsby site (DPOW) and the Medicine division continue to report higher numbers of pressure ulcers. There was a significant decrease in the number of pressure ulcers reported by the Surgical division.

7.2 Hospital Acquired Pressure Ulcers per 1,000 Bed Days

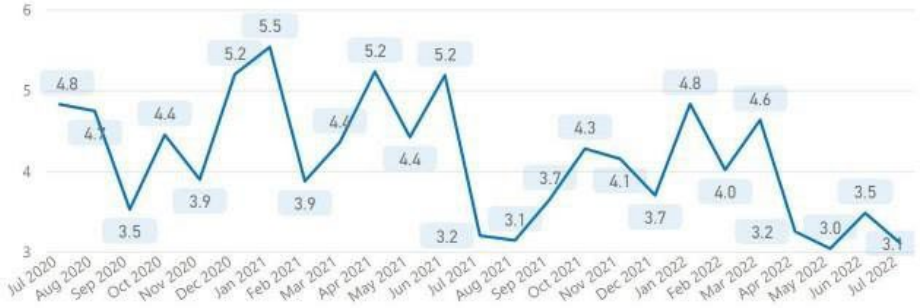
The incidence of reported pressure ulcers per 1000 occupied bed days has decreased in July 2022 and remains higher at the Grimsby site. Caution should be used when interpreting the per 1000 bed days data as not all escalation beds are not included.

Hospital Acquired PU per 1,000 Bed Days Summary — Jul 2022

PU per 1,000 bed days

3.1 ▼ -0.4

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 2022	DPOW	3.4	▼ -0.7	4.1	
Jul 2022	GDH	0.9	▼ -0.9	1.8	
Jul 2022	SGH	3.0	▲ 0.0	3.0	

PU per 1,000 Bed Days by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jul 2022	Community & Therapies	0.0	◆ 0.0		
Jul 2022	Family Services	0.0	◆ 0.0		
Jul 2022	Medicine	3.5	▲ 0.5	3.0	
Jul 2022	Surgery	4.1	▼ -2.8	6.8	

7.3 Wards with the Highest Incidence

Highest Reporting Wards with PU Incidents **Jul 2022**

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 - A1	5	▲ 3	1	▲ 1	0	0	2	▲ 2	8	▲ 6
DPOW - C1 Glover	5	▲ 3	0	0	0	0	1	▲ 1	6	▲ 4
DPOW - B3	4	0	1	▼ -2	0	0	0	0	5	▼ -2
SGH - Ward 18	5	▲ 2	0	0	0	0	0	0	5	▲ 2
DPOW - C5	4	▲ 2	0	0	0	0	0	0	4	▲ 2
SGH - Ward 28	4	▲ 3	0	0	0	0	0	0	4	▲ 3

Highest Reporting Wards - PU per 1,000 Bed Days

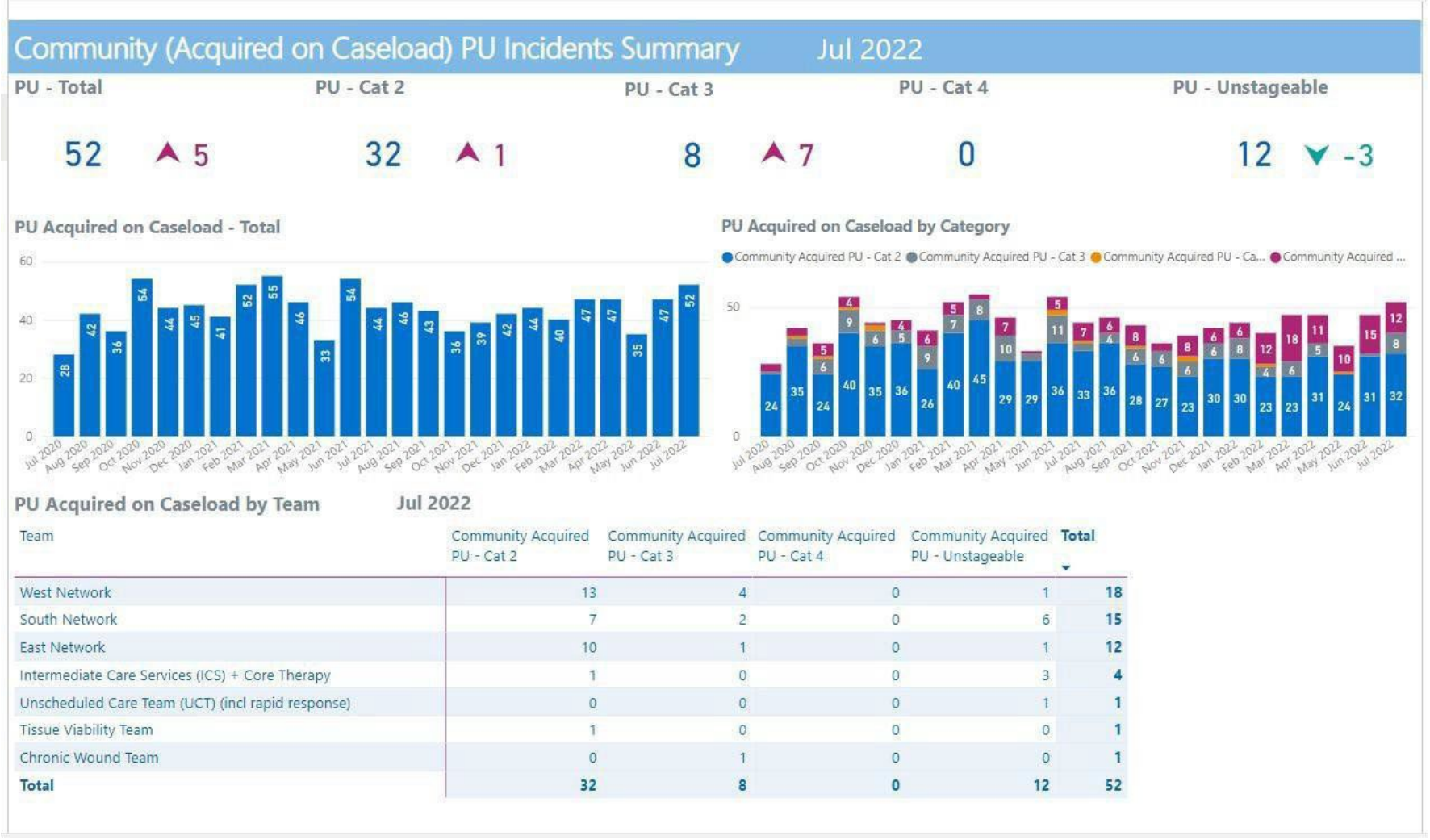
Site - Ward	Hospital Acquired PU per 1000 Bed Days	Change
DPOW - A1	16.2	▲ 12.3
DPOW - ITU	12.8	▲ 12.8
SGH - Ward 18	11.6	▲ 4.4
DPOW - C1 Glover	7.8	▲ 5.2
DPOW - B3	6.6	▼ -3.3

Ward B3 continues to trigger as a higher reporting ward although the total number of pressure ulcers reported in July 2022 has decreased by two.

There are no concerning trends for any of the other higher reporting wards. The areas identified above will be discussed in more detail at the Nursing Metrics Panel alongside other indicators.

7.4 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.



PU Acquired on Caseload by Team Jul 2022

Team	Community Acquired PU - Cat 2	Community Acquired PU - Cat 3	Community Acquired PU - Cat 4	Community Acquired PU - Unstageable	Total
West Network	13	4	0	1	18
South Network	7	2	0	6	15
East Network	10	1	0	1	12
Intermediate Care Services (ICS) + Core Therapy	1	0	0	3	4
Unscheduled Care Team (UCT) (incl rapid response)	0	0	0	1	1
Tissue Viability Team	1	0	0	0	1
Chronic Wound Team	0	1	0	0	1
Total	**32**	**8**	**0**	**12**	**52**

The incidence of pressure ulcers is not significantly reducing despite a Trust-wide action plan and there has been an increase in the number of pressure ulcers reported during July 2022 by 5 from 47 to 52. There have been similar numbers of pressure ulcers reported in all three of the networks with slightly higher in both South and West Networks which is possibly reflective of the caseload sizes. Nurse staffing levels due to vacancies and sickness continue to be a significant challenge in the community, particularly in the nursing networks although there have been some improvements, this impacts on the patient caseloads and the frequency of patient reassessments and visits.

Following an increase in pressure ulcers reported by Intermediate Care Services in June 2022, the numbers reported this month are reflective of the usual numbers reported by this team. This is despite the team experiencing staffing pressures and an increased caseload of patients during July 2022. The Intermediate Care team have recently received some tissue viability training delivered by the Community Tissue Viability Nurse to ensure the team were up to date.

The most reported pressure ulcers overall are category 2 which is a consistent theme each month. This is suggestive that preventative interventions put in place by network teams have impacted on further deterioration of category 2 pressure ulcers. However, we have had an increase in category 3 pressure ulcers in July from 1 to 8 and no category 4 pressure ulcers. There has been a slight decrease in the number of unstageable pressure ulcers from 15 to 12.

A review of the moderate incidents (cat 3's and unstagables) for July shows the following

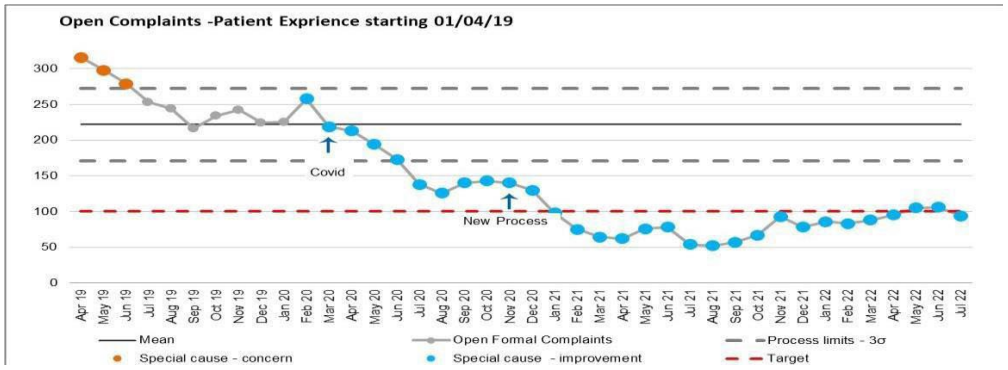
Pressure Ulcer	**Developed in patients own home/network**	**Developed in residential/care home setting (name if known)**
Category 3	5 (3 in West, 1 in South, 1 attended the wound clinic))	3 (1 in Wrawby Hall, 1 in Norwood House, 1 in Warley House)
Unstageable	3 (2 in South, 1 in East)	9 (1 in Bridgewater Park, 1 in Richeden Park, 1 in Warley House, 4 did not specify)

There are no themes from this data except 2 of the pressure ulcers were developed in Warley House, the teams will keep this under review.

All pressure ulcers are validated by the Tissue Viability Nurse for Community, the main theme arising from this has been incorrect categorization of pressure ulcers when reporting. There has been some recent training and education on pressure ulcers for Community Nursing staff, with a particular focus on categorization. Themes from the review of pressure ulcers at the Pressure Ulcer Scrutiny Panel are fed back to the community nursing network teams as lessons learnt and so actions can be taken. Thematic analysis into the findings of the PUFFINS from the last year will be undertaken by the Quality Development Team to inform next steps, with a report to share in Quarter 3.

8.0 Patient Experience

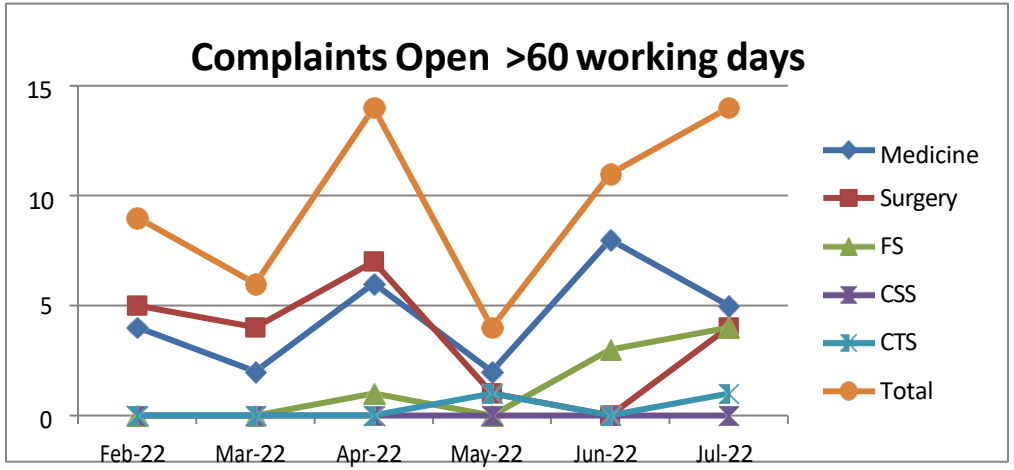
New formal complaint numbers have decreased by 34% from last month to 27 new complaints during July. In July at the point of reporting there were 94 open ongoing complaints and 1 new reopened complaint, this can be seen below in graph A.



Graph A

The complexity and tone of new complaints has been noted through the triage system and it is felt that this, combined with 25% of all complaints involving bereaved families, is impacting on the delivery of timescales.

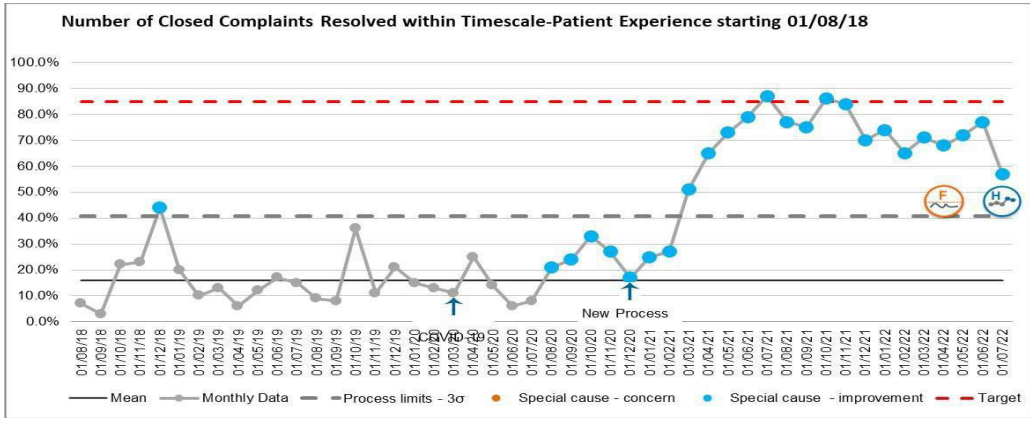
Complaints greater than 60 working days rose again as shown in July's data graph B. This reflects the challenge's divisions are facing with highly complex complaints as described above and compounded by the holiday period, where staff have summer leave, and this can be extended at times. Divisions have been asked to be aware of this when allocating lead investigators.



Graph B

In July 28 complaints were closed, 12 of the closed complaints were over the 60 working day timescale, 0 cases were over 100 days. This has unfortunately led to the lowest compliance against the Trust KPI since the new process was fully implemented last year.

An overall total of 57% closed complaints were managed with Trust timescale, this can be seen in graph C.

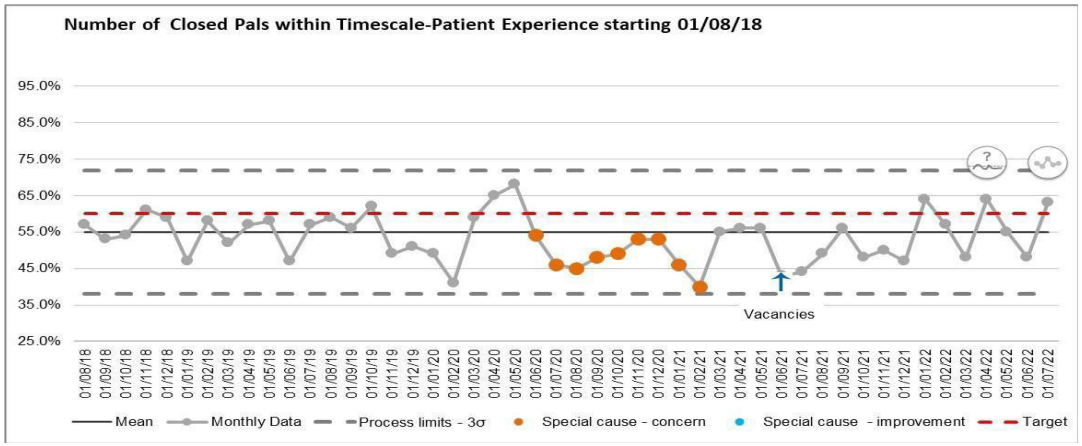


Graph C

A review of all processes is being undertaken in August by the Deputy Chief Nurse, Patient Experience Lead Nurse and acting PALs and Complaints Manager. It is predicted , given the oversight , that this compliance will be lower in August and this has been escalated internally. Divisional actions will be sought following this and increased oversight of their weekly position provided as a priority.

Themes centre around treatment : pathways , management , missed opportunities and communication, within this heading. It is evident that with 25% of all formal complaints involving grieving families, and this featuring in half of those complaints reopened, that further work is required to understand how families can be better helped at this difficult time.

Trust wide the total number of new PALs remained similar to June, at 175. Total open PALS rose 20% in July to 110. 157 PALs were closed in July, with an increase of 63% within the timescale of 5 days or less, as seen in graph D. The KPI remains at 60% and as yet there is a consistent achievement of this. The successful appointment of an additional band 7 role will see a focus on PALs, winter complaint planning and learning, this post will be commenced in October. The substantive Pals and Complaint Manager will return, supported, in September.



Graph D

The themes remain unchanged, with one of the top theme, around appointments, which is taken from PALs data, being explored in more depth to ascertain areas for quality improvement. This will be through the Patient Experience Roundtable Meeting.

The current summary of July FFT data submitted can be seen below and saw a similar position in those reporting a positive experience than in June , with response rates in line with June also. Negative reviews equated to 10% again.

Discussion with the existing contractor, following procurement for a further year, resulted in an extensive improvement plan and a supportive visit in September to assess what further staff engagement and visibility can be offered. The Patient Experience Manager will be released from supporting Pals and complaints in September to add pace to this agenda.

Volunteering has increased its active volunteers by 20% to 112 and shown a positive shift of those in recruitment by 21% to only 65 now. A meeting with recruitment to discuss delays in this process is yet to be undertaken, but work continues in the central team to remove any minor delays.

The meeting to progress a Trust Youth Council was positive and Haris Sultan shared his experience in establishing one and offered further support. He recommended exploring a supportive role to ensure the council is well led and highlighted issues around meetings at weekends and evening to acter for students' educational schedules. Further discussions are needed with the divisional team to progress to the next step once an outline document has been provided.

9.0 Mixed Sex Breaches

From 1 December 2010, the collection of monthly Mixed-Sex Accommodation (MSA) breaches was introduced. NHS organisations were required to submit data on the number of occurrences of unjustified mixing in relation to sleeping accommodation.

The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient.

All Trusts were asked to resume data submission on the number of unjustified mixing from October 2021 following a period of suspension due to Covid-19 and the need to release capacity across the NHS.

In July the Trust declared 22 mix sex breaches at both SGH and DPOW, this involved 6 patients and one action plan was commenced which contained all the actions for all patients affected - the theme for these was that the Trust had declared OPEL 4 on all occasions and there was a lack of capacity in step down beds

Site	Speciality	Date	Sex	No. that occurred	Reason
SGH	Ward 28 HoBs	02.07.22	M	3	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	02.07.22	M	3	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	02.07.22	F	3	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	02.07.22	M	3	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	02.07.22	F	3	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	02.07.22	M	3	OPEL 4 on site, nil bed capacity at SGH to support step down
DPOW	HDU	06.07.22	M	2	OPEL 4 on site, nil bed capacity at DPOW to support step down
DPOW	HDU	06.07.22	F	2	OPEL 4 on site, nil bed capacity at DPOW to support step down
SGH	Ward 28 HoBs	06.07.22	M	2	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	06.07.22	F	2	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	08.07.22	M	3	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	08.07.22	F	3	OPEL 4 on site, nil bed capacity at SGH to support step down

SGH	Ward 28 HoBs	08.07.22	F	3	OPEL 4 on site, nil bed capacity at SGH to support step down
DPOW	HDU	11.07.22	F	3	OPEL 4 on site, nil bed capacity at DPOW to support step down
DPOW	HDU	11.07.22	M	3	OPEL 4 on site, nil bed capacity at DPOW to support step down
DPOW	HDU	11.07.22	M	3	OPEL 4 on site, nil bed capacity at DPOW to support step down
SGH	Ward 28 HoBs	25.07.22	F	3	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	25.07.22	F	3	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	25.07.22	M	3	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	31.07.22	F	3	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	31.07.22	F	3	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	Ward 28 HoBs	31.07.22	M	3	OPEL 4 on site, nil bed capacity at SGH to support step down

10.0 Safe & Secure Medications

QI collaborative

The annual audit for safe and secure storage of medication in 2020 showed only 12 areas achieving over 85% compliance with average compliance of 73%, with 19 areas above 85% with an average of 75% compliance in 2021. A QI collaborative commenced in November 2021 working with frontline ward teams to test ideas to improve their performance. In 2022 the annual audit showed a large improvement with 57 areas achieving over 85% with a trust average of 87% compliance. Monthly audits and reporting are now in place to ensure that these improvements are sustained and early intervention can occur when performance dips.

In addition, these wards reduced their medication stock levels by ~£6,000 combined. One ward also saved 30min per day of nursing time by removing the need to search for treatment room door keys. These ward also saw a reduction in the number of medication related incidents.

Focus continues to be on sustainability of improvements made with 21 wards supported to date. Revisits and support are been undertaken where there have been slippages in performance.

Average audit position across all inpatient wards for June 85%, June 83% August 85% against target position of >85%

11.0 15 Steps Challenges

Acute Visits – July 2022

Date of visit	Ward/ Department	Rating 22-23	Previous Rating
05/07/2022	IAAUB2		
07/07/2022	Holly & Blueberry		
13/07/2022	**Fracture Clinic DPOW Revisit**		
14/07/2022	Fracture Clinic SGH		NA 1st visit
19/07/2022	ITU DPOW		
21/07/2022	**A&E DPOW Revisit**		
26/07/2022	Ward 17		
28/07/2022	NICU DPOW		

Community and Therapy Visits – July 2022

Date	Community Team/ Clinic	Rating 2022	previous rating
01/07/2022	Assisted living DPOW Equipment and wheelchair		N/A
05/07/2022	Global House, South Network		N/A
06/07/2022	Global House, Community Matrons		N/A
15/07/2022	Discharge coordinators, SGH		N/A
25/07/2022	Monarch House, Nutrition and Dietetics		N/A

Outstanding	Good	Requires Improvement	Intensive Support

Thirteen 15 Steps Challenge visits took place throughout July 2022, 8 within the acute schedule and 5 within the community and therapy schedule. 1 visit was cancelled and rescheduled due to operational pressures within the division.

Themes for Areas of Consideration/ Action within the acute schedule

	Themes	Actions
Standard 1: Observations	• Correct storage of notes and management of documentation with patient identifiable details	• Departments and wards have focused on how they can store notes safely and securely where appropriate • Departments have initiated new processes in the movement of documents/notes with patient identifiable details in patient facing areas
	• Unable to gain assurance on cleanliness of equipment, dusty and dirty equipment notes within wards/departments	• Ward manager to monitor the compliance of cleaning regularly used equipment between patient use, routine cleaning of stored equipment and use of 'I am clean' tape or cleanliness checklists
	• Hand Hygiene and overuse of gloves	• Importance of hand hygiene compliance and correct use of PPE discussed at managers/staff meetings and shared in team communications • Appropriate use of gloves communicated with teams
Standard 2: Documentation	• Intentional rounding document: • Poor completion of Food and Fluid charts • Poor completion of pressure area care risk and skin checks	• Clinical sisters completing training and education in their areas supported by Lead Nurse' • Further bespoke training organised for individual ward needs by Lead nurse' and supporting staff • Ward manager discussed in team meetings, Stop & Check and team communication • Clear expectations and responsibilities outlined to non-substantive staff as to ward/department routine and documentation
Standard 3: Patient Feedback	Minimal themes to report • Pain not always managed well, effectiveness of pain not reviewed	• QI project underway looking at reviewing effectiveness of pain
Standard 4: Staff Feedback	Although individual area concerns highlighted minimal themes to report	

Themes and actions from within the community and therapy schedule will be reported quarterly due to the smaller number of visits each month.

12.0 Infection Prevention & Control

COVID-19

We are currently seeing a low number of patients with COVID-19 positive results within the three sites. These patients are managed in isolation rooms on their speciality wards. The national stance of now learning to 'Live with COVID' has now seen a pause to asymptomatic testing in both patients and staff. The coming winter is predicted to be very challenging in the hospital setting regarding isolation / cohorting due to expected surge of COVID-19 and other respiratory illnesses in particular influenza and bronchiolitis. Mitigating actions and controls will remain in place to safeguard patient and staff safety. HEPA filtration units are in use on the wards. Maximising isolation facilities by full use of Redirooms is required.

Alert mandatory organisms

The Trusts trajectory for 2022/23 of no more than 21 C.difficile cases is a significant challenge to achieve. The Trust reported hospital 11 onset cases since 1st April. Through the PIR process antimicrobials shows to be the main predisposing factor, all broadly justified.
Hospital onset positive blood culture cases are in line with predicted numbers. It is 22 months since the last hospital onset MRSA bacteraemia case.

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

Healthcare- associated infections YTD

April – July 2022

Overview 2022/23 YTD

Healthcare-associated cases

Division: All

Cases for each month are not validated until 15th of the subsequent month.
Rate data is available around 20th of the subsequent month

NHS Northern Lincolnshire and Goole NHS Foundation Trust

	PHE Trust-level Targets	Trust	DPOW	SGH	GDH
C. difficile	21	11	8	3	0
MRSA	0	0	0	0	0
MSSA	No Target	7	4	2	1
E. coli	65	23	12	7	4
Klebsiella spp.	25	7	3	4	0
P. aeruginosa	7	7	4	3	0

3

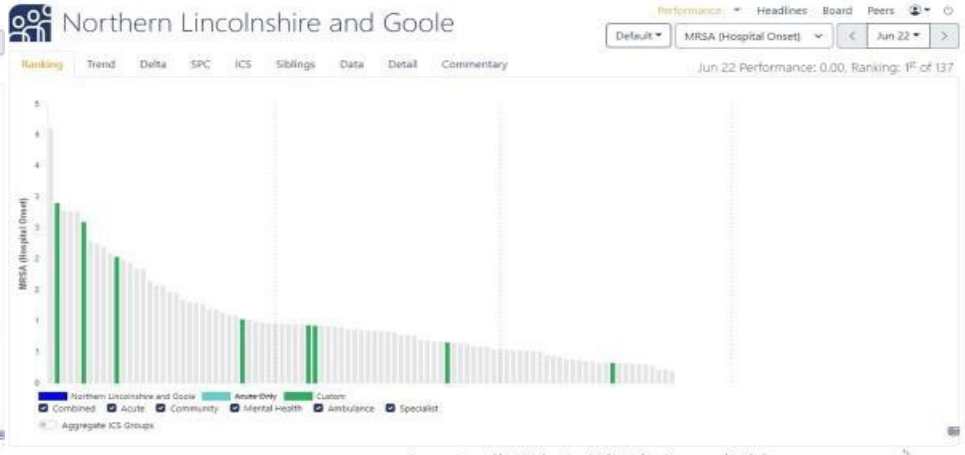
Northern Lincolnshire and Goole NHS
NHS Foundation Trust

Comparison to Peers
C. difficile

Source: https://publicview.health/Auth/Performance/RJL/1/

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

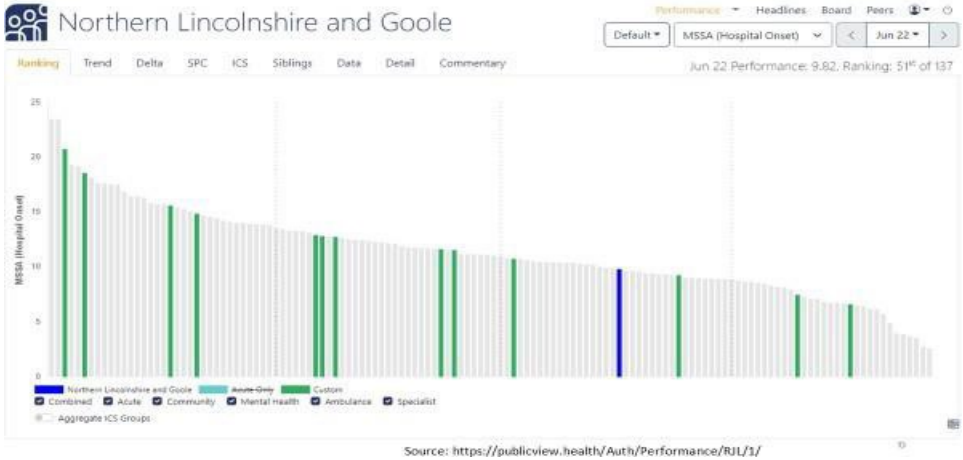
Comparison to Peers
MRSA



Source: https://publicview.health/Auth/Performance/RJL/1/

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

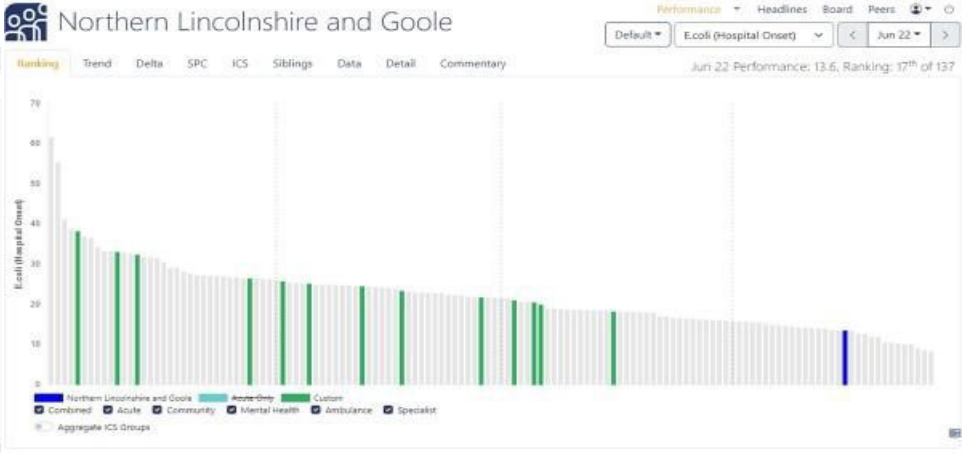
Comparison to Peers
MSSA



Source: https://publicview.health/Auth/Performance/RJL/1/

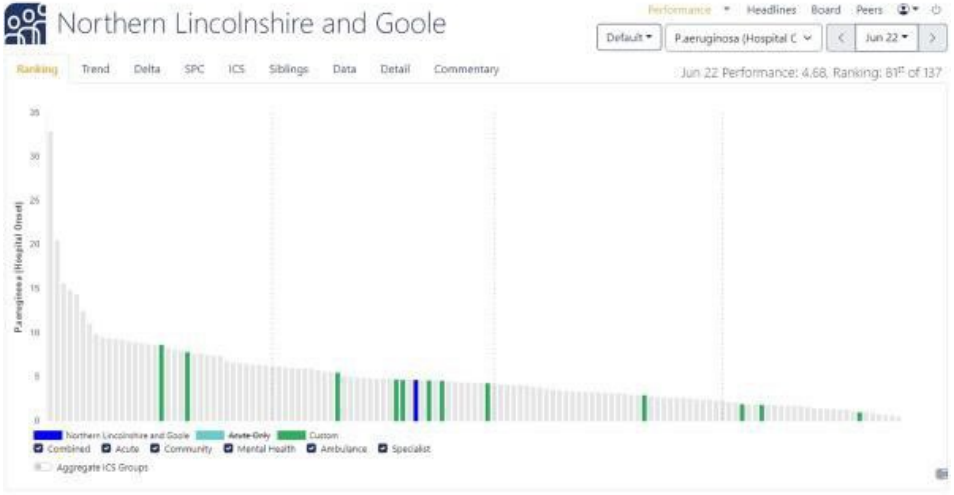
Northern Lincolnshire and Goole NHS
NHS Foundation Trust

Comparison to Peers
E. coli



Source: https://publicview.health/Auth/Performance/RJL/1/

Comparison to Peers
P. aeruginosa



Source: https://publicview.health/Auth/Performance/RJL/1/

13.0 Quality Improvement

Key activities since last update

Two new QI collaboratives have launched focusing on Discharge lounge utilisation and Pain assessment / reassessment.

Improving Pain Assessment: To improve the timely assessment and reassessment of Patients Pain on WEBV across NLAG services by March 2023.

Improving the quality of discharge: Increase the uptake of patient's transferred to the Discharge Lounge by 30% whilst maintaining the quality and safety of discharges by 31st March 2023.

These QI collaboratives are engaging wards in their ideas to improve these areas of focus using a PDSA approach supported by the QI team.

Work has been undertaken to develop an area to capture QI activity across the trust. This has been achieved in the form of a section on the QI hub page call the "QI Showcase" with the aim of increasing transparency across the organisation of improvement activity and act as an area for teams to learn and share from each other's improvement efforts. Work is underway to upload over 100 elements of QI work that the QI team has been involved in since Nov 2021. The QI Showcase will be formally launched in Oct / Nov to encourage all areas of the trust to share and celebrate their improvement works. In addition, data can be pulled from the QI showcase to share with Divisions and Services to celebrate and support their improvement efforts.

The trust QI methodology is based around the Institute for Healthcare Improvements (IHIs) Model For Improvement (MFI). The MFI is at the core of the QI training provided by the trust and role modelled by the QI team. In response to a number of requests a "QI toolkit" has been developed with tools, templates, examples and short videos to make it as easy as possible for people to use the MFI and tools of QI. This QI toolkit is live on the QI hub page with plans to extend it to support larger improvement projects that require greater levels of governance and project management.

14.0 Conclusion

Recruitment and retention work remain a priority due to high nurse staffing vacancies, and collaborative work with colleagues in POE and the QI team continues. Newly qualified nurses and midwives will be receiving their NMC registration over the coming months, and international nurse and midwife recruitment continues. Mass HCA recruitment events are planned for September.

One in-patient fall was reported with moderate harm at Grimsby on Ward C2. The patient sustained fractured humerus. No lapses in care were identified at the huddle.

Two in-patient falls were reported with major harm following each patient sustaining a fracture to the femur. One incident occurred on Ward C5 at Grimsby and the other on Ward 16 at Scunthorpe. No lapses in care were identified at each huddle and de-logs for both incidents were agreed by the Integrated Care Board.

Ward C3 (Short Stay) at Grimsby reported a significantly higher number of falls in July 2022. These were a combination of repeat falls and single falls. The staffing data for July 2022 shows that the ward had one of the lowest fill rates along with a lower substantive fill rate. This could potentially have affected the ability of staff to provide the appropriate level of observation to patients.

The incidence of Community pressure ulcers is not significantly reducing and there has been an increase in the number of pressure ulcers reported during July 2022 by 5. There have been similar numbers of pressure ulcers reported in all three of the networks with slightly higher in both South and West Networks which is possibly reflective of the caseload sizes.

Following an increase in pressure ulcers reported by Intermediate Care Services in June 2022, the numbers reported this month are reflective of the usual numbers reported by this team. This is despite the team experiencing staffing pressures and an increased caseload of patients during July 2022. The Intermediate Care team have recently received some tissue viability training delivered by the Community Tissue Viability Nurse to ensure the team were up to date. Thematic analysis into the findings of the PUFFINS from the last year will be undertaken by the Quality Development Team to inform next steps, with a report to share in Quarter 3.

The concerns related to midwifery staffing continue with July 2022 showing NICE Maternity Red Flag status of 34 in total. There was an error in the reported flags for June with 98 in total for the month. The report had calculated the figure incorrectly and should have read 18 in total. The majority of these relate to delays from admission to the start of the induction process (13) as well as the need to call in the on-call community midwives as part of the escalation process (10).

The complexity and tone of new complaints has been noted through the triage system and it is felt that this, combined with 25% of all complaints involving bereaved families, is impacting on the delivery of timescales. Complaints greater than 60 working days rose again. 28 complaints were closed, 12 of the closed complaints were over the 60 working day timescale, 0 cases were over 100 days. This has unfortunately led to the lowest compliance against the Trust KPI since the new process was fully implemented last year. This reflects the challenge's divisions are facing with highly complex complaints as described above and compounded by the holiday period, where staff have summer leave, and this can be extended at times. Divisions have been asked to be aware of this when allocating lead investigators.

The annual audit for safe and secure storage of medication in 2020 showed only 12 areas achieving over 85% compliance with average compliance of 73%, with 19 areas above 85% with an average of 75% compliance in 2021- this was following the QI collaborative November 2021. Monthly audits and reporting are now in place to ensure that these improvements are sustained and early intervention can occur when performance dips.

We are currently seeing a low number of patients with COVID-19 positive results within the three sites and these patients are managed in isolation rooms on their speciality wards. The coming winter is predicted to be very challenging due to expected surge of COVID-19 and other respiratory illnesses in particular influenza and bronchiolitis. Mitigating actions and controls will remain in place to safeguard patient and staff safety. HEPA filtration units are in use on the wards. Maximising isolation facilities by full use of Redirooms is required.

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Improving Pain Assessment: To improve the timely assessment and reassessment of Patients Pain on WEBV across NLAG services by March 2023.

Improving the quality of discharge: Increase the uptake of patient's transferred to the Discharge Lounge by 30% whilst maintaining the quality and safety of discharges by 31st March 2023.

Appendix 1: Assurance framework – nursing and midwifery staffing

For quality (or other board level) committees and board members to support discussion and challenge surrounding the active staffing challenges faced and the potential impact this may have on patients.

Ref	Details	Controls	Assurance (positive and Negative)	Residual Risk Score / Risk registerreference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review	RAG Rating
	Guidance notes	*Outline the current controls (controls are actions that mitigate risk include policies, practice, process and technologies)*	*Detail both the current positive and negative assurance position to give a balanced view of the current position* *Assurance is evidence that the control is effective – or conversely is evidence that a control is ineffective / there are still gaps* *Recurrent forms of assurance are audit results, key performance indicators, written reports, intelligence and insight.* *Effective Assurance should be a triangulated picture of the evidence (staff shortages, sickness absence,pt outcomes, complaints, harm reviews)*	*What is the remainingrisk score (using the trusts existing risk systems and matrix)* *Are these risks recorded on the risk register?*	*Where there are identified gaps in either control or assurance,outline the additional action to be undertaken to mitigate the risk. Where the organisation is unable to mitigate fully, this should be escalated to the LRF/region/ national teams and outlined in the following column*	*Provide oversight to theboard what the current significant gaps are* *Outline those risks that are currentlynotfully mitigated /needingexternal oversight and support*	*Due to the likely prevailing nature of these risks, outlines through what operational channels and how are these active risk being monitored (e.g daily silver meetings via safe staffing heatmap)*	
1. **Staffing Escalation / Surge and Super Surge Plans**								
1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB safe staffing guidance	Winter Planning Meetings and Plan /Surge Plan/ SOP for Staffing Escalation/Staffing plans for critical care areas through surge, which includes training plans	Each Division has a surge plan that sets out how staff and services will be managed in a surge/ Safecare Live used to review and apply clinical judgement if staffing below establishments and to support deployment of staff/ A review of establishment is completed with every ward move, change of demographic, bed numbers and purpose with the Matrons, Associate Chief Nurses and Deputy Chief Nurse with ultimate sign off by the Chief Nurse/ This is fed into the strategic incident command meetings and daily operationalmeetings. The Nursing Dashboard is reviewed at the Nursing Metrics Panel which has continued throughout the pandemic to ensure safe fundamentals of care/ Daily incidents and Red flags identified on Safecare Live/ training plans in place for deployment to ICU and respiratory areas	N/A	None	None	Staffing level reviews will continue to take place through surge and de- escalation processes. 3 times a day daily operational meetings/Safe Staffing meeting daily/use of safe staffing escalation process/red flag and incident reporting. Monthly Assurance Report to QSC.	G
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.	As above, included in Winter Planning, surge and Escalation plans. Short Term Staffing SOP updated.	Plans developed in conjunction with divisional teams and signed off by Chief Nurse. These are reviewed following every ward reconfiguration, alongside information from the nursing dashboard/red flags and IPC needs.	N/A	None	None	As above	G
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee	Information about staffing has been shared through many public meetings and assurances provided on mechanisms/processes to regulators. They are also available on the Staff hub making them easily accessible.	Information about staffing has been shared through many public meetings and assurances provided on mechanisms/processes to regulators. They are also available on the Staff hub making them easily accessible. Representatives have access to this information	N/A	None	None	As above	G
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	Quality impact assessments	Quality impact assessment are completed by Chief Nurse and Medical Director for services changes or schemes. This needs improving for changes to ward functions and roles. This need embedding into operational policy and surge plans. Evidence of completion by corporate CNO team.	Tobeadded to risk register	Embed within existing structuresforcompletion out of hours and include in Winter/Surge Plans. Review of QIAs to be undertaken within divisions andupdatedaccordingly. Add to risk register	None	Through daily operations meetings	A

2.0 Operational delivery								
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.	Daily ops meeting/ daily nurse staffing meeting / Safecare Live review/ Nursing Metrics/ Red Flags and review of daily incidents.	Staffing discussed at the 3 daily operational meetings and safe staffing daily meeting. Proforma used to communicate and escalate risk that can't be mitigated. No risk assessment or quality impact completed for immediate shortfalls. Safecare live used to escalate staffing shortfalls, to raise red flags and to mitigate based on clinical judgement and acuity. Safety Stop at 2pm each day The daily Safe Staffing Meeting is led by a Divisional Associate Chief Nurse of Deputy Chief Nurse for oversight and to provide leadership. Overview is then sent to the CNO or verbal escalation if required. Have OPEL type escalation process for staffing in place.	N/A	Reviewrequirement for documented risk assessment/ QIA of immediate risks.	None	SafeCare Live, Red flags, review of daily incidents being reported. We also have 'Stop and Check' which is a safety stop at 2pm each day, which includes oversight of fundamentals of care and staffing.	G
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained	Daily operational meetings 8:30, 13:00, 16:00. Safe Staffing meeting daily at 10.00	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Staffing plans shared with silver and gold on call. Escalation to CN or Gold if additional mitigation required.		Review Matrons staffing plans documentation to ensure this is clear and includes mitigation.	None	Safe Staffing meeting. Impact monitored through Safecare Live.	G
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.	Transfer Process/ handover checklist	Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained.		Require evidence that NIC is gaining assurances		Nurse staffing red flags are captured on Safecare. Midwifery red flags captured on Ulysses.	A
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients	Incident forms.	Concerns raised with line mangers. Staff would complete incident forms. Escalate to matron and site manager depending on time of day. Various ways to raise a concern through escalation process and Professional voice inbox and the Stop and Check process.	N/A	Test staff awareness of and process of red flags	None	Internal review, audit and 15 steps process	G
2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.	Agency induction checklist	High temporary workforce utilisation can result in staff being redeployed to areas of the Trust where they haven't worked previously, and this requires individual assessment on arrival to an area by NIC. Agency induction checklist available on the HUB for wards/ department to use. Local inductions are provided to agency staff on arrival to the area of work to include a full handover at the beginning of the shift. Induction checklist is completed with individual agency staff members and an orientation to the ward environment is conducted by a substantive staff member.	N/A	Ensure consistent use of agency induction checklistacrossdivisions	None	Audit of agency induction checklist.	A
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's scope of practice.	Incident forms Safecare live	Formal routes are available for raising staffing concerns through the incident reporting system. Concerns regarding patients' needs can be raised on operational calls. All incidents are reviewed and reported via the workforce report. As per 2.4 and 2.5.	N/A	None	None	As per Staffing review processes, where demographic of ward has changed a staffing review has taken place to review their establishments	G
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on	Workforce report	Incidents and trends are discussed in workforce report . Nursing metrics panel review incidents and triangulate with other quality metrics. As per 2.4,2.5 and 2.6	N/A	Review Safecare live to ensure red flags being actioned/ mitigations documented.	None	Review data in Metrics Panel	G

2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.	Vivup Employee AssistanceProgramme, Remploy Work Based Support HCV Resilience Hub Restorative Clinical Supervision	Comprehensive health and wellbeing offer is in place both at a Trust level and a system level through the HCV Resilience hub. Initiatives implemented to support staff wellbeing continue and staff encouraged to access. Effectiveness of HWB is measured through the staff survey. Trust taking part in the NHDE/I Trailblazer Pilot focusing on 7 areas of staff HWB: Personal H&W, managers & leaders, environment, professional support, relationships, fulfilment at work and data insights. ICU and respiratory wards receiving additional support. Professional Nurse Advocate Programme in place with initial PNAs trained.		Review of recent staff survey and understanding of staff feedback on their HWB and triangulation of findings. Collation of informal feedback	Requirement for additionalsupportto respiratory wards.	This work is being led by PEO. Health and Wellbeing Steering Group in place.	A
2.9	The trust has robust mechanisms for	Safecarelive and daily OPEL	Safecare live used during daily staffing meeting to support safe deployment of staff.	2421/ 2530	None	None	As above	G
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.	Incident report Safe care	Staffing incidents are reported via Ulysses. Safecare live is also available to raise red flags and add clinical judgments. Both reports are used on the workforce report to monitor staffing incidents and trends. The trust is increasing the number of staff trained as Professional Nurse Advocates in recognition of the burn out, mental health problems and widespread stress experienced by staff. The training provides practitioners with the skills to facilitate restorative supervision to colleagues. Daily Stop and Check safety checks introduced at 2pm.	N/A	Continue to recruit and train PNAs and develop trust strategy to support role. Support debriefing with support from POE and HCV resilience hub. Encourage staff to raise concerns about the impact of the pandemic on their mental and physical health.	None	Monitoring of staffing incidents as above.	A
3.0 Daily Governance via EPRR route (when/if required)								
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.	This is done through variousmechanisms,there is a trust wide HWB Steering group, but this is discussed through daily operations meetings	Health and Wellbeing Steering Group in place. Daily operational meeting with Strategic Meeting in place once per week as per EPRR guidelines	N/A	None			G
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).	Opsmeeting and daily nurse staffing meeting	Staffing is recorded on the SITREP which is shared widely across the trust and with external partners. The Nurse staffing meeting report is sent to senior nurse team.	N/A	None	None	As per previously identified structures	G
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.	EPPR meetings Workforce report	Information and pressures shared in local health and care strategic calls - requests for mutual support are through this forum. Additional EPPR meetings are held to review staffing and activity over bank holiday periods. Work closely with HCV Resilience Hub to access H&W resources for staff.	N/A				A
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.	SafeCare / Roster Perform/E roster/ Short Term Staffing SOP	Safecare live is used by all wards to record patient acuity and reviewing staffing to ensure within agreed safe staffing establishment numbers and to support safe deployment of staff to areas identified as in need. Mitigation documented on Safecare Live. Staffing red flags reviewed daily. There are Safe Staffing & Effective Rostering and Nursing Recruitment & Retention Groups focusing on strengthening workforce information, staffing and workforce issues and the people plan. Includes temporary workforce utilisation.	2421/ 2530	None	None	Daily safe staffing reviews. Triangulation of data in Nursing Metrics Panel.	G

4.0 Board oversight and Assurance (BAU structures)								
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short and medium term solutions to mitigate the risks.	Nursing Assurance Report monthly	The quality committee, on behalf of the trust board, receive the Nursing Assurance Report. Any concerns about staffing are included as a highlight within the CNO and CMO highlight report to board.	N/A	None	None	Continue to provide report to Q&S Committee	G
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patien feedback and clinical harms process.	Nursing Metrics Meeting/ Nursing Dashboard/ 15 Steps/ Ward Assurance Tool Monthly Performance Review Meetings/ Quality Governance Group monthly	Nursing Dashboard/ Ward reviews as a part of the establishment process.	N/A	None	None	Nursing Metrics Meeting/ Nursing Dashboard/ 15 Steps/ Ward Assurance Tool	G
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.		The IPR does not include specific data in relation to patients with Covid 19, however the daily sitrep provides this level of detail and data is received by the ICC and reviewed in the Covid 19 Strategic meetings/ The impact of Covid on staffing and quality and safety (nurse sensitive indicators) is triangulated in the Nursing Metrics Meeting and included in the Nursing Assurance Report monthly for QSC.		Reviewof IPRand reporting.	None	Daily sitreps/ Nursing Dashboard	A
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making.		Nursing Assurance Report	N/A	None	None		G
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold)minimises any potential exposure of patients to harm than may occur delivering care	CN discussed with the committee			Continuousreview and triangulation of nurse sensitive indicators.	None		
4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.		not system wide					G
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.	Committee aware of Nursing workforce, other aspectsmonitored through and reported to workforce committee BAF and risk register aligned to elements within the BAF						G
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.erisks outside of the desired appetite		EM will review with HH					A

	are not tolerated without clear discussion and rationale and are challenged if longstanding)							
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework		EM will discuss with HH					A
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus							G
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing	CQC notification through Executives	There is a clear process of formal notification to the CQC regarding any quality concerns. There are regular engagement meetings with the CQC where concerns are discussed. Any concerns raised directly with the CQC or FTSU guardian are fully investigated.	None	None	None	Quality Report to Board	G

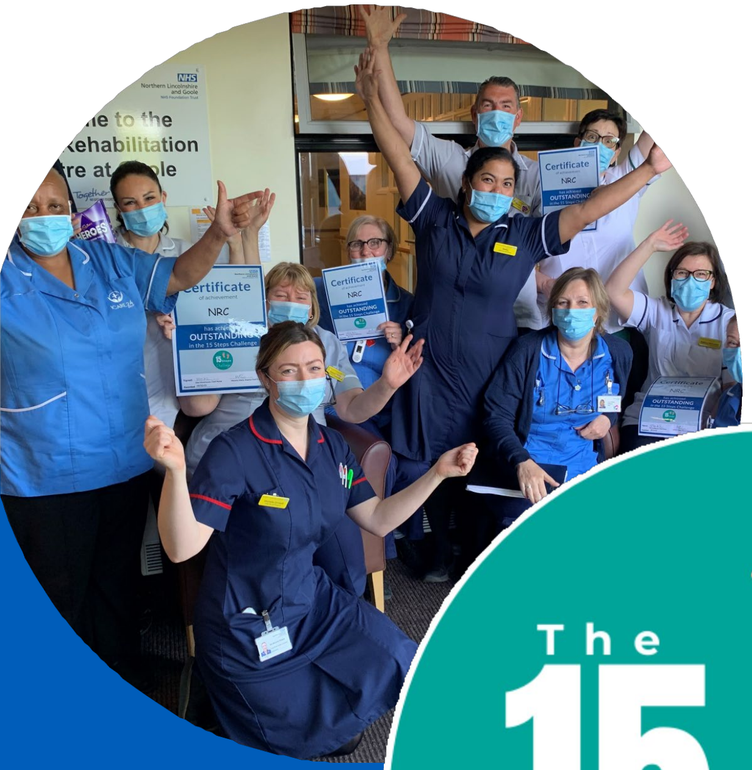
Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	Tuesday 4 October 2022	
Director Lead	Ellie Monkhouse, Chief Nurse	
Contact Officer/Author	Melanie Sharp, Deputy Chief Nurse	
Title of the Report	**15 Steps Annual Report**	
Purpose of the Report and Executive Summary (to include recommendations)	To update the Board on the positive progress achieved in the 15 steps challenge programme for 2021/22. The annual report provides assurance into the quality of care and professional standards provided across our clinical teams in Acute and Community. The report also outlines our priorities for 2022/23.	
Background Information and/or Supporting Document(s) (if applicable)	None	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Quality & Safety Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	None	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not Applicable	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Northern Lincolnshire and Goole NHS Foundation Trust

15 Steps Challenge Annual Report 2021 - 2022



The 15 Steps Challenge

Introduction

This is the annual report of NLaG 15 Steps Challenge Assurance Programme 2021/22.

The 15 Step Challenge was introduced in April 2019 as part of 'The Future 5'- Nursing, Midwifery and AHP strategy, setting out professional standards and best practice through a continuous audit cycle identified by the Chief Nurse. The programme forms part of a suite of metrics designed to provide assurance into the quality of care and professional standards provided across our clinical teams visiting clinical areas, unannounced, using the CQC key lines of enquiry to identify best practice and gain assurance, providing an overall rating based on how safe, well-led, caring, and responsive the areas are.

The Chief Nurse reviews the 15 Step Challenge Programme annually, allowing for continuous improvement based on themes and trends from the previous cycle, ensuring the tool remains relevant and up to date with changes to practice, strengthening the programme as it continues to develop. The programme remains a focus for the Chief Nurse for 2022/2023 and has been expanded to include outpatient areas and Community and Therapy.

> The 15 Step review programme is an excellent way for Governors to get a feel about how the wards and departments in the hospitals are managing on a day to day basis. It also allows the Hospital Management to review processes, staff training and teamwork to ensure patient safety is the primary focus. It is a team based approach and looks at the quality of the service provided by the hospital to patients. As a member of the team, I have found the reviews very enjoyable and gained a lot of knowledge of the processes and hard work being undertaken by staff to ensure patient safety.

Kevin Allen, Public Governor

> ...it's about pinpointing areas where assistance is needed so that help to find solutions can be provided. I've witnessed the 15-steps team positively focus on improvement always looking to help the staff find the right way forward.

Fiona Osborne, Non-Executive Director

> 15 Steps provides an incredible support to clinical areas. With constructive feedback 15 Steps allows staff to realise where they are undertaking excellent practices and provide additional support to area's in which require it. Being part of 15 steps has allowed me to see some of the best clinical practices around the Trust and where teams should be commended for this and supported in a constructive way should it be required. The passion and work the 15 steps team do behind closed doors is incredible and with their support this allows a consistent approach to patient care and staff support in the best way possible

Katherine Green, Space Utilisation Coordinator

Acute Programme

A consequence of the Covid-19 pandemic was that the schedule for 2021/22 had to be paused temporarily however, maintaining assurance throughout this time remained a priority and Trust wide supportive visits were completed across the divisions throughout April and May 2021, the official schedule restarted in June 2021 and completed in May 2022.

The process continues to be well supported by a variety team members including Associate Chief Nurses, Heads of Nursing, Matrons/Lead Nurses, Ward Managers, Quality Improvement Leads, clinical teams (safeguarding, medicine management, IPC etc), ward staff, estates and facilities, Non-Executive Directors and Public Governors.

**Left to right: Corrin Manaley, - Project Support Officer,
Melanie Sharp - Deputy Chief Nurse,
Michelle Drinkell - Lead Nurse Assurance Projects**

2021 - 2022 Acute Process

The process is reviewed annually to ensure it remains relevant and up to date with changes to practice. Feedback is welcomed and where appropriate considered and actioned. A review of the toolkits was completed mid-schedule and minor amendments were made as suggested by regular members of the team, including Non-executive Directors, Trust Governors, estates & facilities colleagues, and senior nursing & AHP colleagues. The 15 Steps Challenge amendment report 2021 (Appendix A) was presented at the Senior Nursing, Midwifery and AHP Board for information and review. For the process to remain consistent consideration of more significant changes were undertaken during the annual review. All 4 standards were reviewed, observations, documentation, patient feedback and staff feedback, changes included;

- A review of the toolkits for the more specific areas within the Trust; Matrons and Ward Managers from emergency care, critical care and theatres assisted with this review
- Standard 2 of the maternity toolkit was reviewed and aligned to reflect specific pathways within their documentation
- Questions were removed based on up to date Covid – 19 guidance
- Where needed further detail was added to ensure team members are clear and consistent on what evidence and detail is required from staff within standard 4
- Questions were amended to reflect changes in practice; ID bands no longer required for patients at risk of falls, lanyards now part of uniform policy

Supportive visits were a welcomed addition, allowing for improvement plans to be reviewed and updated, gaining further assurance on completed actions, capturing positive change and ‘closing the loop’ on learning.
Prior to each individual visit the Lead Nurse for Assurance Projects reviews recent metrics, including pressure ulcer data, falls data, hand hygiene compliance, and escalation of NEWS. PADR, mandatory training and clinical supervision compliance is also reviewed for areas and is shared with the team during the feedback session.

Northern Lincolnshire and Goole NHS Foundation Trust

Community and Therapy Programme

The community and therapy 15 Steps programme launched in 2020. The 15 Steps Leads completed pilots and documentation was adapted from the acute toolkits to ensure it met the unique needs of community and therapy and the variable sites and disciplines visited. The Covid-19 pandemic delayed the start of the programme in 2020 however, the team remained focused and the programme was revisited in 2021 and is now successfully embedded within the division. The process within community and therapy is being constantly developed and aligned with the acute programme, the two schedules whilst managed separately work very closely together and the Lead Nurse for Assurance Projects and Quality Assurance Officer attend as many visits as possible in the Community and Therapy schedule to ensure consistency. Regular meetings are also attended by both the acute and community leads to maintain a consistent rating guidance and reporting pathway. All community and therapy improvement plans are reviewed as part of the divisional action groups, monitoring actions until complete, once it is signed off at the relevant governance meeting it is then available for final review by the Chief Nurse and Deputy Chief Nurse.

Left to right: Sally Shaw - Quality & Development Project Support Officer
Claire Clarke - Quality & Development Nurse
Rachel Greenbeck - Head of Nursing
Donna Smith - Associate Chief Nurse

Ratings received 2021/22

A total of 85 acute visits were undertaken; this includes areas who have received more than one visit due to achieving a rating of requires improvement/ intensive support.

- 19 Received Outstanding
- 34 Received Good
- 29 Received Requires Improvement
- 2 Received Intensive Support

A total of 12 community visits were undertaken.

- 0 Received Outstanding
- 10 Received Good
- 2 Received Requires Improvement
- 0 Received Intensive Support

Cancelled visits

39 visits were rescheduled throughout the 2021/22 acute schedule. 24 of these were due to increased operational pressures, and 9 were due to cancellations within the team. 11 visits were rescheduled throughout the 2021/22 community schedule due to increased operational pressures. The decision to stand down and reschedule visits is always discussed with either the Deputy Chief Nurse or Chief Nurse.

Supportive visits within the Acute

Following the visit the ward/department will receive both verbal and written feedback, along with this written feedback they will be asked to complete an improvement plan within 4 weeks with oversight of their Matron. Once the improvement plan has been completed it is returned to the Lead Nurse for Assurance Projects and a supportive visit can be carried out. Areas highlighted within the improvement plan are reviewed to gain further assurance, the improvement plan is updated and returned to the Matron and Ward Manager for review; if further actions are required support can be provided by the Lead Nurse alongside the Divisions. Supportive visits are also a way of recognising positive change and sharing that recognition with the teams. Once updated the improvement plan is available to the Chief Nurse and Deputy Chief Nurse to offer comments and to sign off. The supportive visits have had a significant impact with many areas going on to improve their ratings when re-visited.

Where wards have received 'intensive support' or concerns remained following the supportive visit the Lead Nurse provides more frequent support to the area including training and mock visits. Regular updates of the improvement plan are made, these are then shared with the Ward Manager, Matron and Head of Nursing to identify any further learning, education or actions that are required. The 15 Steps team will then follow up with an unannounced revisit to gain further assurance and provide an official rating for the area. Where an area does receives requires improvement or intensive support the original 15 Steps Challenge team are invited back to attend tha revisit.

Thank you Michelle and the team for all the support you have shown the department during our 15 steps challenge… As a manager I constantly strive to improve the service provision we deliver every day. To go from requires improvement (21/22) to outstanding (22/23) gives me immense pride in the team who work within the department. Thank you for all your help and support.

Karen Horne, Antenatal Manager DPOW

As the new ward manager for Amethyst, I found the mock 15 step visit very helpful. It helped me focus on the areas that need improvement with clear action plans to follow. It also helped me feedback to the staff areas which have improved since the last visit.

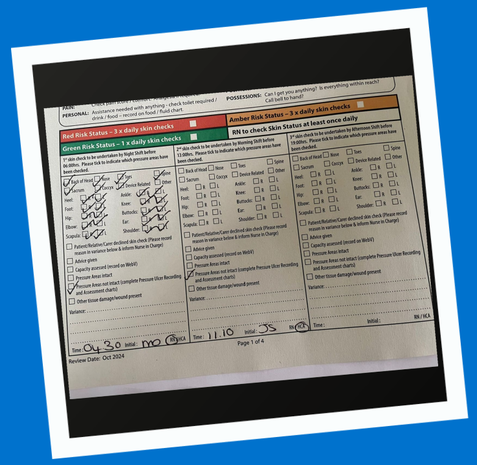
Natalie Stockley, Amethyst Ward Manager

BEFORE

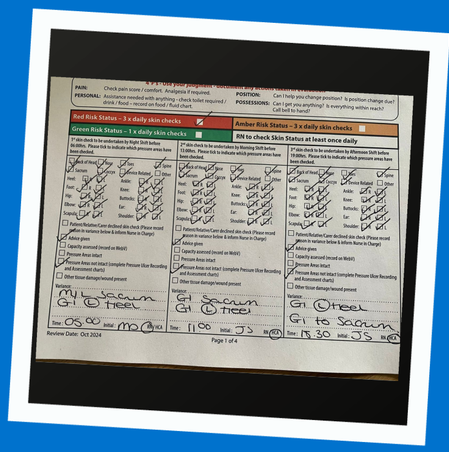
AFTER

Having the supportive visits assisted me in helping me as a new ward manager create change… identifying which areas were of priority and highest concern, as well as which areas were ‘quick fixes’. Working along side the 15 steps team with supportive visits the unit has now improved their rating to a ‘Good’ the visits helped staff and I have a better understanding of expectations, how to makes improvements, and the importance of daily documentation and escalation.

Becky Thomas, C3 Ward Manager



BEFORE



AFTER

BEFORE

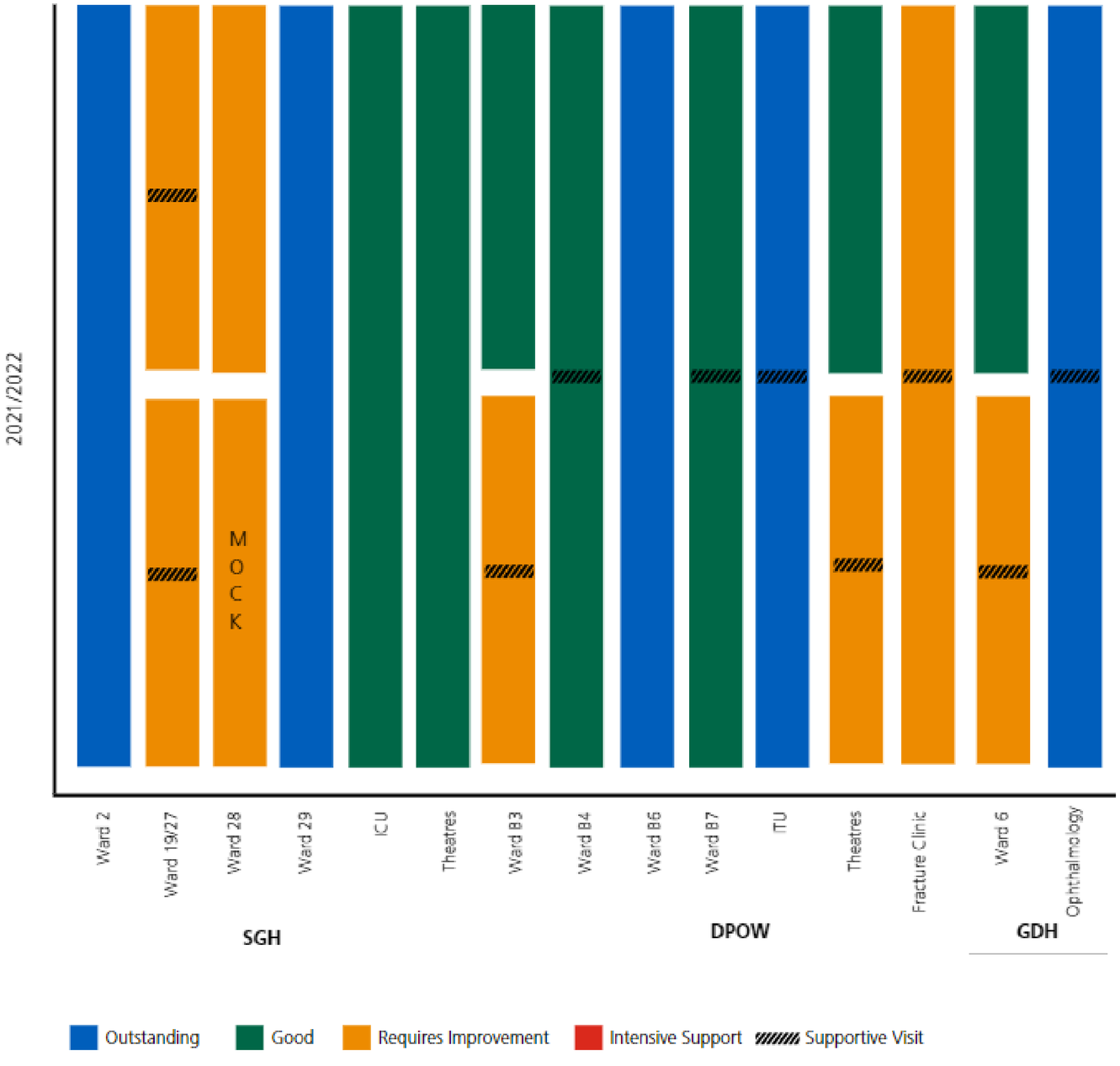
AFTER

The soft close bins purchased by the ward following the 15 steps feedback have improved patient experience by reducing the noise at night.

Jo Colson, HCA B3

Detailed scoring of each area breakdown by division

Surgery

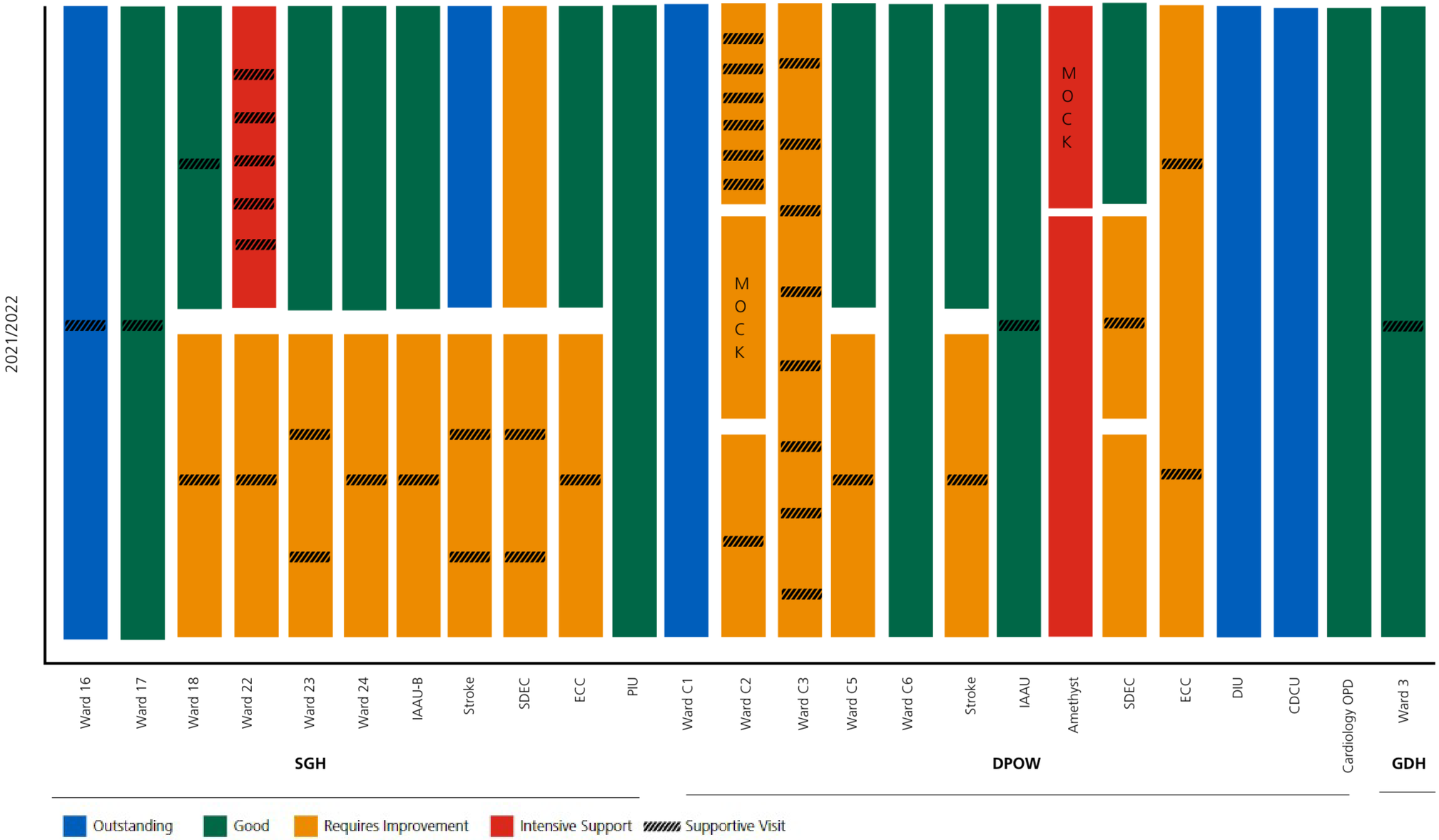


A mock visit was completed on ward 28 to provide a baseline for the newly appointed manager followed by an official visit and rating of requires improvement.

Ward 19/27 remained requires improvement through out their visits however there were lots of positive changes and significant improvements noted and this was recognised and fed back by the 15 Steps team at the time of the revisit.

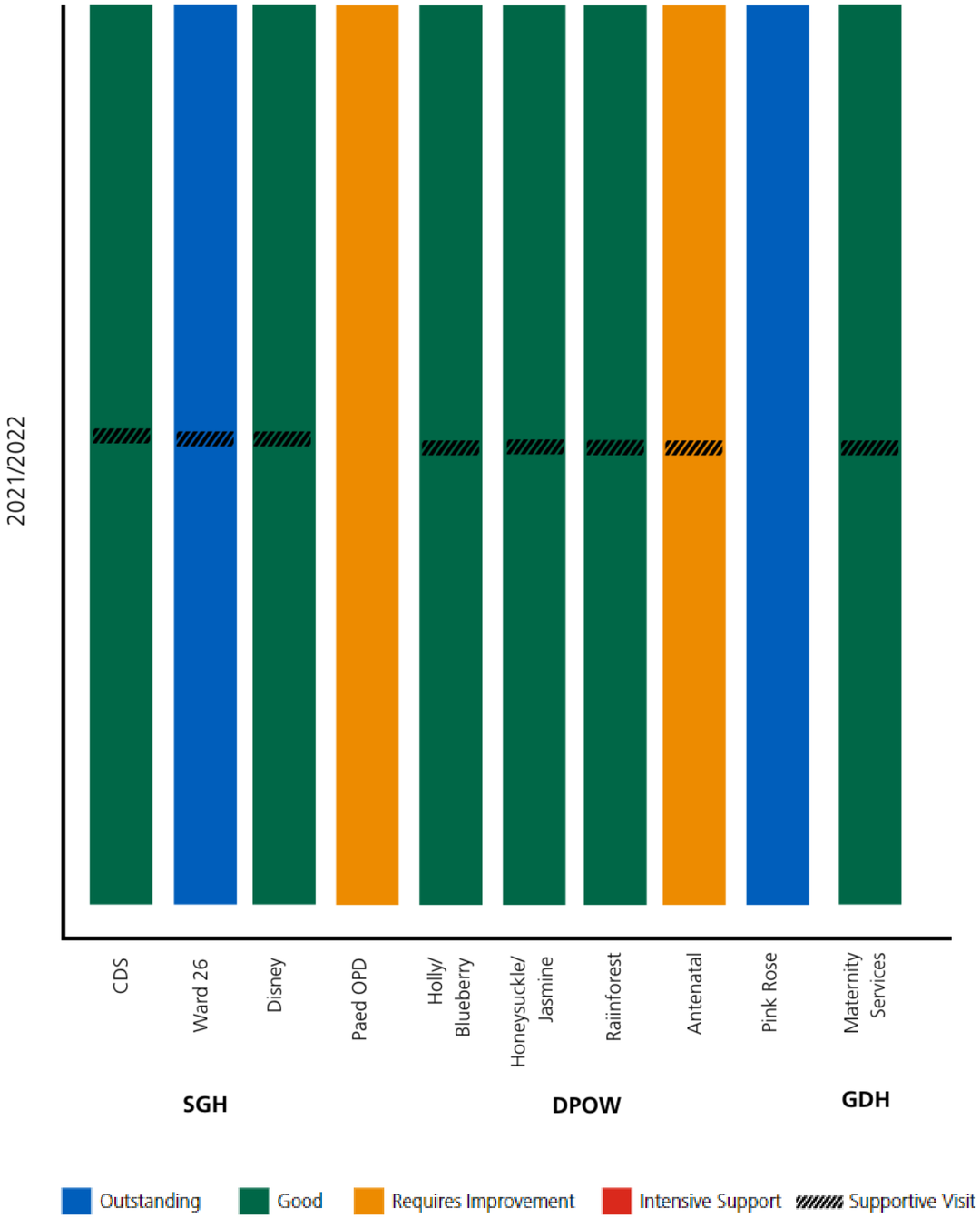
Ward 29, SGH

Medicine



Ward C2 have remained at requires improvement throughout 2021/22 however, supportive visits and regular updates to the improvement plan continue for this area to encourage positive change. Ward C3 recieved its first 15 Steps Challenge and was rated as requires improvement the team are currently working hard to improve professional standards in their area, their hard work is being recognised through supportive visits by the Lead Nurse for Assurance Project. Amethyst was visited in 2021 and required intensive support, since this rating the ward has seen the appointment of a new Ward Manager with significant improvements observed during a mock visit by the Quality Assurance team, an official visit will take place within 3 months. Ward 22 was rated as requiring intensive support and are currently working hard to complete actions within their improvement plan with support of their Matron and the Lead Nurse.

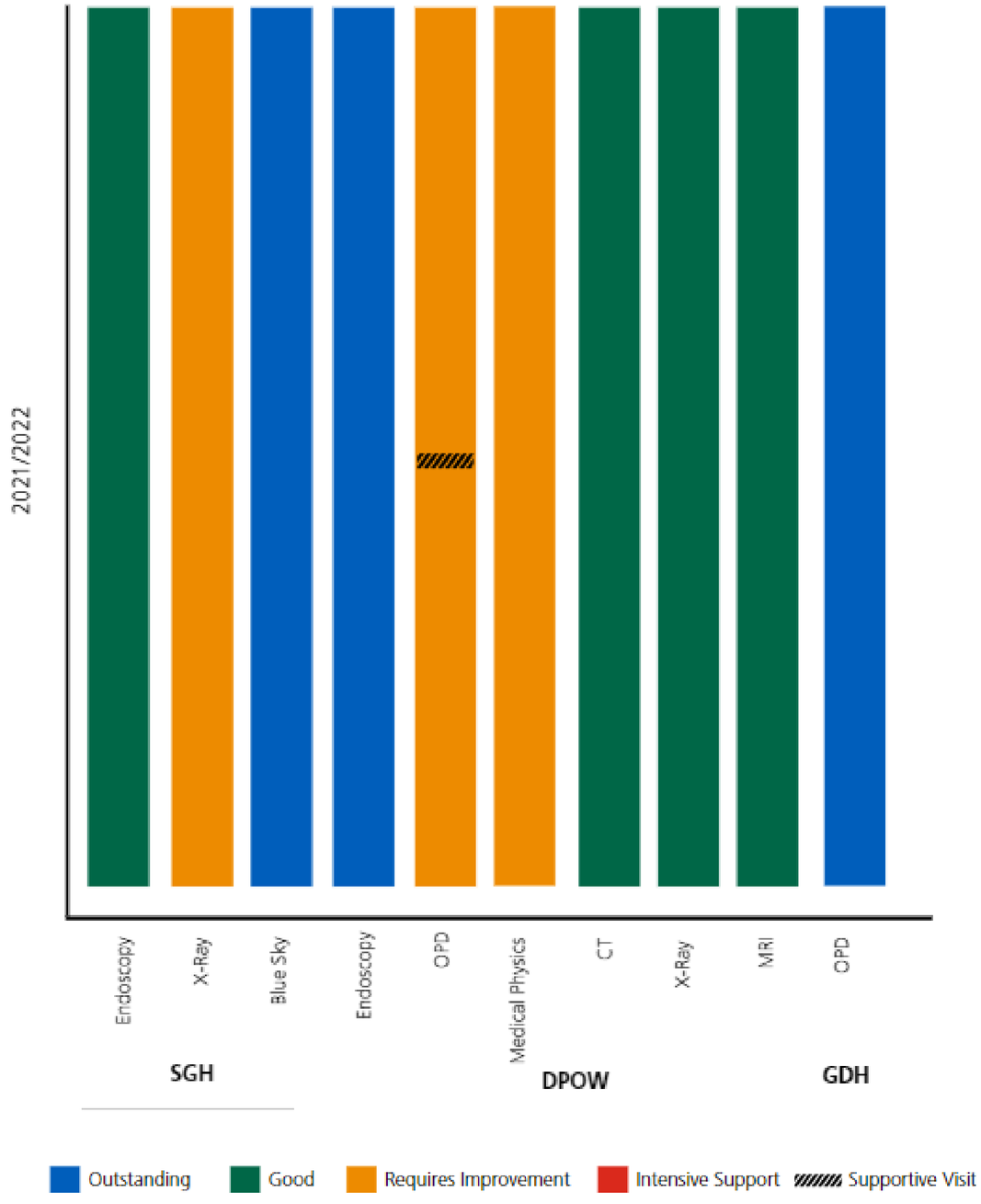
Women's and Children's



Paediatric outpatients at SGH and Antenatal at DPOW received their first 15 Steps Challenge visit in 2021/22 and whilst there were some areas for concern raised both Managers have been very responsive to the process and are keen to embed change.

NICU, SGH

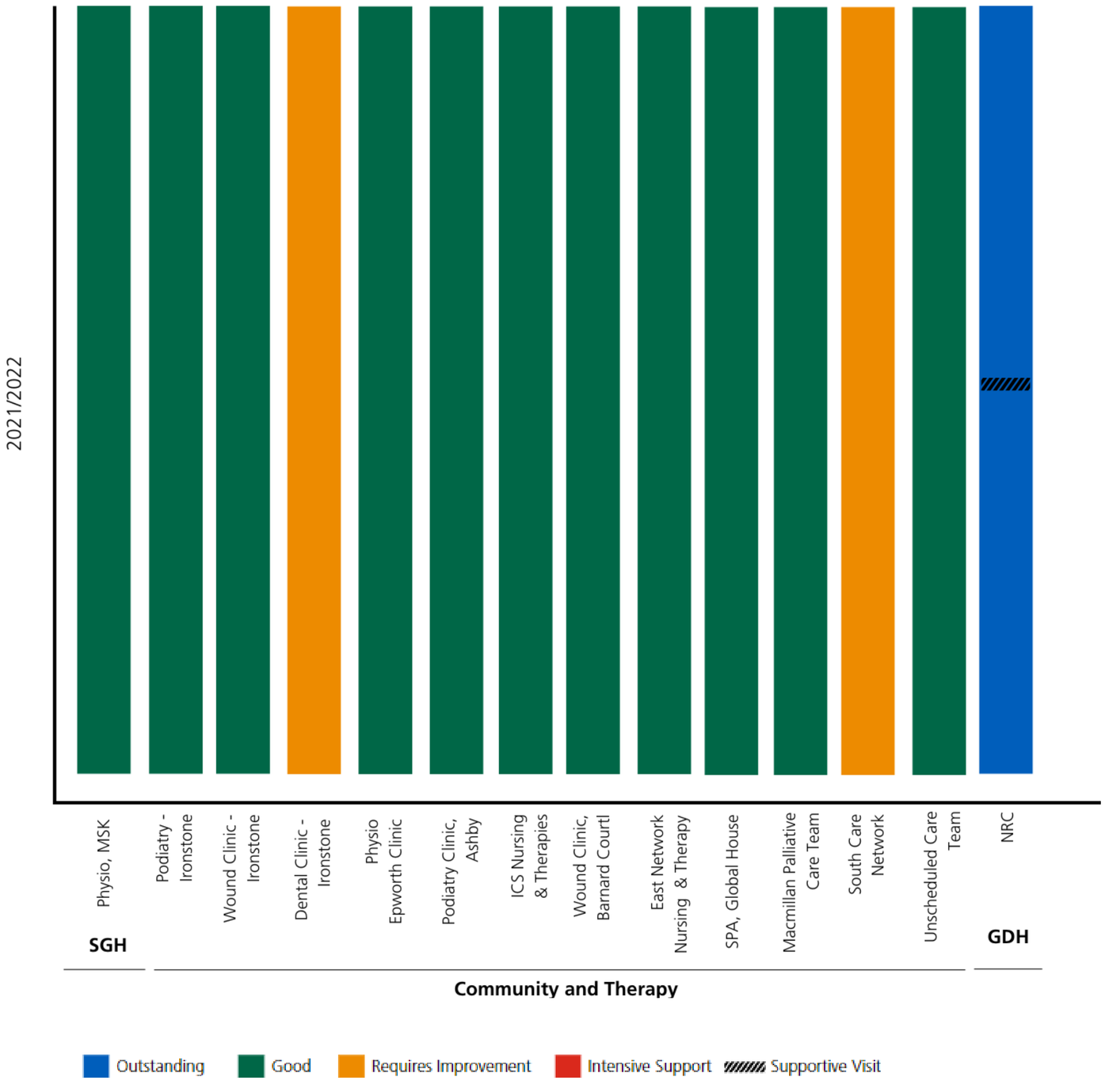
Clinical Support Services



During the 2021/2022 schedule new departments were visited for the first time, including areas within commercial services, these areas are really keen to improve their rating and have been proactive in developing their knowledge of the programme and the positive changes it will bring.

X-Ray, DPOW

Community and Therapy Services



Neurological Rehabilitation Centre (NRC) were visited as part of the acute schedule and achieved a rating of outstanding, with with a high standard of care being delivered to their patients. Only two areas were identified as requiring improvement in the community and both areas are working hard towards improving their rating.

Assurance, Themes & Actions

Within standard 1, 2 and 4 there are patient safety questions which are an important part of the rating process and highlighted bold in the toolkit. As listed below:

Standard	Question
1– Observations	Are staff washing their hands or using alcohol gel before and after patient contacted?
	All medications are securely stored. (e.g., drug cabinets, lockers are locked)
	No medications unattended or accessible.
	Controlled Drug Cupboard checks are maintained daily.
	Clean Utility/ Treatment room doors are locked.
	All medical records are stored securely and not left unattended and hidden from view when not in use.
	Patients on the ward today are wearing a wrist band with their name, D.O.B & NHS No.
2– Documentation	Are NEWS/ PEWS/ OEWS undertaken as per escalation? Is there clear evidence of escalation actions?
	Are fluid charts completed in an accurate and timely way?
	Are bowel charts completed in an accurate and timely way?
	Are food charts completed in an accurate and timely way?
	Are missed/ omitted/ refused doses accurately recorded?
4 - Staff Feedback	Staff have completed all their mandatory training.
	Staff have had Clinical Supervision.
	Staff have had a PADR in the last year.
	Staff can explain how to report incidents or allegations of abuse inside the Trust.

15 Steps Team feedback discussion

Themes and actions are monitored closely and reported through the monthly nursing assurance report. The report highlights the areas who received a visit and the ratings achieved within both the acute and the community and therapy schedule. It also identifies any cancelled and rescheduled visits. The themes and trends highlighted through 15 Steps, along with other methods and data sources such as the quality dashboards, ward assurance tools, insights, patient experience are triangulated and then where common concerns or themes are raised this information is shared amongst the senior teams at the trust nursing metrics to provide support and make improvements moving forward. Where wards/departments are highlighted as requiring intensive support during their 15 Steps visit and or the monthly data suggests a serious or specific risk to quality care being provided, the Chief Nurse will organise a quality summit. This will include key staff members coming together with specific focus on the findings from nursing metrics, agree appropriate actions and facilitate in supporting improvements where required.

Acute themes and actions

Northern Lincolnshire and Goole NHS Foundation Trust

Standard	Area for Consideration	Actions Taken
Standard 1 – Observation	• Quality Ward Board not complete	• New 'Time to Shine' boards in place throughout the trust • Information on what to display and how to get the information continues to be provided by the Project Support Officer
	• Documentation not securely stored, out of site	• New Notes trolleys ordered • Signs in place on trolleys to remind staff • New locks ordered where broken • Notes trolleys relocated • Managers communicated appropriate storage with staff in team communications
	• Poor Hand Hygiene between patient contact	• Increase in ward audits by Ward Managers • Peer review, challenge and audits encouraged on wards • Highlighted within team communications/meetings • Infection Control Team aware of areas of concern to continue monitoring closely • Included in Quality Times and community leadership slides
	• Lack of 'I am clean' tape on stored equipment Commodes Hoists Drip stands ECG Bladder scanner	• Ward Cleanliness standards shared across all areas • Posters made, laminated, and displayed within store rooms • Unique areas adapted the idea and now complete cleanliness checklists within their areas or 'I am clean' posters for bed/chair spaces to gain assurance on cleaning of equipment
Standard 2 – Documentation	• Fluid input and output not consistently recorded. Food charts not consistently recorded.	• Intentional Rounding training for clinical sisters • Intentional rounding training for individual wards • Education display boards completed on ward/departments • Individual ward training where needed on nutrition and hydration • Patient safety days planned throughout the trust • Stop & Check Safety Huddle rolled out to acute wards within medicine and surgery • Included in Quality times for information and at community leadership meeting
	• Bowels Charts not updated daily	• Education boards completed on ward/departments • Stop & Check Safety Huddle rolled out to acute wards within medicine and surgery • Intentional Rounding training for clinical sisters • Intentional rounding training for individual areas • Included in Quality times for information and at community leadership meeting
	• No evidence of EDD on WebV board	• Patient Care navigator taken on role of completing EDD
	• Patient Weights not recorded on EPMA	• Lead Nurse, Assurance Projects checked with EPMA who can add this detail and clarified to wards, nurses and Dr are responsible and able to add • Managers shared information in team communications and weight to be added to EPMA when MUST recorded and updated weekly
Standard 3 – Patient Feedback	• Wards were reported as noisy at night	• Introduction noise sound monitor to some areas to improve patient experience • Old bins replaced with soft close bins • Managers sent out reminders to staff to be aware of noise levels at night
	• Waiting times not communicated well to staff in outpatient areas	• Manager updated staff and introduced white boards with waiting times and escalated importance of keeping up to date • Manager hoping to start a QI project around the improvement of wait times and communication in their area • Included in Quality times for information
	• Call bells out of reach of patients	• Ward/departments have introduced daily checklists for bedsides or bays to gain assurance on bells being within reach of patients and patients being made aware of the bell
Standard 4 – Staff Feedback	• Poor compliance with clinical supervision	• Staff having supervision but unaware that this was clinical supervision – not always formally recorded • Lead Nurse, Assurance Projects gained oversight of team compliance and aware prior to visiting individual areas
	• Lack of awareness about Chief Nurse 'Future 5'	• 'Future 5' information cascaded to the wards/ departments and posters for displaying in staff rooms • Added to the Quality Times for information and discussed at Community Leadership Meeting
	• Lack of awareness about Red Flags and how to report these	• Red Flag poster printed and supplied to areas, information on the appropriate use of red flags cascaded to staff • Added to Quality Times for information • Managers utilised team communications to alert staff to red flags

Community & Therapy themes and actions

Standard	Area for Consideration	Actions Taken
Standard 1	• No COVID risk assessments displayed/updated	• Reminding staff of the importance of the risk assessments and the need to display these. This is undertaken through line manager, Divisional Blog, and newsletters
	• Untidy spaces and storerooms in some bases and inappropriate places used for storage	• To explore the root cause for the untidy spaces and ensure that storage areas are utilised appropriately. • Reaffirm to all staff the importance of keeping areas clean and tidy and share the themes through blog, newsletter, and forward conversation
	• Some information/notice boards out of date	• Notice boards to be updated and a plan for all areas how this will be maintained
	• No PALS posters or leaflets in some areas	• Posters and information obtained and put on walls/boards across the division
	• Not many signs, leaflets, or information in any of the main languages spoken in Scunthorpe apart from English in most clinic areas	• Exploration underway as to alternative language are required for the local population. Once received this will be reviewed and implemented as appropriate across the division in patient access areas.
	• Some very unclean and untidy offices	• Infection control champions to be given responsibility in area/team across the division to review, rectify and escalate any concerns
Standard 2	• NEWS2 score not assessed/documented in all records (been live since Nov 21) • AASKING tool use not evident in all records • MUST assessment not completed in all nursing records	• Ongoing education, training, and supportive conversation through teams to remind all staff of the importance to patient care to complete ▪ MUST ▪ NEWS2 ▪ AASKING
Standard 3	• Some issues with clinics having no reception staff so made it confusing for patients	• This is being reviewed to establish how clinics can be supported to reduce confusion for patients and captured within action plan
Standard 4	• Some staff don't feel supported by managers.	• Monthly team meetings held virtually due to spread of services across 4 sites. • Open door policy with several staff regularly contacting management team via phone/email/teams. • Ongoing engagement across the division with Divisional General Manager Blog, Forward Monthly conversation, newsletter. • To expand on this within the divisional workforce plan and ensuring staff engagement is embedded across our services in line with the trust people strategy
	• Staff reported not enough time to undertake mandatory/core specific training	• To review and support staff with time to undertake mandatory and core specific training across the division. • Ensure that this is structured into their working day.
	• Some staff were unaware of the senior management team names and roles	• Divisional Associate Chief operating officer weekly blog in place and forward conversation monthly supported by Quad. • To ensure staff are aware and time to attend is enabled. Continue to develop staff engagement in line with the Trust People Strategy. • Posters of SMT to be updated and available in all areas for staff information- work on-going with comms team to produce corporate posters

Case Studies

Case studies are undertaken for areas that have made significant improvements in their 15 Steps Challenge Rating.

Stroke Unit, SGH Requires Improvement (September 2021) - Outstanding (April 2022)

Stroke Unit SGH received a rating of Requires Improvement following their visit in September 2021, the feedback was shared with the Ward Manager and their team and an improvement plan was completed in preparation for the re-visit in six months. There was a short delay in revisiting the area due to a covid-19 outbreak, however in the interim an additional supportive visit was completed to gain further assurance.

Requires Improvement (September 2021)

Areas for consideration/ action - Standard 1:

- The resuscitation trolley was not checked daily – 10 daily checks missing over a 3-month period
- Staff breaks were taken during mealtime service, tables were not cleared, and patients were not prepared prior to the meal time service commencing
- **Hand hygiene was inconsistent and often missed after patient contact**
- **The clean utility door was unlocked, and medications were left outside the locked cupboards in the clean utility room**
- **X3 Agency staff sharing x1 Abloy Key**
- **Fridge temperatures checks were missed**
- **Medical records were not stored securely (several sets of current admission notes left on view at the Nurse's station)**

Areas for consideration/ action - Standard 2:

- Lacked any clear documentation re family/ relative communication within the notes
- **Documentation not securely stored (standard 1)**
- **Unable to identify if food chart required -no documentation but not required incomplete**

Areas for consideration/ action - Standard 3:

1x patient didn't get any food when admitted (late PM) – patient made staff aware and asked staff on several occasions and still not provided

Areas for consideration/Action - Standard 4:

Unaware of divisional structure above matron

During the six months, the Stroke Unit were involved in the quality improvement project 'safe and secure medicines' to help support the ward to action changes within their management of medications. Support was also provided by the Lead Nurse for Assurance Projects and the Project Support Officer, who revisited the area in February 2022 with the improvement plan to update any actions complete and identify where further support and action may be needed. During the supportive visit it was clear that many positive changes had been made on the ward, however, some areas for further improvement were identified and fed back to the Ward Manager for action, an additional supportive visit was then carried out in March 2022 where further assurance was gained.

The 15 Steps Team then returned to complete a revisit in April 2022, this visit was very positive with minor areas for consideration noted, all the bold patient safety questions were met.

Outstanding (April 2022)

Positive elements - Standard 1:

- Commodes clean with 'I am clean' tape in place
- **Good evidence of hand hygiene throughout the visit**
- 'I am clean' tape on equipment, cleaned daily, noted very clean
- Excellent mealtime service – protective lids removed from meals, tables cleared and prepared, patients assisted to eat
- Resus checks all complete
- **ID Bands checked and correct**
- **Drs and nursing documentation securely stored**
- **Medications securely stored, in date, CD checks completed, clean utility door closed and room tidy**

Positive elements - Standard 2:

- **Food charts well completed**
- **Bowel charts well completed**
- **Fluid charts well completed note balance not always recorded but could be worked out from detail**
- **All omissions and allergies were completed on EPMA**

Positive elements Standard 3:

- Patients felt well cared for, treated with kindness and compassion
- Patient felt staff were approachable, and would feel comfortable in asking questions at anytime

Positive elements Standard 4:

- All staff were aware of their roles and responsibilities and displayed teamwork
- **All staff asked were up to date with mandatory training and PADRs**
- Supported in role by management, Line manager approachable and supportive, fed back complaints and compliments
- **Aware of how to report incidents - Ulysses**
- Nursing staff aware of red flags
- Sound knowledge of My Life and making reasonable adjustments for the management and care of vulnerable patients

Overall Perception

The environment was in a good state of repair, bright calm and clean with good processes in place and maintained to provide safe patient care. Patients were treated with kindness and compassion, the team witnessed lots of positive, empathetic interactions between staff and patients, they would be assured if their loved one were to be care for on the Stroke Unit. The team witnessed excellent teamwork amongst the staff and MDT. The documentation was of a high standard and consistently completed throughout. Overall the whole team felt that the area deserved a rating of Outstanding and were very impressed with the standard of care provided to patients on the ward.

I felt immense pride that from going to requires improvement to outstanding within 6 months. Amazing achievement! Working together we are continuously improving the high standards of care to patients. Also working together as a team is bringing us closer together.

Jannette Bourke, Ward Manager

Same Day Emergency Care (SDEC), DPOW Requires Improvement (November 2021) - Good (May 2022)

SDEC DPOW received at rating of Requires improvement for the second time in November 2021, 2 supportive visits were completed and one of these included a walk through the area with the New Ward Manager, the improvement plan was updated and any further actions discussed. The ward was revisited by members some of the original team members, based on availability and some new team members in April 2022 where they received a rating of Good with significant with significant improvement noted.

Requires Improvement (November 2021)

Areas for consideration/ action - Standard 1:

- Staff adhering to PPE but shift lead frequently pulling mask down to use telephone
- Dusty equipment in treatment room, lack of dates and signature on 'I am clean tape'
- Medication Storage – very chaotic and unorganised, unsure how stock can be safely rotated
- ID bands bands not necessary where patient has capacity – no patients required
- X2 items missing from resus trolley
- **Poor hand Hygiene**
- **Patients had no ID bands (medication provided x1 & transported to Xray x1)**

Standard 2 – not reviewed in this area

Areas for consideration/ action – standard 3:

- SDEC unaware of x2 arrivals this morning – patients reported a poor patient experience

Areas for consideration/Action – standard 4:

- Nurse unaware of future 5 & beyond
- Nurse unsure of what happens with patient feedback
- Nurse unaware of flushing policy and why this is completed

Good (May 2022)

Positive elements - Standard 1:

- Treatment room was locked, cupboard locked, well organised (labelled), expiry dates in date
- **Good evidence of hand hygiene**
- **Documentation securely stored**
- **All patients had ID bands insitu**
- Department bright, uncluttered, and welcoming
- Good evidence of cleaning equipment between use
- Good interactions between staff and patients/ staff and staff
- Resus trolley checked daily and secure

Positive elements – Standard 3:

- All patients said staff introduced themselves
- All patients were offered drinks, patients over lunch were offered sandwiches
- All patients were aware why they was here and felt involved in their care
- All felt things were explained to them
- Felt staff were approachable and able to ask questions
- Overall a very positive experience – confident with treatment received

Good (May 2022) continued...

Positive elements - Standard 4:

- Morale has boosted since new manager in post, staff feel like they are listened too and actions are actioned timely
- Aware of roles and responsibilities
- Felt department is compliant with hand hygiene/ bare below elbows
- **PADRs up to date and Mandatory training compliance good**
- **RN aware of clinical supervision**
- **X1 aware how to report incidents**
- Aware of how to access interpreters
- Aware of future 5
- RN and HCA aware of my life

Areas for consideration/ Action across all 4 standards included:

- Medicines management highlighted department don't use blue sharps bins for disposing medication and should order these
- Issues found with sluice and taking ownership of this for cleaning and storage as this is a shared room and no one appears to take responsibility
- Fan in frailty bay and thermometer in bay out of date for PAT testing
- No I am clean tape on any equipment - note equipment was clean
- Team huddle board updated last month (out of date), time to shine board partially completed
- No red flag poster on display
- No sign in/ out sheet for abloy keys

Being able to review the improvement plan while on the ward with the 15 steps lead was really helpful and helped us to achieve a good rating on our revisit

Sarah Smith, Ward Manager

<u>Overall Perception</u>

The revisit to SDEC was very positive, the team were welcomed onto the department by all of the staff. The Ward Sister then provided the team with a tour of the department. The 15 Steps team recognised lots of improvements had been made following the previous visits in August and November 2021. Patient and staff feedback were outstanding with no areas of consideration identified. There were a minor area of concern highlighted in standard 1 that the team can work towards improving prior to their next visit.

The overall rating achieved was good, the team were very proud and keen to maintain and even improve on this rating in the future.

Education & Training

To raise the profile of the 15 Steps Challenge the ‘Quality Times’ has been devised; it is produced monthly and circulated to clinical teams. It is an opportunity to feedback directly to the wards and departments within the trust. It is used as a tool to communicate themes for learning, to provide insight into the process; toolkits, ratings, and supportive visits and to provide support in completing improvement plans highlighting available resources to assist with actions and has been well received by all.

The toolkits are shared and have more recently been used within some areas visited to gain assurance within their individual areas and to help maintain their professional standards and achievements.

Outpatient areas have featured heavily in the 2021/2022 schedule and the programme has been welcomed by many of those areas, reaching out for advice and information so they can involve staff and pre-empt improvements within their areas.

15 Steps training continues throughout the schedule, new team members are welcomed. Training sessions are made available to ensure everyone undertaking the visits are fully aware of the process and confident in their role within the team.


THE QUALITY TIMES

Bringing you all the information on The 15 Steps Challenge

Celebrating Success!

Themes from July

THE QUALITY TIMES

Bringing you all the information on the 15 Steps Challen

UNIFORM

The Future 5 & Beyond

CONTACTS

FEBRUARY 2022 VISITS

THE QUALITY TIMES

OUR TIME TO SHINE

WORKING TOWARDS EXCELLENCE

GOOD & OUTSTANDING ACHIEVEMENTS

Recognition of our high achieving areas

The Chief Nurse is always keen to celebrate with the areas that achieve outstanding and good, by personally visiting areas to congratulate staff and present them with their certificates. The Chief Nurse also recognises those areas that may not have improved their rating however have made significant improvements in their area and are working hard to improve their rating on future visits.

As a Trust, there are several ways in which we celebrate success and achievements:

- The new ‘time to shine’ boards have a designated area for the 15 Steps Challenge certificates to be displayed for visitors to see, areas are also encouraged to share their success within their own ‘time to shine’ folders.
- Each area receives an A3 certificate to display on the ward/ department and several A4 certificates for this purpose.
- Pictures of ward/ department areas receiving their certificates are shared on NLAG social media channels to share achievements and promote the success widely
- The Quality Times newsletter highlights areas on a monthly occasion who have achieved outstanding or good in the 15 Steps Challenge

Celebrating Star Accredited Wards/Departments

As part of the Nursing, Midwifery and AHP Strategy star accreditation awards will be considered where areas have achieved outstanding and maintained this rating over three consecutive visits. The next schedule is likely to see the first wards/departments to achieve three outstanding's; this achievement alongside the wards metrics dashboard will be the consideration for achieving excellence which as a trust we are keen to recognise and celebrate!

Priorities 2022/23

The 15 Steps Programme continues to be well received by the clinical teams, giving us valuable insight and assurances of how our areas are preforming and where improvements can be made so that we are able to continue to embed and raise our professional standards. The 15 Steps Programme allows for common themes to be raised and shared to support continuous improvement within the organisation.

Some of the key priorities throughout the next cycle will include working closely with our colleagues in the quality improvement (QI) and patient experience teams to focus on patient centred care, highlighting concerns that may benefit from a QI project and supporting in identifying themes within the 15 Steps toolkit, standard 3 patient feedback, so that this data can be triangulated, assurance gained or areas for consideration flagged and actioned.

Continuing to build on professional standards with the introduction of the star accreditation programme will be a priority throughout the next year. Raising the profile of those areas that have achieved outstanding and maintained this rating over 3 consistent visits. The next schedule is likely to see the first wards to achieve three consecutive outstanding ratings, this achievement alongside metrics data will be the consideration for achieving star accreditation which as a trust we are keen to recognise and celebrate!

Following the introduction of supportive visits during the last schedule it is important that this becomes a firmly embedded process that assists in producing improvement plans that support in building professional standards and providing harm free care by utilising tools such as the ‘stop & check', the ward assurance tools and intentional rounding. A key part of making the improvement plans a success will be working collaboratively to bring divisional oversight and ownership, supporting actions and making positive change.

We will continue work to develop and review the 15 Steps Challenge annually ensuring the programme remains a robust and effective process, that supports continuous improvement and development within the organisation.

Appendix A - Acute Toolkit Review

During the initial roll out of the 15 Steps Challenge it was agreed to review the assessment tool annually. The toolkits were previously reviewed prior to the 2021 schedule commencing in June, following on from that review further minor amendments have been suggested from members of our 15 steps team. These team members have included the Non – executive Directors, Trust Governors, Estates & Facilities colleagues and also some of the Senior Nursing & AHP staff within the trust. Feedback is always welcomed as part of the 15 steps process and where appropriate actioned.

Considering the feedback from 15 steps team members we have made the following minor alterations and additions to the toolkit for the next schedule; to commence once all areas have been visited, ensuring the process remains fair and consistent.

Some of the feedback actioned within the tool:

Standard 1 - Observation

- Fridge checks complete' after liaising with medicines management team the temperature is now recorded centrally via electronic tag
- 'Time to Shine' boards have been rolled out across the trust and therefore replaced the previous quality board question
- Team Huddle board completion has been added
- Appropriate locking of mobile computers that are a new addition to the ward to protect confidentiality
- Further descriptive detail added where required to explain to the team what is being referred to be the question
- Observation of telephones being answered timely – communication

Standard 2 - Documentation

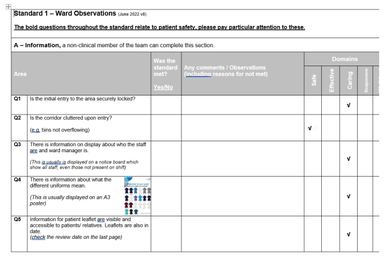
- Where appropriate, analgesia is offered and effectiveness reviewed? (Pain Chart)
- Are any special dietary requirements considered and addressed

Standard 3 - Patient Feedback

- Questions re-worded to help patients be specific in their answers

Standard 4 - Staff Feedback

- Open ended questions 'can you explain' rather than 'do you know'
- Are staff aware of how to access 'Staff Wellbeing services'
- Ulysses replaced datix in the question of reporting incidents

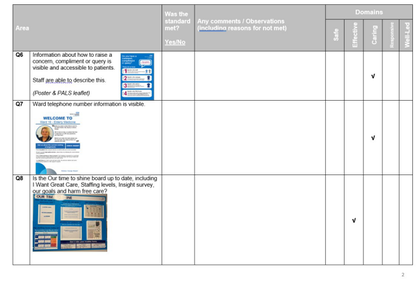


Standard 1 – Ward Observations (June 2022 v6)

The bold questions throughout the standard relate to patient safety, please pay particular attention to these.

A – Information, a non-clinical member of the team can complete this section.

Area		Was the standard met? Yes/No	Any comments / Observations (excluding reasons for not met)	Domains				
				Safe	Effective	Caring	Responsive	Well Led
Q1	Is the initial entry to the area securely locked?					√		
Q2	Is the corridor cluttered upon entry? (e.g. bins not overflowing)			√				
Q3	There is information on display about who the staff are and ward manager is. (This is usually displayed on a notice board which show all staff, even those not present on shift)					√		
Q4	There is information about what the different uniforms mean. (This is usually displayed on an A3 poster)					√		
Q5	Information for patient leaflet are visible and accessible to patients/ relatives. Leaflets are also in date. (check the review date on the last page)					√		



Area		Was the standard met? Yes/No	Any comments / Observations (excluding reasons for not met)	Domains				
				Safe	Effective	Caring	Responsive	Well Led
Q6	Information about how to raise a concern, compliment or query is visible and accessible to patients. Staff are able to describe this. (Poster & PALS leaflet)					√		
Q7	Ward telephone number information is visible.					√		
Q8	Is the Our time to shine board up to date, including I Want Great Care, Staffing levels, Insight survey, our goals and harm free care?				√			

Certain team members also fed back Standard 1 does not flow well and therefore to try to resolve this, the order of some points have been reviewed. Observations that should be ongoing throughout the visit such as hand washing, timely answering of call bells, staff and patient interaction have beenplaced at the beginning of the standard with the hope of making standard 1 easier to follow and more timely. Standard 3 & 4 has also been revised to flow better placing questions together that relate to similar themes.

There had been some questions raised from the more unique areas within the trust of whether the tool kit could be adjusted to relate more specifically to their individual departments. These areas include ECC and Theatres. Feedback from the senior team within these areas has been welcomed and will be considered at the next annual review.

Members of the senior nurse team have also identified that Standard 4 captures only those patients with a voice and that the more vulnerable patients are not always considered. It was suggested that a phone call to a vulnerable patient's next of kin be made during the patient feedback standard to ask a few simple questions about their family members care. This will also be considered in the full annual review.

NLG(22)188

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	04 October 2022	
Director Lead	Michael Whitworth, Non-Executive Director and Chair of Workforce Committee	
Contact Officer/Author	Michael Whitworth, Non-Executive Director and Chair of Workforce Committee	
Title of the Report	**Workforce Committee Minutes - July 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	The Workforce Committee Minutes from the meeting held on Tuesday, 19 July 2022, and approved at its meeting on Tuesday, 20 September 2022, are for information.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Workforce Committee
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
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1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday, 19 July 2022 at 14:00 hours via Microsoft Teams

Present:

Fiona Osborne	Associate Non-Executive Director (Chair)
Christine Brereton	Director of People
Maneesh Singh	Associate Non-executive Director

In Attendance:

Abolfazl Abdi	Deputy Chief Operating Officer
Nico Batinica	Associate Director for Workforce Systems and Recruitment
Paul Bunyan	Associate Director of Workforce Operations
Alison Dubbins	Associate Director of Leadership, Culture and OD
Helen Harris	Director of Corporate Governance
Diane Hughes	Associate Director, Special Projects
Robert Pickersgill	Governor, Membership Office
Liz Houchin	Freedom to Speak Up (FTSU) Guardian (agenda item 6)
Karl Portz	Equality, Diversity & Inclusion Lead (agenda items 7 and 8)
Jennifer Moverley	Head of Compliance and Assurance (agenda item 10)
Kate Wood	Medical Director (agenda item 11)
Dave Sprawka	Head of Recruitment and Employment Services (agenda item 13)
Wendy Stokes	Executive Personal Assistant to Director of People (taking minutes)

1 Apologies for absence

Apologies were received from Michael Whitworth, Michael Proctor, Peter Reading, Jenny Hinchliffe and Gillian Ponder

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 meeting held on Tuesday, 31 May 2022

The minutes from the previous meeting held on Tuesday, 31 May 2022 were accepted as a true and accurate record.

4 Matters arising from the previous minutes

Robert Pickersgill asked about the frequency of the Schwartz rounds, he felt they should be held every two weeks and at least monthly. Alison Dubbins reported that Cate Neal, Business Partner – Health and Wellbeing is leading on the Schwartz rounds and funding has been received from NHSE/I to support that. The initial scoping meeting has taken place with those staff that want training and questions were raised around rigor and robustness of the service provided, fitness of purpose and frequency. Cate is preparing a summary of the meeting for Christine and Alison and the frequency will be based on the needs of the service. This will become part of normal business and what the trust does. Alison added that for agile responses to incidents there is critical incident risk management and for the deeper dives they are bringing in Schwartz rounds which is part of the Health and Wellbeing (HWB) two-year plan and reported through HWB progress reporting. A progress report on Health and Wellbeing will be brought to the Committee as part of focus/deep dive and an update on this will be provided.

4.1 Review of action log

Action 96 - Medical Education Report - add 'Update on Progress Made' to the agenda for the July meeting
Christine Brereton to speak to Kate Wood regarding a half page update to be presented at the November 2022 meeting.
Action: Christine Brereton

Action 97 - NHS People Plan - share the slide detailing the four areas of work
Christine Brereton had done an update on one page and she agreed to circulate that.
Action: Christine Brereton

Action 98 - BAF - Look at Strategic Risk and make a recommendation to Trust Board
To be discussed as part of the agenda.

Action 99 - Recruitment KPI - circulate to committee
The Recruitment KPI was circulated on 31 May 2022. It was agreed to remove this item from the action log.

5 People Strategy Focus - Leadership Strategy Update

Christine Brereton and Alison Dubbins provided an update via a presentation and the following was noted:

Strand 1 – Foundations in Leadership

- Foundations in Leadership will launch an induction plan for new People leaders and a leadership individual development analysis will also be launched in September/October, the Chair asked if that would impact on the people directorates time and whether any leadership support from Execs, senior teams or any other individuals was required. Christine was very mindful of the risks and resources available and highlighted that a lot of the groundwork had already been done with the launch of the Culture Transformation Board (CTB) and Culture Transformation Working Group (CTWG). Alison also has an external facilitator to support the team from October.
- Christine Brereton noted that engagement has taken place with the operations teams and with the pressures on the trust, no time is a good time to launch something new but both Shaun Stacey and Abolfazl Abdi are very supportive, and Alison will engage and work closely with Abdi and his teams.

- Maneesh Singh felt putting lots of things into the workforce at the same time often results in things being diluted. Alison provided assurance, lots of consideration has been given to scoping and planning, and NLaG is no different to any other trust.
- The online assessment for the leader individual development analysis will take an average of 45 minutes to complete for existing leaders. Development/training to fill the core skills gaps identified from the development analysis can then be spread out over a period of 18 months. It is much more manageable for new starters and will include a People leader induction in September.

Strand 2 – Professional Leadership Development

- The Portfolio Boards to oversee all professional leadership (as well as all core skills training) will be set up by November 2022.

Strand 3 – Values Based Leadership

- The design and scope for the VBL programme has been completed. This will contain a number of modules. The programme delivery will start with the senior teams and then the focus will be on the operations teams to deliver that based around the requirements of the organisation.

Regarding the amount of work involved and the impact on the OD team, Christine stressed that the work had been scoped out within the available resources of the team and the impact on service delivery. Alison Dubbins confirmed that £150k had been secured from the business planning round to assist with the delivery of the Leadership Development Programme.

Robert Pickersgill asked if the committee could have more detail around how the £150k was distributed and how the spend was being analysed, and why only this amount had been secured for Leadership Development. Christine Brereton explained that a business case had been submitted and this had had been considered amongst other priorities of the Trust and had been agreed by the Executive Team. The Chair commented that the Finance and Performance Committee had oversight of the annual business planning and spend.

Robert Pickersgill commented that he would like to see further information on Leadership Development, and it was agreed that he would discuss with Michael Whitworth what information may be useful to report through the Committee moving forward. It was noted that a detailed report/strategy had already been submitted to the Board in May 2022 and that the purpose of the updates through the Committee are to provide updates on the three-strand model, which the presentation aimed to do.

6 Freedom to Speak Up Guardian Update - Quarter 1 Report

Liz Houchin presented the Freedom to Speak Up Quarter 1 highlights from the report that was available on SharePoint. There were 35 concerns raised, and 3 anonymous, that Liz responded to by putting a generalized outcome onto her hub page. Main themes are behaviours, patient safety and process. The trust is in the lowest quartile for bullying and harassment concerns. There is a new national policy being released in September and the trust has until January 2024 to show that has been incorporated including all FTSU Guardians taking a competency test annually. Liz submitted a 100 voices case study and the National Guardians Office have agreed to put that in their annual report that goes to Parliament this week.

Maneesh Singh asked what the patient safety issues were, and Liz replied staffing levels, getting answers about the acuity of patients, and moving staff around to ensure the care for patients is safe and effective. Staff were raising concerns that they couldn't devote the quality of care they wanted to deliver. Concerns are looked at case by case and Liz goes back and provides the detail and lessons learnt. Maneesh Singh asked if there was any way that nurse movement could be made less stressful for staff and to give them an awareness of the environment and who they will be working with. Abdi replied that everyone is committed to reducing the number of transfers and an obvious factor that can help recruitment is to have a plan for new international recruitment, to give a more positive impact. There are vacancies, staff sickness, staff isolating, and bank staff but patient safety must be observed. A good caliber of doctors has been secured and that will help deal with the acuity of patients. Diane Hughes added the nursing directorate is working hard with nurses to make people feel welcome and staff are being asked 'how do you welcome staff onto the ward' because that can make a big difference. Staff should have an induction and AHPs are on rotation from when they first start with the trust. The trust needs to make decisions to keep staff safe and they need to understand people's skills set and what staff can do, rather than focusing on what they cannot do. Christine Brereton stated that some work has already been done on frailty and there have been some walk arounds where concerns about moving around wards have already been raised by staff. It was noted that this particular area of concern had been raised with Peter Reading, so he was aware of the situation and that it had been appropriately responded to, accepting that this was challenging for staff.

7 Workforce Race Equality Standards (WRES) Annual Report

Karl Portz reported WRES was introduced from the NHS Equality and Diversity Council and forms part of the standard NHS Contract. It is the Trusts contractual responsibility to deliver that and there has been some improvement in certain areas but still lots to do. The Trust Equality and Diversity Strategy and Equality Objective are in place and the two-year action plan is under development which will set out the trusts commitment to actions required to redress disparity, progress, timescales and supporting evidence. The trust is engaging face-to-face with different staff groups and holding two events in the canteen each month. A total of 800 conversations have taken place with staff form all equality groups to understand their needs and build them into actions going forward. Karl works closely with and supports the Trust's Freedom to Speak Up Guardian. A total of 80% of all trust staff are women and this was celebrated on International Women's Day on 08 March. On Saturday 23 July they are supporting the local Grimsby Pride Event, which is the first one held for a very long time. They are working with recruitment making sure recruitment panels are trained and are aware of unconscious bias. The culture transformation programme also links in with staff equality networks. There have been some challenges, but there are now 80 BAME staff members, including 40 disabled, in equality groups and the trust is giving them a voice and understanding their needs. The trust is one of the largest employers in the area and it has launched Project Search, working with Jug Johal's team, to give support to young adults with learning disabilities. Interns are being interviewed on Friday and will start at the trust in September for one year and it is hoped to give jobs to some of them.

Christine Brereton stated that the Trust knows, through WRES and WDES, that there are concerns about behaviours and culture in the organisation which unfortunately negatively impact on BAME and disabled staff, as demonstrated through the WRES/WDES data. The Trust is about to launch the Clever Together platform to engage with staff. There has got to be a specific focus on BAME staff and there are some pilots taking place with international nurses to find out why people behave the way they do. A member of the network group will also join the Culture Transformation Working Group (CTWG).

Abdi stated that the trust needs defined strategies to proactively approach international staff, either bi-monthly or quarterly, for them to give feedback. It will take them time, probably years, to understand things. Christine Brereton stated that Peter Reading and herself had discussed a forum for international nurses and them having a voice in the working groups as well. Through the welcome induction, focus care camps and signposting for international nurses that will allow people to reach out and make connections and friends.

Maneesh Singh felt that any member of staff from any background wants to be valued and respected. Social media engagement is great, and he asked if there is real engagement of around 10% of staff, will that make any difference to them having a voice. He would like to see more detail on how that is achieved, how that makes it better and what the trust is doing in the short term. He is looking for a list of actions that can make a difference, just go, and talk to staff, find out what is causing their problems and address their issues in various departments.

Christine replied that the Board have signed up to and committed to the culture transformation programme of work and it will take a long time to turn the culture of the organisation round. Christine heard Maneesh's frustration, things are not improving as the trust would like, that cannot be done in one year, and the trust needs to determine what information goes through the Workforce Committee. Christine agreed about speaking to minority groups, they don't want to be a separate group, and that is what the Clever Together platform will do. The platform launches in August and the trust will get the report end of September/October and will have some tangible things it can do to make staff feel more valued. For the first year, the focus is on culture improvement. Christine asked the committee to work with her and her team and to trust the process that NLaG has signed up to. Alison added they have been working with corporate nursing colleagues around conscious and non-conscious thinking. Firstly, the trust needs to educate with the culture pilot; secondly, present the principles and thirdly the practical application of that with senior advocacy and role modelling, people do not role model what we would like to see in the organisation.

8 Workforce Disability Equality Standards (WDES)

The Chair felt that the statistics don't make good reading as the trust still has a long way to go before achieving WDES however, the OD team are doing themselves a disservice in the commentary as there has been significant improvement. The disability equality paper is an example of that, in metric 1 it states 'a slight increase in disabled staff numbers' however, when you look at the numbers it is up by 17% from previous years, that is an improvement, not a slight increase. Regarding medical staff, work is ongoing, but that is not represented in the report. Christine added the narrative can be reviewed but it is only the data that can be published, not the narrative.

9 BAF 2022-23, Quarter 1 Report

Concerns were raised that the report did not adequately represent the current position, risks and mitigation and would benefit from an update. It would also be useful to consider the current climate with regards to salaries and cost of living etc.

Christine Brereton agreed as the responsible Executive to update the BAF to better reflect the current position.

A discussion also took place on whose responsibility it was to review the BAF score, and it was agreed to confirm this outside of the meeting. Christine Brereton to discuss with Helen Harris.
Action: Christine Brereton and Helen Harris

10 CQC Update

Jennifer Moverley reported that two actions have improved from amber to green: sufficient staff with the right qualifications, skills and training in Community and Therapies and the Trust must develop a clinical and financial strategy that addresses the delivery of safe and sustainable services. Mandatory training and appraisal data is now being obtained from the Power BI Dashboards. The CQC inspection took place from 28 to 30 June across all sites, with the well-led element planned for 26 to 28 July.

There are 7 amber actions, 1 to highlight: maternity emergency training for anaesthetic staff. All staff were trained at the same time and dropped out of compliance together. Divisions are working collaboratively, and it is expected to improve the percentage in the next two months.

11 Medical Revalidation Report

Kate Wood stated the report is a national requirement to be considered at Workforce Committee to recommend to the Trust Board for CEO to sign the 'Statement of Compliance' at the end of the report confirming the organisation is compliant with the RO regulations. The report provides oversight of medical staff appraisals for the last year. Maneesh Singh felt this is an excellent report, very through and nothing to ask, he would certainly recommend the report to Trust Board.

Kate Wood clarified that under NHS indemnity CNST all NHS work is covered under that indemnity. It is recommended that people have additional indemnity for those who work outside of NLAG and by law doctors would make sure that they are covered.

Kate discussed the process for medical appraisals and data, and updated the committee that further work was underway in her team to validate and improve the data to support the process.

12 Workforce IPR Performance Report - Trust and Directorate

Nico Batinica reported a sharp increase in registered nursing vacancies at 13.7% from March to May due to an increase of 6.38% in substantive establishment from April 2022. There are recruitment plans, the team is working with divisions, and this will be included as part of the recruitment KPI.

Unregistered nursing showed a sharp increase at 18.6% with 9.49% being due to the increase in substantive establishment. There is lots of recruitment events taking place during August and September and it is expected that new staff should start between October 2022 and March 2023. Deep dives have taken place around staffing levels, culture and career development and recruitment is working closely with Alison Dubbins and the OD team.

Regarding nursing vacancies, the Chair asked with the three-stage approach, stopping increases, detailing with leveling and reducing vacancy levels what trajectory would achieve that and when will people start in post. Nico Batinica stated that they are still working with divisions but there will be 120 international nurses up to March and 80 newly qualified nurses coming in. There are approximately 70 vacancies outstanding and there is a dedicated recruitment campaign.

13 Recruitment KPI Dashboard

Dave Sprawka reported that the dashboard shows trust wide and directorate recruitment data and that goes out monthly to be discussed at PRIMs meetings. The KPIs have been agreed with

divisions and it has been agreed that divisional nursing workforce plans will be shared with TMB. Going forward WRES and WDES data will also be included quarterly. The dashboard shows an overview of active vacancies and equality representatives are on panels to ensure the panel is as diverse as is practical and they can halt the interview processes at any time if that is not the case. The KPI is 90% and the trust currently stands at 97%. The overview of performance is split by staff group and KPIs are in column C, showing the number of working days taken. The recruitment team performance shows time taken to move through the process at each stage. There is a lot of data, generally green is good and red is not so good. Shortlisting issues are shown to be linked with people being on annual leave and not appointing deputies to act on their behalf. The trust is working on issues with pre-employment checks and there is a new process in Occupational Health which should help with capacity issues. The data is split by division and shows areas that need further support. The customer service response is low, and comms will go out to encourage people to complete questionnaires.

The last tab is broken down by medical staff which is useful for the two recruitment teams, one deals with medical staff and one deals with non-medical staff.

Regarding conversions around conditional offers for new staff, the Chair asked if recruitment could get rid of the time delay and give rates based on when people have started with the trust. Dave confirmed it could. Dave confirmed that the data includes both internal and external applicants. Diane Hughes stated that the trust is encouraging career progression internally and she asked if that could be improved. Dave stated that he will explore that with TRAC.

Robert Pickersgill asked about the issues of the interview process and if the increasing trend was internal applications. Dave confirmed that the trend is not linked to internal applicants, he is watching that, because the trust does not have more vacant posts. This is restricted to one return to the customer service response, it is an isolated incident and Dave is looking into that. It could be that some jobs are only advertised internally, and they should go out externally, only in a specific set of circumstances should vacancies be advertised internally. Robert added that bias can often arise you need to make sure your objectives are clear. Christine Brereton added the trust is running some unconscious bias training for recently new managers, this is quite powerful stuff and includes equality champions on panel as well.

14 Trust Board Highlight Report

The following would be highlighted to Trust Board:

- Achievements with Leadership Strategy
- WRES Annual Report and WDES Annual Report
- Recruitment Dashboard
- Committee approved the Medical Revalidation Report

Robert Pickersgill asked if the Chair wanted to add, the committee's responsibility regarding the BAF, he felt it was still a bit of a puzzle, there needs to be ownership of updating the relevant sections as it looks out of date. Christine Brereton confirmed it was her responsibility and she agreed to make sure it is updated. The Chair confirmed she would have a discussion with NEDs and she wouldn't add this to the highlight report.

Robert added that at the Audit, Risk and Governance Committee some things in the risk register are not in the BAF and he felt that is a worry. The Chair advised that NEDs have asked for risks associated with each BAF item to be circulated with the BAF reviews to ensure that the BAF reflected these risks.

15 Items for information (not for printing)

15.1 Minutes of the Health and Wellbeing Steering Group meetings held on 27 April 2022 and 25 May 2022

Nothing discussed.

16 Any Other Urgent Business

Nothing discussed.

16.1 Workforce Committee Annual Workplan - July 2022

Accepted by the Committee for proposal to the Board.

17 Date, time, and venue of next meeting:

Tuesday, 20 September 2022 at 14:00 hours via Microsoft Teams

The meeting closed at 15:51 hours

Cumulative Record of Workforce Committee Attendance (2022/2023)

Attendee Name	Possible	Actual	Attendee Name	Possible	Actual
Michael Whitworth	2	1	Sean Lyons	2	1
Michael Proctor	2	1	Peter Reading	2	1
Fiona Osborne	2	2	Robert Pickersgill	2	2
Maneesh Singh	2	1	Helen Harris	2	1
Christine Brereton	2	2			

NLG(22)189

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	4 October 2022	
Director Lead	Simon Parkes, NED / Chair of Audit, Risk & Governance Committee	
Contact Officer/Author	Simon Parkes	
Title of the Report	**Audit, Risk & Governance Committee Minutes of meeting held on 10 June 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Audit, Risk & Governance Committee held on 10 June and approved at its meeting on 27 July 2022.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: ARG Committee
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Oversight of entire BAF process, completion and achievement.
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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MINUTES

MEETING:	Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**	
DATE:	**10 June 2022** via MS Teams	
PRESENT:	Simon Parkes	Chair of ARG Committee / Non-Executive Director
	Gill Ponder	Non-Executive Director
IN ATTENDANCE:	Lee Bond	Chief Financial Officer
	Peter Reading	Chief Executive Officer
	Mike Norman	External Audit – Auditor (Mazars)
	Helen Higgs	Managing Director / Head of Internal Audit (Audit Yorkshire)
	Chris Boyne	Deputy Director / Internal Audit Manager (Audit Yorkshire)
	Danielle Hodson	Assistant Internal Audit Manager (Audit Yorkshire)
	Sally Stevenson	Assistant Director of Finance – Compliance & Counter Fraud
	Nicola Parker	Assistant Director of Finance – Planning & Control (Item 6.1)
	Ade Beddow	Associate Director of Communications & Engagement (Item 6.5)
	Rob Pickersgill	Governor Representative
	Anne Sprason	Directorate Admin Manager / PA to CFO (Minutes)

Item 1 06/22 **Welcomes**

Simon Parkes welcomed Peter Reading, Chief Executive, to the meeting, which was to approve the accounts and other year-end related audit matters.

Item 2 06/22 **Apologies for Absence:**

Apologies received from Sean Lyons; Michael Whitworth; and Helen Harris.

Item 3 06/22 **Declarations of Interests**

Simon Parkes asked if there were any additional declarations of interest not otherwise disclosed on the Trust Declaration system. None were advised.

Item 4 06/22 **Minutes of Previous Meetings**

4.1 The minutes from the meeting held on 21 April 2022 were agreed as an accurate record.

4.2 The Highlight Report from 21 April 2022 had been provided and noted.

4.1 Minutes from the meeting held on 21 April 2022.

Simon Parkes referred to an issue raised by Christine Brereton that a previous discussion held by the Committee did not accurately reflect the substance of what was happening in relation to the issue under discussion. Peter Reading confirmed that Christine Brereton had raised this concern with him, adding that it was no criticism of anyone at the meeting. Simon Parkes agreed that any clarification could be appended to the minutes.

Peter Reading stated that when discussions took place relating to particular Directorates the Executive Director should be invited to attend to ensure that the full story was told. Simon Parkes stated that Directors were welcome to attend the ARG Committee meetings for items relating to their area of responsibility and suggested reviewing the papers as early as possible and invite the relevant Director if required.

Lee Bond noted that the concerns raised in fact referred to the previous meeting (24 Feb 2022) minutes which went to the April 2022 Trust Board meeting, in respect of the discussion on Internal Audit Follow-up Recommendations.

Lee Bond asked if all Executive Directors should be invited to the discussion on the audit recommendations as it covered the entirety of Executive Directors. Peter Reading advised that this would not be necessary. It was agreed therefore that the dates of the meetings would be sent to all Executive Directors, with an expectation that they would only attend if invited to discuss a particular issue relevant to their Directorate.

Simon Parkes commented that the Internal Audit recommendation follow-up report covered all Directorates and it was difficult to know what the Committee would raise in the meetings, however he agreed he would try and anticipate areas that may require further discussion either in terms of follow-ups or Internal Audit reports.

Following discussion on the minutes from the February 2022 meeting the minutes from the last meeting held on 21 April were agreed as an accurate record of the meeting.

4.2 Highlight Report

The highlight report from the last meeting had been provided and noted.

Item 5 06/22 **Matters Arising/Review of Action Log**

Deferred to the next full meeting in July 2022.

Item 5 06/22 **Public Disclosure Statements**

6.1 Audited Annual Accounts 2021/22

Lee Bond presented the report and highlighted the very helpful summary provided by Nicola Parker, which identified the narrative and numeric changes since the draft accounts had been reviewed at the last meeting.

Lee Bond also referred to the Statement of Comprehensive Income (SOCI) on page 3 of the accounts and the discussion at the last meeting where it was agreed to show both the adjusted financial performance surpluses for the Trust and ICS for completeness i.e. £86k and £43k respectively.

There were no questions raised and the accounts were agreed.

6.2 Audit Completion Report / Management Letter of Representation 2021/22

Mike Norman presented the report which was a summary of findings and opinion in relation to the accounts audit process and referred to the main summary (page 5) and confirmed that an unqualified opinion was still expected to be issued. Mike Norman added that there were no additional issues to report on VFM, or any other areas, there were no material amendments and no unadjusted misstatements, and that they expected to complete by the National Audit Office deadlines.

Mike Norman briefly highlighted areas to note within the Report including:

- Assets - land and building had some outstanding queries with Valuers but nothing outstanding to the report presented.
- Annual Report – The usual checking process would be undertaken and it would be confirmed if any further changes were to be made
- Closing procedures – subject to approval by the ARG Committee the opinion would be issued.
- Section 5 – One low priority recommendation related to the new ledger with acknowledgement of the mitigations put in place.
- VFM – Split reporting in relation to audit opinion and auditor report. Following the meeting the Trust would receive a draft and full commentary. No additional significant recommendations were to be made.
- The Regulator's judgement in relation to quality and financial special measures was an automatic reference that needed to be included.
- Letter of Representation (Appendix A) – One slight change, which was common across the sector, related to the Russia / Ukraine situation; no impact had been identified.

Mark Surridge confirmed that this gave the Committee the ability to adopt the accounts and stated that it was one of the cleanest reports that had been issued this year and acknowledged the pandemic challenges and additional challenges from NHSE/I - twice in the same period. Mark Surridge stated that nationally the standard of accounts had deteriorated whereas NLAG's had not, which was testament to the quality of the work that the Finance team continued to deliver quality accounts under enormous pressures and thanked Nicola Parker and the whole Finance team.

Simon Parkes noted the opinion on the VFM aspect given the Trust was still in special measures, but that could not be changed and was looking forward to having them removed for the following year. Peter Reading echoed this view, and stated that understood and accepted it, but also hoped it would be removed next year.

Simon Parkes expressed, on behalf of the Committee, congratulations to Lee Bond, Nicola Parker and the Finance team on the high quality of the accounts. They had been produced in draft format in a timely way and concurred with the auditors that it was a very good piece of work, adding that he was not used to seeing no unadjusted misstatements and it was unusual for accounts to be this good. Simon Parkes asked for it to be formally recorded on the quality of the work during a difficult time and added his personal thanks to Nicola Parker and the team. Simon Parkes also provided confirmation in respect of the new Ukraine question.

6.3 Annual Governance Statement 2021/22 (AGS) – final version

Peter Reading presented the report in the absence of both Helen Harris and Alison Hurley. Peter Reading confirmed the AGS was a fair representation and was happy to put his name to it.

Gill Ponder referred to Finance and Sustainability on page 23 (10.1) specifically paragraph two and suggested the last sentence could be worded to make more sense. Lee Bond also noted the following paragraph, in the same section, which was a duplication. Peter Reading agreed to revisit and amend.

Action: Peter Reading

Post meeting note: The Finance and Sustainability section was duly revisited and slightly reworded by Lee Bond and signed off by Peter Reading for inclusion in the final version of the AGS.

Subject to the amendments the Committee agreed that the statement could be signed. Peter Reading asked that thanks be placed on record to Alison Hurley for taking the lead in the production of the document, in the absence of Helen Harris.

6.4 Head of Internal Audit Opinion (HoIAO) 2020/21

Helen Higgs presented the report which had been updated to include the number of recommendation follow-ups that had been completed or had revised dates added, acknowledging the effort by the Trust to address these with a pleasing result in the end. She stated that it would be preferable to see a natural process across the year rather than a flurry of activity at year-end. A 'Significant Assurance' rating had been given in the HoIAO.

Peter Reading thanked the Internal Auditors for working collaboratively and having a very good relationship with the Trust over the last year. In terms of chasing up recommendations he asked if the position deteriorated in the future to contact him directly so that he picks up with the individual Executive Directors as their line manager. This was duly noted. Peter Reading acknowledged that it had been an exceptional year due to the ongoing pandemic and the Directors had been distracted and therefore not able to give full support to the follow-up process.

Peter Reading noted there was one limited assurance report i.e. Medical Job Planning and speaking on Kate Wood's behalf that by 31 March 2022 the Trust had 80% of job plans signed-off which was the best the Trust had achieved and compared well across the region. Peter Reading highlighted that the Medical Director only took responsibility for Job Planning in May 2021 and whilst the historical job plans had not been completed, each clinician had a detailed matrix which required sign-off. Peter Reading asked that the substantial progress made during this period since the audit report was originally issued was recorded in the minutes. Simon Parkes confirmed agreement to minuting this positive progress.

Helen Higgs highlighted that the Auditors would look to continue tracking recommendations, but good progress had been made, and agreed to highlight any issues to Peter Reading's attention.

Simon Parkes highlighted that it had been discussed at the Auditors/NEDs meeting, prior to the meeting, and acknowledged the pressure that the Trust had been under over the last two years so it was good to get to the position at the end of the year and hoped that it would he possible to keep on top of it throughout the next financial year. Simon Parkes stated he was grateful for the work done to get to the current position.

6.5 Trust Annual Report 2021/22

Adrian Beddow attended the meeting to present the Annual Report and highlighted the gaps that would be completed over the course of the following week including a complete proof-read. He noted there should be no material or substantial changes to be made to the draft presented at the meeting.

Gill Ponder noted some amendments required as follows:

- Page 18, reference to theatres closing in 2018/19 which needed to be deleted.
- Page 70, responsibility of Finance & Performance Committee only referred to Finance and not Performance or Estates.
- Page 90, paragraph 2 – NEDs attending COG sub-group which was now replaced by GAG (Governors Assurance Group)
- Page 104 – Simon Parkes appeared to have attended seven RATs Committee meetings out of a possible six.

Lee Bond noted that Sean Lyons was referred to the Annual Report as Joint Chair whereas he was in fact Chair of two separate organisations. Peter Reading confirmed this would be changed.

With the above noted it was agreed that Adrian Beddow would review and amend the report as necessary.

Action: Adrian Beddow

Simon Parkes commented that overall, it had been very good to get statements to where they were and be able to sign-off accounts later in the month. It was noted that the Letter of Representation would be signed-off when the VFM section had been completed.

Simon Parkes commented that he would look forward to the Annual Report being finalised and put together with everything else.

3.20pm Adrian Beddow left the meeting.

Item 7 06/22 **Internal Audit (Audit Yorkshire)**

7.1 Internal Audit Progress Report

Danielle Hodson attended the meeting and presented the progress report which included several reports from the 2021/22 plan, issued since the last meeting i.e. three final reports and three in draft i.e. Clinical Harm & Risk Stratification and Waiting List Management; Use of Agency Staff; and Data Security and Protection Toolkit. All audit reports had been given Significant Assurance, with Financial Ledger (Transfer of Balances), given High Assurance with no recommendations made.

Rob Pickersgill was intrigued on the smoothness of the transition of the new financial ledger which he stated was a credit to the Finance staff to achieve that during the year with everything else going on, and asked if the e-financial system was standard for the sector. Nicola Parker explained that it was not standard across the whole NHS but HUTH used the same system with a shared service for transactions.

Lee Bond referred to the Managing Resources audit, which reviewed the effectiveness of the Resource Centre in managing the Trust's workforce requirements specifically rota management and stated that the recommendations will form a useful starting point for conversation later in the year.

Following discussion, the report was noted.

7.2 Annual Internal Audit Report 2021/22

Chris Boyne presented the report which was a combination of everything brought to the Committee throughout the year and had nothing further to highlight. It was a good result and noted the flexibility required throughout the year. He thanked Lee Bond and Sally Stevenson for their support since taking over as Auditor Manager for NLAG.

Simon Parkes stated that the challenge within the Trust was recognised and thanked the Internal Auditors for the flexibility shown throughout the year.

Item 8 06/22 Documents for Review / Approval

8.1 Audit, Risk and Governance Committee Annual Report 2021/22

Simon Parkes presented the report and asked if there were any comments before approving it for submission to the Trust Board and Council of Governors. Sally Stevenson advised that she would update the report to reflect the number of reports now finalised and the improved position in terms of outstanding internal audit recommendations.

Action: Sally Stevenson

Following the discussion, the report was approved.

Item 9 06/22 Any Other Business

9.1 Board Assurance Framework and Strategic Risk Register (Q4)

Simon Parkes noted that the BAF Q4 had not been to the April 2022 meeting as it was not ready at that point, and as it had since been to Trust Board there was nothing to highlight.

Rob Pickersgill raised the future of the economic environment particularly supply chains, drugs etc. and could not believe that there were no threats associated to it. Simon Parkes stated that such issues would be in the BAF if they were considered to be a significant risk and would be picked up at the appropriate Committee, including the Finance & Performance Committee. He explained that it was the remit of the ARG Committee to ensure the BAF process was functioning as expected and overall assurance was appropriate; individual items were picked up in other Committees.

Peter Reading agreed that Rob Pickersgill was right to raise the issue, making a comparison with Brexit, noting the issues with supply of oil from Ukraine was affecting the Trust kitchens but mitigation was in place to make the oil last longer where possible, etc. He added that supply chain issues were picked up on an ad hoc basis as necessary. Peter Reading also highlighted that the capital works programme had been affected but good business continuity arrangements were in place. Lee Bond noted that risks were picked up through the risk register and risk management processes and not the BAF which related to risks to strategic objectives. Lee Bond went on to say that they also talk to supply chain on a regular basis to understand emerging issues.

Rob Pickersgill referred to an OECD (Organisation for Economic Co-operation and Development) report predicting a recession next year and with supplier insolvencies needed to be aware. Simon Parkes acknowledged that they were good points made but explained they were recognised by the organisation and on people's agenda as Peter Reading had set out. The issues raised would relate to specific areas within the Trust and reflected in their reporting or the risk register which was more appropriate and would then be escalated to the BAF through the usual routes.

Peter Reading added that business continuity was included in the BAF and tested noting specifically during the pandemic it was tested regularly, however it was hard to predict if drugs or equipment would be in short supply but each Department had ways to adequately respond and adjust accordingly.

Gill Ponder also noted that the Finance & Performance Committee was assured by the business continuity plan presented to it.

9.2 Any Other Urgent Business

There was no other urgent business raised.

Item 10 06/22 Matters for Escalation to the Trust Board

The following items were agreed to be escalated to the Trust Board.

- Assurance on financial statements
- Internal Audit Opinion
- Modifications to the VFM Opinion to be explained

Item 11 06/22 Matters to Highlight to other Trust Board Assurance Committees

There were no issues to highlight to other Trust Board Assurance Committees

Item 12 06/22 Review of ARG Committee Workplan

The ARG Committee workplan was noted.

Item 13 06/22 Review of the Meeting.

Simon Parkes advised he was happy to take any comments in terms of the meeting. Gill Ponder noted the whole process to get the end of year documentation signed-off was testament to the quality of the documents and had been a painless and incredibly smooth process, which in turn meant the ARG Committee meeting had gone smoothly.

Simon Parkes agreed that it was fortunate to have the draft statements the previous month which made the process easier. He was grateful to both Internal and External Auditors for their contribution and their work over the last year. He added that it was sad if Mazars were not able to continue and if this was to be their last meeting, he was grateful for everything they had done to support the organisation.

Item 20 06/22 Date and Time of the next full meeting

The next meeting was scheduled as follows:

Wednesday, 27 July 2022 – 1.00pm-4pm via MS Teams

NLG(22)190

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	4 October 2022	
Director Lead	Neil Gammon, Chair of Health Tree Foundation Trustees' Committee	
Contact Officer/Author	Lee Bond, Chair Financial Officer	
Title of the Report	**Health Tree Foundation Trustees' Committee Minutes of meeting held on 14 July 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Health Tree Foundation Trustees' Committee held on 14 July and approved at its meeting on 8 September 2022.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: HTF Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **14 July 2022 – Via Teams Meeting**

Present:	Neil Gammon	Independent Chair of HTF Trustees
	Gill Ponder	Non-Executive Director
	Maneesh Singh	Associate Non-Executive Director
	Peter Reading	Chief Executive
	Lee Bond	Chief Financial Officer
	Jug Johal	Director of Facilities
	Paul Marchant	Chief Financial Accountant
	Clare Woodard	HTF Charity Manager
	Victoria Winterton	Head of Smile Health
In attendance:	Lucy Skipton	HTF Community Champion
	Simon Leonard	Communications Assistant
	Lauren Short	Finance Admin Assistant (For the Minutes)

Item 1 07/22 **Apologies for Absence**

Apologies for absence were received from: Mike Proctor; Ellie Monkhouse, Kate Wood and Christine Brereton.

Item 2 07/22 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declarations of Interests". None were raised.

Item 3 07/22 **Minutes of meeting held on 5 May 2022**

The minutes of the meeting held on 5 May 2022 were reviewed for accuracy and completion of actions with the following amendments:

- 9.1 – 'k' missing on the money
- Job title of Victoria Winterton to be updated to Head of Smile Health

Item 4 07/22 **Matters Arising**

4.1 Proposed new HTF KPIs

Clare Woodard felt this was a good opportunity to look at HTF performance indicators since securing the new contract and look to see how they better reflected the charities goals and ambitions.

The KPIs have now been split into different sections:

- Financial
- Engagement
- Patient Centred

Both Clare Woodard and Victoria Winterton drafted these KPIs and sought feedback from the wider team, Neil Gammon, finance, and the communications team to ensure all bases were covered before presenting to Trustees. Clare welcomed the Trustees' views.

Neil Gammon asked for input regarding the financial section first.

Jug Johal expressed an interest in having an additional KPI which focused on every £1 raised, how much of that gets spent on improving outcomes and management costs. Jug thought this would be a powerful KPI to have going forward. Clare Woodard confirmed that this is already reported within the monthly accounts which Paul Marchant reports on, however this will also be added to the KPIs.

Victoria Winterton confirmed that work would take place to identify four or five similar NHS charities that HTF can compare with comfortably, as this information would be helpful.

Neil Gammon moved on to ask Trustees to review the engagement sections and to pose any questions.

Gillian Ponder queried what is meant by the 10% at three months in relation to the £5k.

Neil Gammon confirmed there being lots of wishes funded under £5k/£10k and that it would be difficult to gain and monitor feedback for all of those wishes, therefore it was agreed to monitor and review just 10% coverage.

Gillian Ponder was not sure on what the value for money this work would arm Trustee's with as there is not much of a review taking place for scrutiny.

Neil Gammon asked other Trustee views on the subject, adding that a trial may be worth undertaking for 9 or 12 months. If Trustees then feel it is not achieving what it is intended to do, the work could be cancelled. He noted that the HTF team is not a large team and that it would be unnecessary to expand its size.

Gillian Ponder was worried about driving up admin costs and diverting valuable resource which could be generating funding or helping the HTF spend their funds, with the work undertaken for the 10% reviews not being viable.

Maneesh Singh agreed with Gillian Ponder but wondered whether it was worth completing a one-time trial to review the data collected and monitor the administration work required.

Victoria Winterton explained that the low value wishes can sometimes be the most beneficial to patients. These stories are usually posted in the Wish Wednesday posts on social media and then fed into the Newsletter. She confirmed that the process is managed effectively, hence why the figure of 10% feedback was chosen. She was in favour of the trial for a couple of months.

Action: Clare Woodard

4.2 Capital Depreciation Cost Discussion (updated Circle of Wishes form)

Neil Gammon asked Trustees to review the attached document, noting the added section relating to capital depreciation costs for wishes.

Jug Johal queried which group had been agreed to have oversight and review of those wishes where capital funding is required.

Clare Woodard confirmed that the Equipment Group have oversight of these requests, with nothing being finalised until agreement has been sought from the Equipment Group.

Lee Bond focused more on the need to understand the revenue costs and consequences associated with the wishes and gave helpful examples for Trustees to understand.

For examples, purchasing equipment such as scanners, the Trust may require additional staff to run the equipment.

Clare Woodard was content with the information provided to enable her to update section 10 of the wishes form.

Action: Clare Woodard

4.3 Fairchild Legacy Project Plan

Clare Woodard touched on the ongoing research and work being completed to ensure this legacy is spent appropriately. Her recommendation was to ask for the relevant departments to come and present their wishes in relation to providing a dementia friendly Trust.

Gillian Ponder found the paper helpful in explaining how to address some of the challenge's patients face and thought it brought unimaginable issues to life. Gillian Ponder supported Clare's proposed recommendation.

It was agreed for Clare Woodard to ask Jackie Fenwick and Melanie Sharp to present the proposed wishes at the next committee meeting in September.

Action: Clare Woodard

Gillian Ponder asked whether there could be a reference somewhere as to who had provided this amazing legacy.

Peter Reading offered his support to Gillian Ponder's point and proposed that the legacy be suitably marked at the entrance to Scunthorpe Hospital.

It was agreed for Clare Woodard to investigate and report back at the September committee meeting.

Action: Clare Woodard

Item 5 07/22 **Review of Action Log**

- Trustee Development – Clare Woodard has set a diary date for 3 November 2022 after the HTF Trustees' committee meeting takes place. Neil Gammon trusted that the Trustees have received this notification in their diaries.

- Fairchild Legacy – Update covered in the item 4.3

- QI Teams – Meeting set up for 25th July 2022 to discuss ongoing projects.

Item 6 07/22 **Items for Discussion / Approval**

None.

Item 7 07/22 **Updates from Health Tree Foundation**

7.1 HTF Manager Update Report

Clare Woodard took the report as read and highlighted the following key points within the report:

- The Stage 2 community funding that HTF received from NHS Charities Together has now been distributed to the 18 community projects. This committee will receive progress reports throughout these projects' lives.
- The A&E fund raising appeals for both sites have raised almost £70k with some of the equipment already delivered, for DPOW especially. The fund raising will officially come to an end when both units are up and running.
- A working group has been created to improve signage and way finding across the 3 sites and consideration will be given to this project being funded or part funded by HTF.

Peter Reading was delighted with the work happening regarding the signage as this will massively improve patient experience and reduce the number of times patients become lost with all the emotions and physical distress which comes with this immediately before their appointments.

This issue had been raised via staff on Ask Peter, Governors and by the CQC when they undertook their inspection.

Peter Reading stated that would be of huge patient benefit, once the main building work has been completed, understanding that this will be expensive and welcomed HTF funding to get it right first time, walking the routes thinking like a patient.

Gillian Ponder commented this is a small change which will have huge benefit with it being an excellent opportunity to co-design it with patients and visitors as they are the experts on this. This is particularly important when it comes to medical terminology on signs.

Maneesh Singh asked Jug Johal whether there is a digital way of mapping the directions for patients.

Jug Johal informed members that there is an NHS app available, however with the demographics of the patients, some of whom are frail and elderly, we cannot assume that they are digitally able to use this facility. Traditional signage is the best, however NLAG's at present is far too complicated.

Peter Reading agreed with Jug Johal and stated that disabled members of the public would struggle for example those who use crutches with using a digital device to gain directions.

Gillian Ponder also made a point regarding patients and visitors who may have to switch between a pair of glasses for different vision control as digital would not be the best facility for those members of the public either.

Neil Gammon was pleased to see greater engagement by members of staff, coming forward with ideas to raise money and hitting £35k in June 2022.

Neil Gammon queried the progress of the HTF newsletter, and Clare Woodard confirmed that they are issued quarterly and are also attached to all the thank you letters which are sent out acknowledging donations.

7.2 HTF Staffing Updates

Victoria Winterton will be commencing maternity leave towards the end of the year. Smile had undertaken an internal recruitment process for her cover in which Clare Woodard had been successful.

As a result of that a process now needs to take place to provide cover for one year for the Health Tree Foundation Manager. In the past there has been Trustee involvement so Neil Gammon urged Trustees to contact him directly if they would be happy to be involved in the process.

The recruitment process is to take place in August 2022.

7.3 Sparkle Project Officer Contract Extension

Clare Woodard provided background information as to why this post was originally required and requested a contract extension of 12 months (ending August 2023) which would allow the team to complete outstanding projects and which would in turn encourage more ideas for improvements throughout the Trust.

Jug Johal was in favour of the extension as staff within Estates and Facilities are stretched with all the capital schemes taking place at the moment. Having a specified Sparkle Project Officer to work on these projects is a huge benefit and help to the Trust as evidenced by the progress made since the current incumbent took up post in September 2021.

Neil Gammon touched on this post being an NLAG post on Agenda for Change T&Cs with 80% of the costs funded by HTF. Human Resources have advised that once a temporary contract reaches 2 years, the employee has full employment rights.

Discussions took place and it was agreed that the Sparkle Projector Officer post would be required for as long as HTF keep fundraising, therefore the view of Trustees was to make the position permanent.

Jug Johal urged for the conversation to be had with the person currently in post.

Clare Woodard to liaise with Human Resources to make the temporary position a permanent one.

Action: Clare Woodard

Item 8 07/22 **Sparkle Programme**

8.1 Sparkle Update

Neil Gammon noted the amount of progress made since the Sparkle Project Officer took up post, making a huge difference to patients and staff.

Neil Gammon asked for any comments on the report. There were none.

Item 9 07/22 **Finance Update**

9.1 Finance Report – June 2022

Paul Marchant presented the Finance report and highlighted the key points, including;

- Income for the 3 months to June 2022 is £424k which includes £233k of NHSCT grant income. This was not in the plan but has now been included in the full year forecast. When NHSCT grant income is excluded, income is £191k, which is £27k less than budget.
- Expenditure for the 3 months to June 2022 is £427k which includes £233k of NHSCT grant payments. When these are excluded expenditure is £194k, which is £25k less than budget.
- Equipment purchased in the 3 months to June includes: Feature Ceiling for DPOW A&E £29k, MotoMed Exerciser £7k and ECG & trolley £7k.
- The CCLA Investment Fund was revalued on 30th June resulting in a loss of £121k. Investments will be revalued again at 30th September.

Jug Johal stated that the figures are fantastic and that the HTF needs to be shouting about them and referred to an infographic which some other Charities currently use on their websites.

Gillian Ponder expressed her disappointment regarding the amount of money the charity is holding with there being not one wish to approve on the meeting agenda.

Neil Gammon noted this disappointment and confirmed that he would do what he could to encourage the submission of more wishes through several different avenues, including making the Trust Board aware when he presented the HTF Trustees' Committee Highlight Report at the August 2022 Public Trust Board.

Peter Reading requested a meeting with Clare Woodard to discuss her attending the Trust Management Board and Senior Leadership Briefing to give a short presentation, and to contact Ellie Monkhouse with a view to attending the monthly Nursing and Midwifery forum.

Item 10 07/22 **Any Other Business**

None.

Item 11 07/22 **Matters for Escalation to the Trust Board**

It was agreed that Neil Gammon would highlight the following to the Trust Board:

- New KPIs
- Fairchild Legacy progress
- Sparkle Project Officer position

Item 12 07/22 **Date and Time of the next meeting:**

Thursday 8th September 2022
1:00pm – 3.30pm
Via MS Teams

Attendance Record:

Name	Sept 2021	Nov 2021	Jan 2022	March 2022	May 2022	July 2022
Neil Gammon	✓	✓	Cancelled	✓	✓	✓
Peter Reading	✓	✓		✓	✓	✓
Terry Moran						
Linda Jackson	-	Apols				
Gill Ponder	Apols	✓		✓	✓	✓
Mike Proctor	-	✓		✓	Apols	Apols
Maneesh Singh	✓	✓		✓	✓	✓
Lee Bond	Apols	✓		✓	✓	✓
Jug Johal	✓	Apols (Rep)		Apols	-	✓
Kate Wood	✓	✓		✓	✓	Apols
Ellie Monkhouse	Apols (Rep)	Apols (Rep)		✓	Apols (Rep)	Apols
Christine Brereton	✓	Apols (Rep)		-	✓	-
Paul Marchant	✓	✓		✓	✓	✓
Andy Barber	Apols	-		-	-	-
Victoria Winterton	✓	✓		Apols	✓	✓
Clare Woodard	✓	✓		✓	✓	✓
Adrian Beddow	✓	Apols (Rep)		-	-	-
Ian Reekie (Governor)	Apols	-				
Tony Burndred				✓	-	-
Total	**9**	**10**		**10**	**10**	**9**

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	4/10/2022
Director Lead	Adrian Beddow, Associate Director of Communications
Contact Officer/Author	Charlie Grinhaff, Communications Manager
Title of the Report	**Communications Round up – October 2022**
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights some of the key projects the Communications team are working on to improve staff morale and engagement and reputation through external communications. It covers July and August 2022 and includes an overview of team plans and progress. The Trust Board is recommended to note the report.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ✓ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

October 2022

Kindness • Courage • Respect

October update 2022 – covering July and August

Contents

Headlines

Progress and plans

Improve Trust reputation through external communications and patient experience	Improve staff morale and engagement
What we've already done • Launched a new website in line with accessibility requirements • Consistently achieved goals around responsiveness to media enquiries • Responded to 95%+ FOIs within statutory time limits.	**What we've already done** • Created a regular drumbeat for internal communications – Monday Message, Weekly Wednesday News, Building our Future on Thursdays and #ThumbsUpFriday • Put in place a new Thank You System for staff to easily share compliments boosting morale • Created a safe space for staff to raise concerns via the Ask Peter forum • Set up a staff Facebook group to reach staff with no access to the Hub/emails (3.8k members) • Introduced Team Brief Live • Re-invigorated the way we swapping #ThankYouTuesday for #ThankYouNHS has so far had 92,000 impressions
What we're working on • How we can work more closely with our local media, providing positive news stories • Introduce more video content where relevant • Reviewing our social media channels	**What we're working on** • Targeted line management communication • Work with senior leaders on their approach to engagement and communication • Supporting the People division with the Health and Wellbeing and Culture Transformation work.

Supporting the Trust's priorities

Trust Priority 1 – Our People
Our team supported and attended the culture transformation launch – Be The Change – and our Big Conversation.

In total, there were 471 ideas, 350 comments and 5,174 votes during our Big Conversation and the ideas will soon be worked through and the achievable actions will be decided and shared with staff.

We've now held three Team Brief Live events which have covered topics including Digital, Estates and Facilities and the culture transformation programme.

Trust Priority 2 – Quality and Safety

We supported the Trust Learning Group with a week long campaign called Sepsis 6 – more than just ticks. We're limited with the analytics we can do, especially on the Hub so don't have access to how many people read the blogs on the Hub announcements or opened the pdfs on the hub page, or clicked on the ESR banner or read the Wednesday Weekly News article but we can access the following stats:

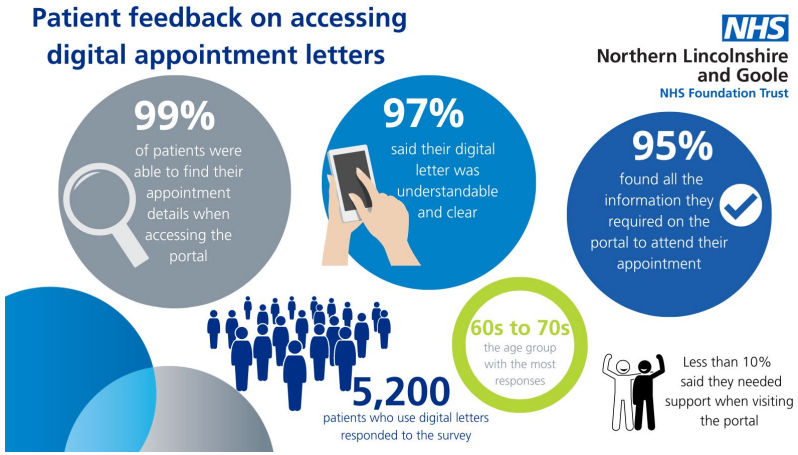
Sepsis hub page (via hot topic)– 118 views during the week
Staff facebook group posts:
Post 1: 1470 reach, 6 likes, 11 photo views
Dr blog: 1034 reach, 5 likes, 5 photo views
Nursing blog: 1251 reach, 7 likes, 5 photo views

Supporting the Trust's priorities

Trust Priority 3 – Restoring Services
We continue to support the various workstreams around outpatient transformation: digital letter rollout, PKB and PIFU. We created this infographic to highlight the success of the digital letter project:

Trust Priority 4 – Reducing Health Inequalities
We have continued to support both the tobacco dependency staff and public agenda, sharing this with staff in a recent Monday Message, with more news coming soon on the staff offer. We are also looking to share some case studies and success stories from our Alcohol Care Team.

Trust Priority 5 – Collaborative and System working
The whole team met with the new ICB Communications Director to explore ways of working together in close partnership



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Supporting the Trust's priorities

Trust Priority 8 – Capital Investment
The continued high level of interest and regard in our Trust's history and preserving that legacy became apparent when we had a 62% increase in unique visitors to our external Building Our Future web pages in August (compared to July) – most of which came as a result of sharing the first pictures of the memorial stonework in place at Scunthorpe ED. A number of members of the public contacted us to share stories about their family connections to the Trust and the original buildings.

Trust Priority 9 – Digital
Our focus during July and August has been on the improvements being made to our systems, structure and network by Digital Services. We shared news of the weekend Service Desk pilot, the changes to the ITSM and the importance of adopting Multi Factor Authentication to increase our Digital security.

Trust Priority 10 – The NHS Green agenda
We have promoted Adopt a Courtyard, the carbon footprint calculator, reusable water bottles, WEEE, the Arrive and Drive event at Scunthorpe, a smart cycling light project, Cycle to Work Day, Every Can Counts, donating old uniforms to Ghana, plastic recycling, Jacob's Well donations, sustainability tips and reducing internal mail.

Key Campaigns

Campaigns and awareness weeks

We supported and promoted Pride Month, MRI Safety Week, People's Pulse survey, Cycle to Work Day, World Breastfeeding Week, free security cycle events, Be The Change, a campaign to encourage more clinicians to use Attend Anywhere and a regional campaign around Patient initiated Follow Up.

Health Tree Foundation:
We sent out a news release on the charity cricket match with doctors at Scunthorpe General Hospital (SGH) vs local GPs. This raised funds for the new SDEC and IAAU currently being built at SGH. This was featured in local online media and staff were interviewed on BBC Radio Humberside. We also sent out a news release on Sue Hoodless who raised a total of £20,000 for The Pink Rose Suite at Diana, Princess of Wales Hospital (DPoW). Sue has battled breast cancer twice and raised the funds through a series of fashion shows. This story featured in local online and print media.

THE HEALTH TREE FOUNDATION
Your hospital charity

Improving staff morale and engagement

Keeping staff informed

All staff emails

Each week we send to all staff the Monday Message (a blog from a senior leader on a key topic), Wednesday Weekly News (an e-news round-up of news and updated) and on Thursdays we have a dedicated 'Building Our Future' update covering updates on the capital programmes in both estates and digital. In addition to this there are times when we need to issue a separate all staff email, such as promoting Covid and flu vaccinations.

NLaG Staff Facebook group

Our closed staff Facebook group continues to grow and is one of our most used communication channels. It's a useful way of reaching staff who do not work in front of a computer all day so have limited access to the Hub, emails etc. We have 3,800 staff members on there and popular topics include training and development, positive feedback for colleagues and celebrating long service. The group continues to be moderated by members of the Communications and OD team and any serious breaches of the group rules being escalated to HR.

"Issues, concerns and questions can be answered and disseminated to many staff throughout the Trust. It is a valuable site for positive feedback, staff well-being and information."
Staff Facebook Group member

Facebook group stats
3780 members
811 posts in this period
4,849 comments
15,744 reactions

Improving staff morale and engagement

Monday Message

Topics have included:

- Update following the Trust Board meeting
- Culture transformation - launch of Clever Together
- Health inequalities
- CQC inspection
- Augmented reality glasses
- Pride month
- Security
- Ockenden update

Senior Leadership Briefing

93 senior leaders attended the SLC briefing in July and 82 joined in August

Updates included:

Culture transformation

Finance update

Circle of wishes

Digital services update

82
Senior leaders attended the last SLC briefing

Improving staff morale and engagement

Giving staff a voice

Ask Peter
An extremely popular forum for staff to raise concerns and ask questions about absolutely anything.
There was an increase in the number of Ask Peter's in July (166) mainly due to changes to covid-19 sickness absence. This is the most received in one month since March 2020 when we were at the start of the pandemic. The board was quieter in August (40) due to it being closed for two and a half week due to Peter's annual leave.

Hot topics include bank incentives, working in the heat, mask wearing and parking permits.

206
Ask Peter questions

Staff Thank You
Since the 'Thank you' system launched in January staff have sent more than 820 compliments to their colleagues to date. These are emailed directly to the staff member and can also be shared with their manager and/or the Communications Team. Many of these are shared in the Wednesday Weekly News.

"Melanie Wood said thank you to Natasha Garnett: "Thank you so much for taking such good care of my little girl Lily during her A&E visit. You were amazing with her and it honestly made such a difference, not just for last night but for the long-term. I think you really helped relieve her worries about hospitals, as well as helping her thumb."

Improving reputation through external communications

Media coverage

There were 76 stories about the Trust in the media during this period. 89% of media coverage was positive or neutral in tone. In August 91% of the coverage was positive or neutral, a record since this report has been produced.
The majority of media coverage was in print or online media (87%)

We categorise the media coverage into themes – in this period '**service developments'** was the top theme, mainly due to the augmented reality glasses**. '**Care issues' and 'fundraising' were the next most categorised themes.

We issued 10 proactive news releases and the most covered was a story was the Augmented reality glasses which was covered locally, nationally and even internationally. Staff have been interviewed on this, our ED performance and the WebV/ePMA interface. We secured positive national media coverage for the digital letters project in 'Digital Health'

Community and Therapy Services have had the most positive media coverage.

89%
Of media coverage was positive or neutral

Media enquiries

52 media enquiries were handled in this time, 85% were dealt with within the requested timescale.
The majority of requests, 52%, came from print/online media outlets.

The top theme for media enquiries was press releases with 18 coming in on the back of proactive news releases. The main reason journalists got in touch was to request information. 3 reactive statements were issued in this period

85%
Of media enquiries dealt with on deadline

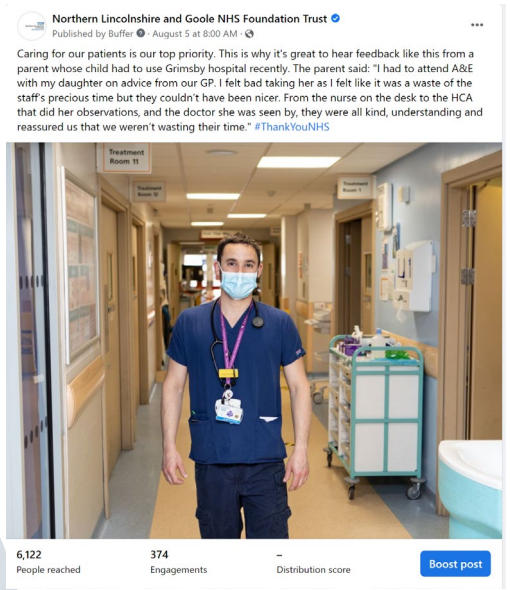
Improving reputation through external communications

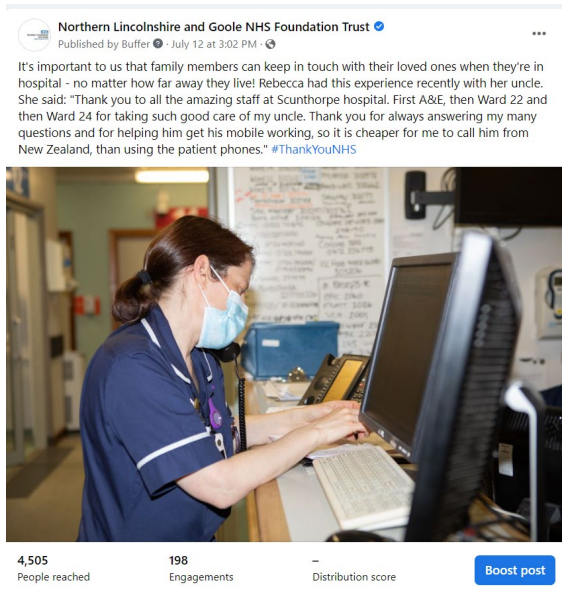
Social media

Followers update for the Trust's corporate accounts:

- 13,366 on the Trust's Facebook page
- 5,277 followers on Twitter
- 4,352 followers on LinkedIn
- We are rated 4.6 out of 5 stars on reviews on Facebook

We shared 20 #ThankYouNHS posts and 19 #ThumbsUpFriday posts in this period. Our new approach to sharing thank you's is working well and we continue to see much higher levels of engagement than the previous #ThankYouTuesday posts. So far there have been more than 92,000 post impressions. Examples in this period include:





Improving reputation through external communications

Twitter
Our top tweet, (by impressions) was a post celebrating the raising of th
Pride flag and our top mention was from Donna Smith in Community.

JUL 2022 SUMMARY

Tweets	81
Tweet impressions	32.6K
Profile visits	6,048
Mentions	181
New followers	54

AUG 2022 SUMMARY

Tweets	68
Tweet impressions	27.5K
Profile visits	7,179
Mentions	184
New followers	30

Top tweet July

Top Tweet earned 5,429 impressions

We recently raised the Pride flag at our hospitals in Scunthorpe, Grimsby and Goole! 🏳️‍🌈

We think it's important we make LGBTQ+ staff, patients and visitors feel safe and welcome and confident in accessing our services 💙 pic.twitter.com/8lZwwZoxcf

4 5 40

Top tweet August

Top Tweet earned 3,093 impressions

What a spectacle! Read about how some of our community nurses are testing futuristic specs which will free them up from admin duties giving them more time to spend on direct patient care. buff.ly/3A5UXFn pic.twitter.com/xD0VGZkrNx

3 10 24

Top mention July

Top mention earned 206 engagements

Donna Smith
@DSmithNLAG · Jul 8

Days like today the drive up to north Lincs doesn't seem so bad - excited to be spending some time with **#ucr** SPA & Unscheduled care **@NHSNLaG** today pic.twitter.com/jlkAvkZtRO

5 1 50

Top mention August

Top mention earned 106 engagements

Donna Smith
@DSmithNLAG · Aug 2

Found this on my desk from my lovely colleagues **@NHSNLaG** yesterday 😀 pic.twitter.com/Oqlb8XETQQ

4 37

This report covers July and August 2022

Improving reputation through external communications

Facebook page
The Facebook post with the highest engagement and reach was one promoting our Healthcare Assistant open days.

August 16, 2022 11:08am

Places are filling fast for our Healthcare Assistant open days in September! On the day you'll find out more about the role, be interviewed and possibly be offered a job on the same day. No previous caring experience required, all training is provided. Full-time and part-time positio

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
2,041	35	21,247	19,801	10.43%	—

Improving reputation through external communications

General enquiries

The team receives general enquiries via a form on the Trust website. In this period 141 were received and dealt with. These can be anything from chasing appointments and results to providing feedback on services. For many of these the team act as a conduit for the Trust and filter them to other teams to deal with, but some are more complex and take more time.

Freedom of Information requests (FOIs)

Complex FOIs are continuing to require more time than in the past to pull together an appropriate response which meets the statutory requirements. There were 123 submitted in this period – of these 113 are closed, 7 are still in progress and 3 are awaiting a response from the requester.

External website – www.nlg.nhs.uk

Key stats:

- 46,472 users, 77,091visits and 193,480 page views
- 74% of visitors were new users
- 00% of users were in the UK
- Safari was the top browser used to access the site followed by Chrome. IOS was the top operating system
- 80% of people came to the website via a search15% direct, 3.3% from social media (mainly Facebook) and 1.1% from other websites
- Most visited page: staff page followed by the Grimsby hospital home page

The top three news releases viewed on the website were ‘healthcare assistant open days’, ‘please return your nhs equipment’ and ‘smart glasses are a spectacle to behold’

141
General enquiries dealt with

123
FOIs received

193,480
Page views on our website

This report covers July and August 2022